Connecticut Quality Council
2024 Aligned Measure Set Annual Review
Measure Specifications for Measures to be Discussed During March 21st Quality Council Meeting

Asthma Medication Ratio (AMR)

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 5–64 years of age who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater during the measurement year.

Definitions

Oral medication dispensing event

One prescription of an amount lasting 30 days or less. To calculate dispensing events for prescriptions longer than 30 days, divide the days supply by 30 and round down to convert. For example, a 100-day prescription is equal to three dispensing events (100/30 = 3.33, rounded down to 3). Allocate the dispensing events to the appropriate year based on the date when the prescription is dispensed.

Multiple prescriptions for different medications dispensed on the same day are counted as separate dispensing events. If multiple prescriptions for the same medication are dispensed on the same day, sum the days supply and divide by 30.

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

Inhaler dispensing event

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

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

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

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

Injection dispensing event

Each injection counts as one dispensing event. Multiple dispensed injections of the same or different medications count as separate dispensing events. For example, if a member received two injections of Medication A and one injection of Medication B on the same date, it would count as three dispensing events.

Use the medication lists to determine if drugs are the same or different. Drugs in different medication lists are considered different drugs. Allocate the dispensing events to the appropriate year based on the date when the prescription was dispensed.

Units of medication

When identifying medication units for the numerator, count each individual medication, defined as an amount lasting 30 days or less, as one medication unit. One medication unit equals one inhaler canister, one injection, one infusion or a 30-days or less supply of an oral medication. For example, two inhaler canisters of the same medication dispensed on the same day counts as two medication units and only one dispensing event.

Use the package size and units columns in the medication lists to determine the number of canisters or injections. Divide the dispensed amount by the package size to determine the number of canisters or injections dispensed. For example, if the package size for an inhaled medication is 10 g and pharmacy data indicate the dispensed amount is 30 g, three inhaler canisters were dispensed.

Eligible Population

Product lines

Commercial, Medicaid (report each product line separately).

Stratifications

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

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

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

Ages

Ages 5–64 as of December 31 of the measurement year. Report the following age stratifications and a total rate:

- 5–11 years.
- 12–18 years.
- 19–50 years.
- 51–64 years.
- Total.

The total is the sum of the age stratifications for each product line.

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

Allowable gap No more than one gap in enrollment of up to 45 days during each year of continuous enrollment. To determine continuous enrollment for a Medicaid beneficiary for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage during each year of continuous enrollment.

Anchor date December 31 of the measurement year.

Benefits Medical. Pharmacy during the measurement year.

Event/diagnosis Follow the steps below to identify the eligible population.

Step 1 Identify members as having persistent asthma who met at least one of the following criteria during both the measurement year and the year prior to the measurement year. Criteria need not be the same across both years.

- At least one ED visit or acute inpatient encounter (ED and Acute Inpatient Value Set), with a principal diagnosis of asthma (Asthma Value Set).
- At least one acute inpatient discharge with a principal diagnosis of asthma (Asthma Value Set) on the discharge claim. To identify an acute inpatient discharge:
  1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
  2. Exclude nonacute inpatient stays (Nonacute Inpatient Stay Value Set).
  3. Identify the discharge date for the stay.
- At least four outpatient visits, telephone visits or e-visits or virtual check-ins (Outpatient and Telehealth Value Set), on different dates of service, with any diagnosis of asthma (Asthma Value Set) ***and*** at least two asthma medication dispensing events for any controller or reliever medication. Visit type need not be the same for the four visits. Use all the medication lists in the tables below to identify asthma controller and reliever medications.
- At least four asthma medication dispensing events for any controller or reliever medication. Use all the medication lists in the tables below to identify asthma controller and reliever medications.

Step 2 A member identified as having persistent asthma because of at least four asthma medication dispensing events, where leukotriene modifiers or antibody inhibitors were the sole asthma medication dispensed in that year, must also have at least one diagnosis of asthma (Asthma Value Set), in any setting, in the same year as the leukotriene modifier or antibody inhibitor (the measurement year or the year prior to the measurement year).

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

- Members who had a diagnosis that requires a different treatment approach than members with asthma (Respiratory Diseases With Different Treatment Approaches Than Asthma Value Set) any time during the member's history through December 31 of the measurement year. Do not include laboratory claims (claims with POS code 81).

- Members who had no asthma controller or reliever medications (Asthma Controller and Reliever Medications List) dispensed during the measurement year.
- Members who use hospice services (Hospice Encounter Value Set; Hospice Intervention Value Set) or elect to use a hospice benefit any time during the measurement year. Organizations that use the Monthly Membership Detail Data File to identify these members must use only the run date of the file to determine if the member elected to use a hospice benefit during the measurement year.
- Members who die any time during the measurement year.

Administrative Specification

Denominator The eligible population.

Numerator The number of members who have a medication ratio of ≥0.50 during the measurement year. Follow the steps below to calculate the ratio.

Use all the medication lists in the Asthma Controller Medications table below to identify asthma controller medications. Use all the medication lists in the Asthma Reliever Medications table below to identify asthma reliever medications.

Step 1 For each member, count the units of asthma controller medications dispensed during the measurement year. Refer to the definition of *Units of medications*.

Step 2 For each member, count the units of asthma reliever medications dispensed during the measurement year. Refer to the definition of *Units of medications*.

Step 3 For each member, sum the units calculated in step 1 and step 2 to determine units of total asthma medications.

Step 4 For each member, calculate the ratio of controller medications to total asthma medications using the following formula. Round (using the 0.5 rule) to the nearest whole number.

$$\frac{\text{Units of Controller Medications (step 1)}}{\text{Units of Total Asthma Medications (step 3)}}$$

Step 5 Sum the total number of members who have a ratio of ≥0.50 in step 4.

Asthma Controller Medications

Description	Prescriptions	Medication Lists	Route
Antibody inhibitors	• Omalizumab	Omalizumab Medications List	Injection
Anti-interleukin-4	• Dupilumab	Dupilumab Medications List	Injection
Anti-interleukin-5	• Benralizumab	Benralizumab Medications List	Injection
Anti-interleukin-5	• Mepolizumab	Mepolizumab Medications List	Injection
Anti-interleukin-5	• Reslizumab	Reslizumab Medications List	Injection
Inhaled steroid combinations	• Budesonide-formoterol	Budesonide Formoterol Medications List	Inhalation

Description	Prescriptions	Medication Lists	Route
Inhaled steroid combinations	• Fluticasone-salmeterol	Fluticasone Salmeterol Medications List	Inhalation
Inhaled steroid combinations	• Fluticasone-vilanterol	Fluticasone Vilanterol Medications List	Inhalation
Inhaled steroid combinations	• Formoterol-mometasone	Formoterol Mometasone Medications List	Inhalation
Inhaled corticosteroids	• Beclomethasone	Beclomethasone Medications List	Inhalation
Inhaled corticosteroids	• Budesonide	Budesonide Medications List	Inhalation
Inhaled corticosteroids	• Ciclesonide	Ciclesonide Medications List	Inhalation
Inhaled corticosteroids	• Flunisolide	Flunisolide Medications List	Inhalation
Inhaled corticosteroids	• Fluticasone	Fluticasone Medications List	Inhalation
Inhaled corticosteroids	• Mometasone	Mometasone Medications List	Inhalation
Leukotriene modifiers	• Montelukast	Montelukast Medications List	Oral
Leukotriene modifiers	• Zafirlukast	Zafirlukast Medications List	Oral
Leukotriene modifiers	• Zileuton	Zileuton Medications List	Oral
Methylxanthines	• Theophylline	Theophylline Medications List	Oral

Asthma Reliever Medications

Description	Prescriptions	Medication Lists	Route
Short-acting, inhaled beta-2 agonists	Albuterol	Albuterol Medications List	Inhalation
Short-acting, inhaled beta-2 agonists	Levalbuterol	Levalbuterol Medications List	Inhalation

Note

- *Do not use RxNorm codes when assessing the numerator.*
- *When mapping NDC codes, medications described as "injection," "prefilled syringe," "subcutaneous," "intramuscular" or "auto-injector" are considered "injections" (route).*
- *When mapping NDC codes, medications described as "metered dose inhaler," "dry powder inhaler" or "inhalation powder" are considered "inhalation" (route) medications.*
- *Do not map medications described as "nasal spray" to "inhalation" medications.*

Data Elements for Reporting

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

Table AMR-A-1/2: Data Elements for Asthma Medication Ratio

Metric	Age	Data Element	Reporting Instructions
AsthmaMedicationRatio	5-11	Benefit	Metadata
	12-18	EligiblePopulation	For each Stratification
	19-50	ExclusionAdminRequired	For each Stratification
	51-64	NumeratorByAdmin	For each Stratification
	Total	NumeratorBySupplemental	For each Stratification
		Rate	(Percent)

Table AMR-B-1/2: Data Elements for Asthma Medication Ratio: Stratifications by Race

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

Table AMR-C-1/2: Data Elements for Asthma Medication Ratio: Stratifications by Ethnicity

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

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

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

Rules for Allowable Adjustments of HEDIS

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

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

Rules for Allowable Adjustments of Asthma Medication Ratio

NONCLINICAL COMPONENTS		
Eligible Population	**Adjustments Allowed (Yes/No)**	**Notes**
Product lines	Yes	Using product line criteria is not required. Including any product line, combining product lines, or not including product line criteria is allowed.
Ages	Yes, with limits	Age determination dates may be changed (e.g., select "age as of June 30"). The denominator age may be changed within the specified age range (ages 5–64 years). The denominator age may also be expanded to 65 years of age and older.
Continuous enrollment, allowable gap, anchor date	Yes	Organizations are not required to use enrollment criteria; adjustments are allowed.
Benefits	Yes	Organizations are not required to use enrollment criteria; adjustments are allowed.
Other	Yes	Organizations may use additional eligible population criteria to focus on 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 medication lists and value sets may be used to identify visits. Medication lists, value sets and logic may not be changed.
Denominator Exclusions	**Adjustments Allowed (Yes/No)**	**Notes**
Required exclusions	Yes, with limits	Apply required exclusions according to specified value sets. The hospice 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**
Medication Ratio of 0.50 or greater	No	Medication lists and logic may not be changed.

Breast Cancer Screening (BCS-E)

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 members 50–74 years of age who were recommended for routine breast cancer screening and had a mammogram to screen for breast cancer.
Measurement period	January 1–December 31.
Clinical recommendation statement	The U.S. Preventive Services Task Force recommends screening women 50–74 years of age for breast cancer every 2 years. (B recommendation) The Fenway Institute recommends that for patients assigned female at birth who have not undergone chest reconstruction (including those who have had breast reduction), breast/chest screening recommendations are the same as for cisgender women of a similar age and medical history. The University of California San Francisco Center of Excellence for Transgender Health recommends that transgender men who have not undergone bilateral mastectomy, or who have only undergone breast reduction, undergo screening according to current guidelines for non-transgender women. The World Professional Association for Transgender Health recommends health care professionals follow local breast cancer screening guidelines developed for cisgender women in their care of transgender and gender diverse people with breasts from natal puberty who have not had gender-affirming chest surgery.
Citations	Fenway Health. 2021. *Medical Care of Trans and Gender Diverse Adults*. https://fenwayhealth.org/wp-content/uploads/Medical-Care-of-Trans-and-Gender-Diverse-Adults-Spring-2021-1.pdf University of California San Francisco Center of Excellence for Transgender Health. 2016. *Guidelines for the Primary and Gender-Affirming Care of Transgender and Gender Nonbinary People*. https://transcare.ucsf.edu/sites/transcare.ucsf.edu/files/Transgender-PGACG-6-17-16.pdf U.S. Preventive Services Task Force. 2016. “Screening for Breast Cancer: U.S. Preventive Services Task Force Recommendation Statement." *Ann Intern Med* 164(4):279–96.

	World Professional Association for Transgender Health. 2022. *Standards of Care for the Health of Transgender and Gender Diverse People, Version 8.* https://www.tandfonline.com/doi/pdf/10.1080/26895269.2022.2100644
Characteristics	
Scoring	Proportion.
Type	Process.
Stratification	• Breast Cancer Screening. – Product line: ▪ Commercial. ▪ Medicaid. ▪ Medicare. – SES (for Medicare only): ▪ SES—Non-LIS/DE, Nondisability. ▪ SES—LIS/DE. ▪ SES—Disability. ▪ SES—LIS/DE and Disability. ▪ SES—Other. ▪ SES—Unknown. – 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	**Allocation:** The member was enrolled with a medical benefit October 1 two years prior to the measurement period through the end of the measurement period.

	No more than one gap in enrollment of up to 45 days for each full calendar year (i.e., the measurement period and the year prior to the measurement period). No gaps in enrollment are allowed from October 1 two years prior to the measurement period through December 31 two years prior to the measurement period. The member must be enrolled on the last day of the measurement period. **Reporting:** For Medicare plans, the SES stratifications are mutually exclusive. NCQA calculates a total rate for Medicare plans by adding all six Medicare stratifications. 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:** For Medicare plans, I-SNP and LTI exclusions are not included in the measure calculation logic, and must be programmed manually. 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. SES and 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	October 1 two years prior to the measurement period through the end of the measurement period.
Initial population	Members 52–74 years of age by the end of the measurement period who were recommended for routine breast cancer screening and also meet the criteria for participation. Include members recommended for routine breast cancer screening with any of the following criteria:

<table>
<tr><td></td><td>

Administrative Gender of Female (AdministrativeGender code F) at any time in the member's history.
Sex Assigned at Birth (LOINC code 76689-9) of Female (LOINC code LA3-6) at any time in the member's history.
Sex Parameter for Clinical Use of Female (SexParameterForClinicalUse code Female-typical) during the measurement period.

</td></tr>
<tr><td>Exclusions</td><td>

Members who use hospice services (Hospice Encounter Value Set; Hospice Intervention Value Set) or elect to use a hospice benefit any time during the measurement period. Organizations that use the Monthly Membership Detail Data File to identify these members must use only the run date of the file to determine if the member elected to use a hospice benefit during the measurement period.
Members who die any time during the measurement period.
Members who had a bilateral mastectomy or both right and left unilateral mastectomies any time during the member's history through the end of the measurement period. Any of the following meet the criteria for bilateral mastectomy:

Bilateral mastectomy (Bilateral Mastectomy Value Set).
Unilateral mastectomy (Unilateral Mastectomy Value Set) with a bilateral modifier (CPT Modifier code 50) (same procedure).
Unilateral mastectomy found in clinical data (Clinical Unilateral Mastectomy Value Set) with a bilateral qualifier value (SNOMED CT Modifier code 51440002) (same procedure).

Note: The "clinical" mastectomy value sets identify mastectomy; the word "clinical" refers to the data source, not to the type of mastectomy.

History of bilateral mastectomy (History of Bilateral Mastectomy Value Set).
Any combination of codes from the table below that indicate a mastectomy on both the left and right side on the same date of service or on different dates of service.

<table>
<tr><th>Left Mastectomy
(any of the following)</th><th>Right Mastectomy
(any of the following)</th></tr>
<tr><td>Unilateral mastectomy (Unilateral Mastectomy Value Set) with a left-side modifier (CPT Modifier code LT) (same procedure)</td><td>Unilateral mastectomy (Unilateral Mastectomy Value Set) with a right-side modifier (CPT Modifier code RT) (same procedure)</td></tr>
<tr><td>Unilateral mastectomy found in clinical data (Clinical Unilateral Mastectomy Value Set) with a left-side qualifier value(SNOMED CT Modifier code 7771000) (same procedure)</td><td>Unilateral mastectomy found in clinical data (Clinical Unilateral Mastectomy Value Set) with a right-side qualifier value(SNOMED CT Modifier code 24028007) (same procedure)</td></tr>
<tr><td>Absence of the left breast (Absence of Left Breast Value Set)</td><td>Absence of the right breast (Absence of Right Breast Value Set)</td></tr>
</table>
</td></tr>
</table>

<table>
<tr><td></td><td>
<table>
<tr><th>Left Mastectomy
(any of the following)</th><th>Right Mastectomy
(any of the following)</th></tr>
<tr><td>Left unilateral mastectomy (Unilateral Mastectomy Left Value Set)</td><td>Right unilateral mastectomy (Unilateral Mastectomy Right Value Set)</td></tr>
</table>

Members who had gender-affirming chest surgery (CPT code 19318) with a diagnosis of gender dysphoria (Gender Dysphoria Value Set) any time during the member's history through the end of the measurement period.
Medicare members 66 years of age and older by the end of the measurement period who meet either of the following:

Enrolled in an Institutional SNP (I-SNP) any time during the measurement period.
Living long-term in an institution any time during the measurement period, as identified by the LTI flag in the monthly membership detail data file. Use the run date of the file to determine if a member had an LTI flag during the measurement period.

Members 66 years of age and older by the end of the measurement period, with frailty and advanced illness. Members must meet BOTH frailty and advanced illness criteria to be excluded:

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

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

Members receiving palliative care (Palliative Care Assessment Value Set; Palliative Care Encounter Value Set; Palliative Care Intervention Value Set) any time during the measurement period.
Members who had an encounter for palliative care (ICD-10-CM code Z51.5) any time during the measurement period. Do not include laboratory claims (claims with POS 81).

</td></tr>
<tr><td>Denominator</td><td>The initial population, minus exclusions.</td></tr>
<tr><td>Numerator</td><td>One or more mammograms (Mammography Value Set) any time on or between October 1 two years prior to the measurement period and the end of the measurement period.</td></tr>
</table>

Data criteria (element level)

Value Sets:

- **BCSE_HEDIS_MY2024-3.0.0**
  - Absence of Left Breast (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1329)
  - Absence of Right Breast (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1330)
  - Bilateral Mastectomy (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1042)
  - Clinical Unilateral Mastectomy (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1948)
  - History of Bilateral Mastectomy (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1331)
  - Mammography (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1168)
  - Unilateral Mastectomy (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1256)
  - Unilateral Mastectomy Left (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1334)
  - Unilateral Mastectomy Right (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1335)
- **NCQA_AdvancedIllnessandFrailty-3.0.0**
  - Acute Inpatient (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1810)
  - Advanced Illness (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1465)
  - Dementia Medications (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1729)
  - ED (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1086)
  - Frailty Device (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1530)
  - Frailty Diagnosis (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1531)
  - Frailty Encounter (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1532)
  - Frailty Symptom (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1533)
  - Nonacute Inpatient (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1189)
  - Online Assessments (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1446)
  - Outpatient (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1202)
  - Telephone Visits (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1246)
- **NCQA_Claims-3.0.0**
  - Inpatient Stay (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1395)
  - Nonacute Inpatient Stay (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1398)
- **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_PalliativeCare-3.0.0**
  - Palliative Care Assessment (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.2225)
  - Palliative Care Encounter (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1450)
  - Palliative Care Intervention (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.2224)

- **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:

- **BCSE_HEDIS_MY2024-3.0.0**
  - codesystem "CPT": 'http://www.ama-assn.org/go/cpt'
  - codesystem "SNOMEDCT": 'http://snomed.info/sct/731000124108'
  - code "Bilateral Procedure [50]": '50' from "CPT" display 'Bilateral Procedure [50]'
  - code "Left (qualifier value)": '7771000' from "SNOMEDCT" display 'Left (qualifier value)'
  - code "Left side (used to identify procedures performed on the left side of the body) [LT]": 'LT' from "CPT" display 'Left side (used to identify procedures performed on the left side of the body) [LT]'
  - code "Right (qualifier value)": '24028007' from "SNOMEDCT" display 'Right (qualifier value)'
  - code "Right and left (qualifier value)": '51440002' from "SNOMEDCT" display 'Right and left (qualifier value)'
  - code "Right side (used to identify procedures performed on the right side of the body) [RT]": 'RT' from "CPT" display 'Right side (used to identify procedures performed on the right side of the body) [RT]'
- **NCQA_PalliativeCare-3.0.0**
  - codesystem "ICD-10-CM": 'http://hl7.org/fhir/sid/icd-10-cm'
  - code "Encounter for palliative care": 'Z51.5' from "ICD-10-CM" display 'Encounter for palliative care'
- **NCQA_Terminology-3.0.0**
  - codesystem "ActCode": 'http://terminology.hl7.org/CodeSystem/v3-ActCode'
  - codesystem "ClaimTypeCodes": 'http://terminology.hl7.org/CodeSystem/claim-type'
  - 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 "Institutional": 'institutional' from "ClaimTypeCodes"
- 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 "Pharmacy": 'pharmacy' from "ClaimTypeCodes"
- code "Professional": 'professional' from "ClaimTypeCodes"
- 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'

Data Elements for Reporting

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

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

Metric	Data Element	Reporting Instructions
BreastCancerScreening	InitialPopulation	Report once
	ExclusionsByEHR	Report once
	ExclusionsByCaseManagement	Report once
	ExclusionsByHIERegistry	Report once
	ExclusionsByAdmin	Report once
	Exclusions	(Sum over SsoRs)
	Denominator	Report once
	NumeratorByEHR	Report once
	NumeratorByCaseManagement	Report once
	NumeratorByHIERegistry	Report once
	NumeratorByAdmin	Report once
	Numerator	(Sum over SsoRs)
	Rate	(Percent)

Table BCS-E-A-3: Data Elements for Breast Cancer Screening

Metric	SES Stratification	Data Element	Reporting Instructions
BreastCancerScreening	NonLisDeNondisability	InitialPopulation	For each Stratification
	LisDe	ExclusionsByEHR	For each Stratification
	Disability	ExclusionsByCaseManagement	For each Stratification
	LisDeAndDisability	ExclusionsByHIERegistry	For each Stratification
	Other	ExclusionsByAdmin	For each Stratification
	Unknown	Exclusions	(Sum over SsoRs)
	Total	Denominator	For each Stratification
		NumeratorByEHR	For each Stratification
		NumeratorByCaseManagement	For each Stratification
		NumeratorByHIERegistry	For each Stratification
		NumeratorByAdmin	For each Stratification
		Numerator	(Sum over SsoRs)
		Rate	(Percent)

Table BCS-E-B-1/2/3: Data Elements for Breast Cancer Screening: Stratifications by Race

Metric
BreastCancerScreening

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

Table BCS-E-C-1/2/3: Data Elements for Breast Cancer Screening: Stratifications by Ethnicity

Metric
BreastCancerScreening

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

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

**Race/Ethnicity = "Unknown" is only reported for Source = "Unknown" 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 Breast Cancer Screening—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	Age determination dates may be changed (e.g., select, "age as of June 30"). The denominator age range may be expanded to 40–74 years.
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 a population of interest such as gender, race and ethnicity, socioeconomic, sociodemographic characteristic or geographic region.
CLINICAL COMPONENTS		
Initial Population	**Adjustments Allowed (Yes/No)**	**Notes**
Event/diagnosis	NA	There is no event/diagnosis for this measure.
Exclusions	**Adjustments Allowed (Yes/No)**	**Notes**
Exclusions	No	Only specified exclusions may be applied. Value sets may not be changed.
Exclusions: Hospice, deceased member, palliative care, I-SNP, LTI, frailty and advanced illness	Yes	These exclusions are not required. Refer to *Exclusions* in the *Guidelines for the Rules for Allowable Adjustments.*
Denominator	**Adjustments Allowed (Yes/No)**	**Notes**
Denominator	No	The logic may not be changed.
Numerator Criteria	**Adjustments Allowed (Yes/No)**	**Notes**
Mammogram	No	Value sets and logic may not be changed.

Cervical Cancer Screening (CCS)

SUMMARY OF CHANGES TO HEDIS MY 2024

- Replaced references to "women" with "members recommended for routine cervical cancer screening."
- Added criteria for "members recommended for routine cervical cancer screening" to the eligible population.
- Added a laboratory claim exclusion to value sets for which laboratory claims should not be used.
- Added an exclusion for members who were assigned male at birth.
- Clarified that "Unknown" is not considered a result/finding for medical record reporting.

Description

The percentage of members 21–64 years of age who were recommended for routine cervical cancer screening and were screened for cervical cancer using any of the following criteria:

- Members 21–64 years of age who were recommended for routine cervical cancer screening and had cervical cytology performed within the last 3 years.
- Members 30–64 years of age who were recommended for routine cervical cancer screening and had cervical high-risk human papillomavirus (hrHPV) testing performed within the last 5 years.
- Members 30–64 years of age who were recommended for routine cervical cancer screening and had cervical cytology/high-risk human papillomavirus (hrHPV) cotesting within the last 5 years.

Eligible Population

Product lines	Commercial, Medicaid (report each product line separately).
Ages	Members 24–64 years as of December 31 of the measurement year.
Continuous enrollment	*Commercial:* The measurement year and the 730 days prior to the measurement year. *Medicaid:* The measurement year.
Allowable gap	No more than one gap in enrollment of up to 45 days during each year of continuous enrollment. To determine continuous enrollment for a Medicaid beneficiary for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage (e.g., a member whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).
Anchor date	December 31 of the measurement year.
Benefit	Medical.
Event/diagnosis	None.
Members recommended for routine cervical cancer screening	Include members recommended for routine cervical cancer screening with any of the following criteria: • Administrative Gender of Female (AdministrativeGender code F) any time in the member's history.

- Sex Assigned at Birth (LOINC code 76689-9) of Female (LOINC code LA3-6) any time in the member's history.
- Sex Parameter for Clinical Use of Female (SexParameterForClinicalUse code Female-typical) during the measurement year.

Required exclusions

Exclude members who meet any of the following criteria:

- Hysterectomy with no residual cervix (Hysterectomy With No Residual Cervix Value Set) any time during the member's history through December 31 of the measurement year.
- Cervical agenesis or acquired absence of cervix (Absence of Cervix Diagnosis Value Set) any time during the member's history through December 31 of 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).
- Members with Sex Assigned at Birth (LOINC code 76689-9) of Male (LOINC code LA2-8) at any time in the patient's history.

Administrative Specification

Denominator

The eligible population.

Numerator

The number of members recommended for routine cervical cancer screening who were screened for cervical cancer. Either of the following meets criteria:

- Members 24–64 years of age as of December 31 of the measurement year who were recommended for routine cervical cancer screening and had cervical cytology (Cervical Cytology Lab Test Value Set; Cervical Cytology Result or Finding Value Set) during the measurement year or the 2 years prior to the measurement year.
- Members 30–64 years of age as of December 31 of the measurement year who were recommended for routine cervical cancer screening and had cervical high-risk human papillomavirus (hrHPV) testing (High Risk HPV Lab Test Value Set, SNOMEDCT code 718591004) during the measurement year or the 4 years prior to the measurement year, ***and*** who were 30 years or older on the test date.

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

Hybrid Specification

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

Numerator The number of members who were recommended for routine cervical cancer screening and were appropriately screened for cervical cancer, as documented through either administrative data or medical record review.

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

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

- Members 24–64 years of age as of December 31 of the measurement year who were recommended for routine cervical cancer screening and had cervical cytology during the measurement year or the 2 years prior to the measurement year.
  - Documentation in the medical record must include both of the following:
    - A note indicating the date when the cervical cytology was performed.
    - The result or finding. "Unknown" is not considered a result/finding.
  - Count any cervical cancer screening method that includes collection and microscopic analysis of cervical cells. Do not count lab results that explicitly state the sample was inadequate or that "no cervical cells were present"; this is not considered appropriate screening.
  - Do not count biopsies, because they are diagnostic and therapeutic only and are not valid for primary cervical cancer screening.

  Note: *Lab results that indicate the sample contained "no endocervical cells" may be used if a valid result was reported for the test.*
- Members 30–64 years of age as of December 31 of the measurement year who were recommended for routine cervical cancer screening and had cervical high-risk human papillomavirus (hrHPV) testing during the measurement year or the 4 years prior to the measurement year ***and*** who were 30 years or older as of the date of testing.
  - Documentation in the medical record must include both of the following:
    - A note indicating the date when the hrHPV test was performed. Generic documentation of "HPV test" can be counted as evidence of hrHPV test.
    - The results or findings. "Unknown" is not considered a result/finding.
  - Do not count biopsies, because they are diagnostic and therapeutic only and are not valid for primary cervical cancer screening.

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

Data Elements for Reporting

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

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

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

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 Cervical Cancer Screening

NONCLINICAL COMPONENTS		
Eligible Population	**Adjustments Allowed (Yes/No)**	**Notes**
Product lines	Yes	Organizations are not required to use product line criteria; product lines may be combined and all (or no) product line criteria may be used.
Ages	Yes, with limits	Age determination dates may be changed (e.g., select, "age as of June 30"). The denominator age may not be expanded.
Continuous enrollment, allowable gap, anchor date	Yes	Organizations are not required to use enrollment criteria; adjustments are allowed.
Benefit	Yes	Organizations are not required to use a benefit; adjustments are allowed.
Other	Yes	Organizations may use additional eligible population criteria to focus on an area of interest defined by gender, race, ethnicity, socio-economic or sociodemographic characteristics, geographic region or another characteristic.
CLINICAL COMPONENTS		
Eligible Population	**Adjustments Allowed (Yes/No)**	**Notes**
Event/diagnosis	NA	There is no event/diagnosis for this measure.
Denominator Exclusions	**Adjustments Allowed (Yes/No)**	**Notes**
Required exclusions	Yes, 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**
Cervical Cancer Screening	No	Value sets and logic may not be changed.

Chlamydia Screening in Women (CHL)

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 women 16–24 years of age who were identified as sexually active and who had at least one test for chlamydia during the measurement year.

Eligible Population

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

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

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

The total is the sum of the age stratifications.

Continuous enrollment The measurement year.

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

Anchor date December 31 of the measurement year.

Benefit Medical.

Event/diagnosis Follow the steps below to identify the eligible population.

Step 1 Identify members who are sexually active. Two methods identify sexually active women: pharmacy data and claim/encounter data. The organization must use both methods to identify the eligible population; however, a member only needs to be identified in one method to be eligible for the measure.

Claim/encounter data. Members who had a claim or encounter indicating sexual activity during the measurement year. Any of the following meets criteria.

- Diagnoses Indicating Sexual Activity Value Set. Do not include laboratory claims (claims with POS code 81).
- Procedures Indicating Sexual Activity Value Set.
- Pregnancy Tests Value Set.

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

Contraceptive Medications

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

Step 2 For the members identified in step 1 based on a pregnancy test alone, remove members who meet either of the following:

- A pregnancy test (Pregnancy Tests Value Set) during the measurement year and a prescription for isotretinoin (Retinoid Medications List) on the date of the pregnancy test or 6 days after the pregnancy test.
- A pregnancy test (Pregnancy Tests Value Set) during the measurement year and an x-ray (Diagnostic Radiology Value Set) on the date of the pregnancy test or 6 days after the pregnancy test.

Retinoid Medications

Description	Prescription
Retinoid	Isotretinoin

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

Data Elements for Reporting

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

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

Metric	Age	Data Element	Reporting Instructions
ChlamydiaScreening	16-20	EligiblePopulation	For each Stratification
	21-24	ExclusionAdminRequired	For each Stratification
	Total	NumeratorByAdmin	For each Stratification
		NumeratorBySupplemental	For each 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 Chlamydia Screening in Women

NONCLINICAL COMPONENTS		
Eligible Population	**Adjustments Allowed (Yes/No)**	**Notes**
Product lines	Yes	Organizations are not required to use product line criteria; product lines may be combined and all (or no) product line criteria may be used.
Ages	Yes, with limits	The age determination dates may be changed (e.g., select, "age as of June 30"). The denominator age may not be expanded.
Continuous enrollment, allowable gap, anchor date	Yes	Organizations are not required to use enrollment criteria; adjustments are acceptable.
Benefit	Yes	Organizations are not required to use a benefit; adjustments are acceptable.
Other	Yes	Organizations may use additional eligible population criteria to focus on an area of interest defined by gender, race, ethnicity, socio-economic or sociodemographic characteristics, geographic region or another characteristic.
CLINICAL COMPONENTS		
Eligible Population	**Adjustments Allowed (Yes/No)**	**Notes**
Event/diagnosis	Yes, with limits	Only events that contain (or map to) codes in medication lists and value sets may be used to identify sexual activity. Medication lists, value sets and logic may not be changed. Claims/encounter data or pharmacy data may be used to identify sexual activity.
Denominator Exclusions	**Adjustments Allowed (Yes/No)**	**Notes**
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**
Chlamydia Test	No	Value sets and logic may not be changed.

Colorectal Cancer Screening (COL-E)

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.
- Expanded the ages criteria in the *Rules for Allowable Adjustments of HEDIS*.
- 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 members 45–75 years of age who had appropriate screening for colorectal cancer.
Measurement period	January 1–December 31.
Clinical recommendation statement	The U.S. Preventive Services Task Force "recommends screening for colorectal cancer in all adults aged 50 to 75 years (A recommendation) and all adults aged 45 to 49 years (B recommendation)." Potential screening methods include an annual guaiac-based fecal occult blood test (gFOBT), annual fecal immunochemical test (FIT), multitargeted stool DNA with FIT test (sDNA FIT) every 3 years, colonoscopy every 10 years, CT colonography every 5 years, flexible sigmoidoscopy every 5 years or flexible sigmoidoscopy every 10 years, with FIT every year.
Citations	U.S. Preventive Services Task Force. 2021. "Screening for Colorectal Cancer: U.S. Preventive Services Task Force Recommendation Statement." *JAMA* 325(19):1965–1977. doi:10.1001/jama.2021.6238
Characteristics	
Scoring	Proportion.
Type	Process.
Stratification	• Colorectal Cancer Screening. – Product line: ▪ Commercial. ▪ Medicaid. ▪ Medicare. – Age (for each product line): ▪ 46–49 years. ▪ 50–75 years.

	– SES (for Medicare only): ▪ SES—Non-LIS/DE, Nondisability. ▪ SES—LIS/DE. ▪ SES—Disability. ▪ SES—LIS/DE and Disability. ▪ SES—Other. ▪ SES—Unknown. – 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	**Allocation:** The member was enrolled with a medical benefit during the measurement period and the year prior to the measurement period. No more than one gap in enrollment of up to 45 days during each calendar year (i.e., the measurement period and the year prior to the measurement period). The member must be enrolled on the last day of the measurement period. **Reporting:** For Medicare plans, the SES stratifications are mutually exclusive, and the sum of all six stratifications is the total population. 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: For Medicare plans, I-SNP and LTI exclusions are not included in the measure calculation logic, and must be programmed manually. 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. SES and 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 **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 and the year prior to the measurement period.
Initial population	Members 46–75 years as of the end of the measurement period who also meet the criteria for participation.
Exclusions	• Members who use hospice services (Hospice Encounter Value Set; Hospice Intervention Value Set) or elect to use a hospice benefit any time during the measurement period. Organizations that use the Monthly Membership Detail Data File to identify these members must use only the run date of the file to determine if the member elected to use a hospice benefit during the measurement period. • Members who die any time during the measurement period. • Members who had colorectal cancer (Colorectal Cancer Value Set) any time during the member's history through December 31 of the measurement year. Do not include laboratory claims (claims with POS 81). • Members who had a total colectomy (Total Colectomy Value Set; SNOMEDCT code 119771000119101) any time during the member's history through December 31 of the measurement period. • Medicare members 66 years of age and older by the end of the measurement period who meet either of the following: – Enrolled in an Institutional SNP (I-SNP) any time during the measurement period. – Living long-term in an institution any time during the measurement period, as identified by the LTI flag in the monthly membership detail data file. Use the run date of the file to determine if a member had an LTI flag during the measurement period.

	• Members 66 years of age and older by the end of the measurement period, with frailty and advanced illness. Members must meet BOTH frailty and advanced illness criteria to be excluded: – **Frailty.** At least two indications of frailty (Frailty Device Value Set; Frailty Diagnosis Value Set; Frailty Encounter Value Set; Frailty Symptom Value Set) with different dates of service during the measurement period. Do not include laboratory claims (claims with POS 81). – **Advanced Illness.** Either of the following during the measurement period or the year prior to the measurement period: ▪ Advanced illness (Advanced Illness Value Set) on at least two different dates of service. Do not include laboratory claims (claims with POS 81). ▪ Dispensed dementia medication (Dementia Medications List). • Members receiving palliative care (Palliative Care Assessment Value Set; Palliative Care Encounter Value Set; Palliative Care Intervention Value Set) any time during the measurement period. • Members who had an encounter for palliative care (ICD-10-CM code Z51.5) any time during the measurement year. Do not include laboratory claims (claims with POS 81).
Denominator	The initial population, minus exclusions.
Numerator	Members with one or more screenings for colorectal cancer. Any of the following meet criteria: • Fecal occult blood test (FOBT Lab Test Value Set; FOBT Test Result or Finding Value Set) during the measurement period. For administrative data, assume the required number of samples were returned, regardless of FOBT type. • Stool DNA (sDNA) with FIT test (sDNA FIT Lab Test Value Set; SNOMEDCT code 708699002) during the measurement period or the 2 years prior to the measurement period. • Flexible sigmoidoscopy (Flexible Sigmoidoscopy Value Set; SNOMEDCT code 841000119107) during the measurement period or the 4 years prior to the measurement period. • CT colonography (CT Colonography Value Set) during the measurement period or the 4 years prior to the measurement period. • Colonoscopy (Colonoscopy Value Set; SNOMEDCT code 851000119109) during the measurement period or the 9 years prior to the measurement period.
Data criteria (element level)	
Value Sets: • **COLE_HEDIS_MY2024-3.0.0** – Colonoscopy (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1064) – Colorectal Cancer (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1065) – CT Colonography (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1421) – Flexible Sigmoidoscopy (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1102)	

  - FOBT Lab Test (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1959)
  - FOBT Test Result or Finding (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1960)
  - sDNA FIT Lab Test (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1749)
  - Total Colectomy (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1250)
- **NCQA_AdvancedIllnessandFrailty-3.0.0**
  - Acute Inpatient (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1810)
  - Advanced Illness (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1465)
  - Dementia Medications (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1729)
  - ED (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1086)
  - Frailty Device (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1530)
  - Frailty Diagnosis (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1531)
  - Frailty Encounter (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1532)
  - Frailty Symptom (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1533)
  - Nonacute Inpatient (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1189)
  - Online Assessments (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1446)
  - Outpatient (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1202)
  - Telephone Visits (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1246)
- **NCQA_Claims-3.0.0**
  - Inpatient Stay (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1395)
  - Nonacute Inpatient Stay (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1398)
- **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_PalliativeCare-3.0.0**
  - Palliative Care Assessment (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.2225)
  - Palliative Care Encounter (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1450)
  - Palliative Care Intervention (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.2224)
- **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:

- **COLE_HEDIS_MY2024-3.0.0**
  - codesystem "SNOMEDCT": 'http://snomed.info/sct/731000124108'
  - code "History of colonoscopy (situation)": '851000119109' from "SNOMEDCT" display 'History of colonoscopy (situation)'
  - code "History of flexible sigmoidoscopy (situation)": '841000119107' from "SNOMEDCT" display 'History of flexible sigmoidoscopy (situation)'
  - code "History of total colectomy (situation)": '119771000119101' from "SNOMEDCT" display 'History of total colectomy (situation)'
  - code "Stool DNA-based colorectal cancer screening positive (finding)": '708699002' from "SNOMEDCT" display 'Stool DNA-based colorectal cancer screening positive (finding)'
- **NCQA_PalliativeCare-3.0.0**
  - codesystem "ICD-10-CM": 'http://hl7.org/fhir/sid/icd-10-cm'
  - code "Encounter for palliative care": 'Z51.5' from "ICD-10-CM" display 'Encounter for palliative care'
- **NCQA_Terminology-3.0.0**
  - codesystem "ActCode": 'http://terminology.hl7.org/CodeSystem/v3-ActCode'
  - codesystem "ClaimTypeCodes": 'http://terminology.hl7.org/CodeSystem/claim-type'
  - 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 "Institutional": 'institutional' from "ClaimTypeCodes"
  - 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 "Pharmacy": 'pharmacy' from "ClaimTypeCodes"
  - code "Professional": 'professional' from "ClaimTypeCodes"
  - 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'

Data Elements for Reporting

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

Table COL-E-A-1/2: Metadata Elements for Colorectal Cancer Screening

Metric	Age	Data Element	Reporting Instructions
ColorectalCancerScreening	46-50	InitialPopulation	For each Stratification
	51-75	ExclusionsByEHR	For each Stratification
	Total	ExclusionsByCaseManagement	For each Stratification
		ExclusionsByHIERegistry	For each Stratification
		ExclusionsByAdmin	For each Stratification
		Exclusions	(Sum over SSoRs)
		Denominator	For each Stratification
		NumeratorByEHR	For each Stratification
		NumeratorByCaseManagement	For each Stratification
		NumeratorByHIERegistry	For each Stratification
		NumeratorByAdmin	For each Stratification
		Numerator	(Sum over SSoRs)
		Rate	(Percent)

Table COL-E-A-3: Data Elements for Colorectal Cancer Screening

Metric	Age	SES Stratification	Data Element	Reporting Instructions
ColorectalCancerScreening	46-50	NonLisDeNondisability	InitialPopulation	For each Stratification
	51-75	LisDe	ExclusionsByEHR	For each Stratification
	Total	Disability	ExclusionsByCaseManagement	For each Stratification
		LisDeAndDisability	ExclusionsByHIERegistry	For each Stratification
		Other	ExclusionsByAdmin	For each Stratification
		Unknown	Exclusions	(Sum over SSoRs)
		Total	Denominator	For each Stratification
			NumeratorByEHR	For each Stratification
			NumeratorByCaseManagement	For each Stratification
			NumeratorByHIERegistry	For each Stratification
			NumeratorByAdmin	For each Stratification
			Numerator	(Sum over SSoRs)
			Rate	(Percent)

Table COL-E-B 1/2/3: Data Elements for Colorectal Cancer Screening: Stratifications by Race

Metric
ColorectalCancerScreening

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

Table COL-E-C-1/2/3: Data Elements for Colorectal Cancer Screening: Stratifications by Ethnicity

Metric
ColorectalCancerScreening

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

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

**Race/Ethnicity = "Unknown" is only reported for Source = "Unknown" 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 Colorectal Cancer Screening—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"). The denominator age may be expanded to 45-85 years of age.
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 a population of interest such as gender, race and ethnicity, socioeconomic, sociodemographic characteristic or geographic region.
CLINICAL COMPONENTS		
Initial Population	**Adjustments Allowed (Yes/No)**	**Notes**
Event/diagnosis	NA	There is no event/diagnosis for this measure.
Exclusions	**Adjustments Allowed (Yes/No)**	**Notes**
Exclusions	No	Only the specified exclusions may be applied. Value sets may not be changed.
Exclusions: Hospice, deceased member, palliative care, I-SNP, LTI, frailty and advanced illness	Yes	These exclusions are not required. Refer to *Exclusions* in the *Guidelines for the Rules for Allowable Adjustments*.
Denominator	**Adjustments Allowed (Yes/No)**	**Notes**
Denominator	No	The logic may not be changed.

Numerator Criteria	Adjustments Allowed (Yes/No)	Notes
Colorectal Cancer Screening	No	The value sets, direct reference codes and logic may not be changed.

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.

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

Oregon Health and Sciences University

A. DESCRIPTION

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

Data Collection Method: Administrative or Hybrid

Guidance for Reporting:

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

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

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

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

B. ELIGIBLE POPULATION

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

C. GUIDANCE ON DEVELOPMENTAL SCREENING TOOLS

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

D. ADMINISTRATIVE SPECIFICATION

Denominator

Denominator 1

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

Denominator 2

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

Denominator 3

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

Denominator 4

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

Numerators

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

Numerator 1

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

Numerator 2

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

Numerator 3

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

Numerator 4

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

Claims data

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

Important note about appropriate use of claims data

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

Claims NOT included in this measure

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

Exclusions

None.

E. MEDICAL RECORD SPECIFICATION

Denominator

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

Denominator 1

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

Denominator 2

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

Denominator 3

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

Denominator 4

The entire sample of 411 children.

Numerators

Numerator 1

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

Numerator 2

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

Numerator 3

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

Numerator 4

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

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

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

Tools must meet the following criteria:

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

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

Example developmental screening tools that meet criteria for the measure

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

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

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

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

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

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

Tools that do NOT meet the criteria

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

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

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

Exclusions

None.

F. CALCULATION ALGORITHM

Step 1

Determine the denominators.

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

Step 2

Determine the numerators.

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

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

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

Step 3

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

Step 4

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

Total Numerator: Numerator 1 + Numerator 2 + Numerator 3

Total Denominator: Denominator 1 + Denominator 2 + Denominator 3

Sampling Methodology

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

G. OPTIONAL AGE-SPECIFIC OVERSAMPLING FOR THE DENOMINATOR

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

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

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

Eye Exam for Patients With Diabetes (EED)

SUMMARY OF CHANGES TO HEDIS MY 2024

- Added instructions to report rates stratified by race and ethnicity for each product line.
- Updated the event/diagnosis criteria.
- Updated the Diabetes Medications table.
- Removed the required exclusion for members who did not have a diagnosis of diabetes.
- Added a laboratory claim exclusion to value sets for which laboratory claims should not be used.
- Moved previously listed *Exclusions* to *Required exclusions.*
- Revised the method for identifying advanced illness.
- Revised the numerator to clarify settings where CPT Category II code modifiers should not be used (previously covered in a General Guideline).
- Clarified in the *Notes* that inaccessibility of one eye is not considered a result/finding.
- Revised the "Denominator Exclusions" criteria in the Clinical Components table under *Rules for Allowable Adjustments of HEDIS*.

Description

The percentage of members 18–75 years of age with diabetes (types 1 and 2) who had a retinal eye exam.

Eligible Population

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

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

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

- Unknown.
- Total.

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

Stratification

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

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

Note: *Stratifications are mutually exclusive, and the sum of all six stratifications is the total population.*

Ages

18–75 years as of December 31 of the measurement year.

Continuous enrollment

The measurement year.

Allowable gap

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

Anchor date

December 31 of the measurement year.

Benefit

Medical.

Event/diagnosis

There are two ways to identify members with diabetes: by claim/encounter data and by pharmacy data. The organization must use both methods to identify the eligible population, but a member only needs to be identified by one method to be included in the measure. Members may be identified as having diabetes during the measurement year or the year prior to the measurement year.

Claim/encounter data. Members who had at least two diagnoses of diabetes (Diabetes Value Set) on different dates of service during the measurement year or the year prior to the measurement year.

Pharmacy data. Members who were dispensed insulin or hypoglycemics/ antihyperglycemics during the measurement year or the year prior to the measurement year (Diabetes Medications List) and have at least one diagnosis of diabetes (Diabetes Value Set) during the measurement year or the year prior to the measurement year.

Diabetes Medications

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

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

Required exclusions

Exclude members who meet any of the following criteria:

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

- Medicare members 66 years of age and older as of December 31 of the measurement year who meet either of the following:
  - Enrolled in an Institutional SNP (I-SNP) any time during the measurement year.
  - Living long-term in an institution any time during the measurement year as identified by the LTI flag in the Monthly Membership Detail Data File. Use the run date of the file to determine if a member had an LTI flag during the measurement year.
- Members 66 years of age and older as of December 31 of the measurement year (all product lines) with frailty **and** advanced illness. Members must meet **both** frailty and advanced illness criteria to be excluded:
  1. **Frailty.** At least two indications of frailty (Frailty Device Value Set; Frailty Diagnosis Value Set; Frailty Encounter Value Set; Frailty Symptom Value Set) with different dates of service during the measurement year. Do not include laboratory claims (claims with POS code 81).
  2. **Advanced Illness.** Either of the following during the measurement year or the year prior to the measurement year:
     - Advanced illness (Advanced Illness Value Set) on at least two different dates of service. Do not include laboratory claims (claims with POS code 81).
     - Dispensed dementia medication (Dementia Medications List).

Dementia Medications

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

Administrative Specification

Denominator The eligible population.

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

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

Any of the following meet criteria:

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

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

Hybrid Specification

Denominator

A systematic sample drawn from the eligible population.

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

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

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

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

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

Numerator

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

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

Administrative

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

Medical record

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

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

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

Note

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

Data Elements for Reporting

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

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

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

Table EED-A-3: Data Elements for Eye Exam for Patients With Diabetes

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

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

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

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

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

*****Repeat the EligiblePopulation and ExclusionAdminRequired values for metrics using the Administrative Method.
******AskedButNoAnswer is only reported for Source= "Direct."
*******Race/Ethnicity= "Unknown" is only reported for Source= "Unknown" and Source= "Unknown" is only reported for Race/Ethnicity= "Unknown."

Rules for Allowable Adjustments of HEDIS

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

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

Rules for Allowable Adjustments of Eye Exam for Patients With Diabetes

NONCLINICAL COMPONENTS		
Eligible Population	**Adjustments Allowed (Yes/No)**	**Notes**
Product lines	Yes	Organizations are not required to use product line criteria; product lines may be combined and all (or no) product line criteria may be used.
Ages	Yes, with limits	Age determination dates may be changed (e.g., select, "age as of June 30"). Changing denominator age range is allowed within a specified age range (ages 18–75 years). The denominator age may not be expanded.
Continuous enrollment, allowable gap, anchor date	Yes	Organizations are not required to use enrollment criteria; adjustments are allowed.
Benefits	Yes	Organizations are not required to use a benefit; adjustments are allowed.
Other	Yes	Organizations may use additional eligible population criteria to focus on an area of interest defined by gender, race, ethnicity, socioeconomic or sociodemographic characteristics, geographic region or another characteristic.
CLINICAL COMPONENTS		
Eligible Population	**Adjustments Allowed (Yes/No)**	**Notes**
Event/diagnosis	No	Only events or diagnoses that contain (or map to) codes in the medication lists and value sets may be used to identify visits. Medication lists, value sets and logic may not be changed.
Denominator Exclusions	**Adjustments Allowed (Yes/No)**	**Notes**
Required exclusions	Yes	The hospice, deceased member, palliative care, I-SNP, LTI, frailty and advanced illness exclusions are not required. Refer to *Exclusions* in the *Guidelines for the Rules for Allowable Adjustments*.
Numerator Criteria	**Adjustments Allowed (Yes/No)**	**Notes**
Eye Exam for Patients With Diabetes	No	Value sets and logic may not be changed.

Follow-Up Care for Children Prescribed ADHD Medication (ADD-E)

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 newly prescribed attention-deficit/hyperactivity disorder (ADHD) medication who had at least three follow-up care visits within a 300-day (10 month) period, one of which was within 30 days of when the first ADHD medication was dispensed. Two rates are reported. • *Initiation Phase.* The percentage of members 6–12 years of age with a prescription dispensed for ADHD medication, who had one follow-up visit with a practitioner with prescribing authority during the 30-day initiation phase. • *Continuation and Maintenance (C&M) Phase.* The percentage of members 6–12 years of age with a prescription dispensed for ADHD medication, who remained on the medication for at least 210 days and who, in addition to the visit in the initiation phase, had at least two follow-up visits with a practitioner within 270 days (9 months) after the initiation phase ended.
Measurement period	January 1–December 31.
Clinical recommendation statement	American Academy of Child and Adolescent Psychiatry (AACAP) Practice Parameter for the Assessment and Treatment of Children and Adolescents with ADHD: • Recommendation 6: A Well-Thought-Out and Comprehensive Treatment Plan Should Be Developed for the Patient With ADHD. The treatment plan should be reviewed regularly and modified if the patient's symptoms do not respond. Minimal Standard [MS] • Recommendation 9: During a Psychopharmacological Intervention for ADHD, the Patient Should Be Monitored for Treatment-Emergent Side Effects. Minimal Standard [MS] • Recommendation 12: Patients Should Be Assessed Periodically to Determine Whether There Is Continued Need for Treatment or If Symptoms Have Remitted. Treatment of ADHD Should Continue as Long as Symptoms Remain Present and Cause Impairment. Minimal Standard [MS]

	American Academy of Pediatrics Clinical Practice Guideline for the Diagnosis, Evaluation and Treatment of ADHD in Children and Adolescents: • Action Statement 4: The primary care clinician should recognize ADHD as a chronic condition and, therefore, consider children and adolescents with ADHD as children and youth with special health care needs. Management of children and youth with special health care needs should follow the principles of the chronic care model and the medical home (Grade B: Strong Recommendation).
Citations	American Academy of Child and Adolescent Psychiatry (AACAP). 2007. "Practice Parameter for the Assessment and Treatment of Children and Adolescents with ADHD." *J. Am. Acad. Child Adolesc. Psychiatry* 46(7): 894Y921. American Academy of Pediatrics. November 2011. "ADHD: Clinical Practice Guideline for the Diagnosis, Evaluation, and Treatment of Attention-Deficit/ Hyperactivity Disorder in Children and Adolescents." Subcommittee on Attention-Deficit/Hyperactivity Disorder, Steering Committee on Quality Improvement and Management. *Pediatrics* 128 (5) 1007–22; DOI: 10.1542/peds.2011-2654
Characteristics	
Scoring	Proportion.
Type	Process.
Stratification	• Initiation Phase. – Product line: ▪ Commercial. ▪ Medicaid. • Continuation and Maintenance (C&M) Phase. – Product line: ▪ Commercial. ▪ Medicaid.
Risk adjustment	None.
Improvement notation	A higher rate indicates better performance.
Guidance	**General Rules:** The CQL uses Encounter.class codes in conjunction with the Visit Setting Unspecified Value Set to identify eligible numerator encounters in clinical data. Organizations that are not using the digital measure packages should use one of the following to correctly identify eligible encounters: Visit Setting Unspecified Value Set in conjunction with POS code 53; POS code 52; Outpatient POS Value Set; or Telehealth POS Value Set. 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:** *Initiation phase:* The member was enrolled with a medical and pharmacy benefit and had no gaps in enrollment between 120 days prior to the IPSD through 30 days after the IPSD. There is no requirement for the member to be enrolled on the last day of the measurement period. *C&M phase:* The member was enrolled with a medical and pharmacy benefit between 120 days prior to the IPSD through 300 days after the IPSD. No more than one 45-day gap in enrollment is allowed between 31 days after the IPSD through 300 days after the IPSD. To determine participation 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). There is no requirement for the member to be enrolled on the last day of the measurement period. Members who switch product lines or products between rate 1 and rate 2 enrollment periods are only included in rate 1. However, if an organization reports products combined, then a member who switches between those products (e.g., the products included in the HEDIS reporting entity) is included in both rates. For example, if an organization reports HMO and POS products combined and a member switches from HMO to POS between rate 1 and rate 2 enrollment periods, the member is included in both rate 1 and rate 2. This is not included in the measure calculation logic, and must be programmed manually. **Programming Guidance:** The requirement that a practitioner have prescribing authority is not included in the measure calculation logic, and must be programmed manually. 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	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 1	120 days prior to the IPSD through 30 days after the IPSD.
Participation period 2	120 days prior to the IPSD through 300 days after the IPSD.

Intake period	March 1 of the year prior to the measurement period through the last calendar day of February of the measurement period.
Negative medication history	A period of 120 days prior to the IPSD when the member had no ADHD medications dispensed for either new or refill prescriptions.
IPSD	Index prescription start date. The earliest prescription dispensing date for an ADHD medication where the date is in the intake period and there is a negative medication history.
Initiation phase	The 30 days following the IPSD.
C&M phase	The 300 days following the IPSD.
Continuous medication treatment	There must be ≥210 treatment days during the 301-day period, with allowed gaps in medication of up to a total of 91 days. Gaps may include either washout period gaps to change medication or treatment gaps to refill the same medication. Regardless of the number of gaps, there may not be more than 91 total gap days. Count any combination of gaps (e.g., one washout gap of 14 days and numerous weekend drug holidays).
Treatment days (covered days)	The actual number of calendar days covered by prescriptions during the 301-day period. Use the following steps to identify and calculate covered days. **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. ***Note:*** *This step assumes that the member will take one prescription at a time (and start taking the next prescription after exhausting the previous prescription).*

Identifying same or different drugs	**Step 2:** For all other dispensing events (multiple prescriptions for the same medication on different days without overlap; 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. ***Note:*** *This step assumes the member will take the different medications concurrently.* **Step 3:** Count the covered days. Consider each calendar day covered by 1 or more medications to be 1 covered day. Dispensing events from different medication value sets are considered different drugs; dispensing events from the same medication value set are considered the same drug. Use all of the medication lists below to identify ADHD dispensing events: • Dexmethylphenidate Medications List. • Dextroamphetamine Medications List. • Lisdexamfetamine Medications List. • Methylphenidate Medications List. • Methamphetamine Medications List. • Clonidine Medications List. • Guanfacine Medications List. • Atomoxetine Medications List.
Initial population	**Initial population 1** Follow the steps below to identify initial population 1. **Step 1:** Identify all members in the specified age range who were dispensed an ADHD medication (ADHD Medications List) during the 12-month intake period. **Step 2:** For each member identified in step 1, identify the IPSD. **Step 3:** Calculate participation. The member must be enrolled throughout Participation period 1. **Step 4:** Remove members who had an acute inpatient encounter for a mental, behavioral or neurodevelopmental disorder during the initiation phase. Either of the following meets criteria: • An acute inpatient encounter (Acute Inpatient Value Set) with a principal diagnosis of mental, behavioral or neurodevelopmental disorder (Mental, Behavioral and Neurodevelopmental Disorders Value Set). • An acute inpatient admission with a principal diagnosis of mental, behavioral or neurodevelopmental disorder (Mental, Behavioral and Neurodevelopmental Disorders Value Set) on the discharge claim. To identify an acute inpatient admission: 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.

	Initial population 2 Follow the steps below to identify initial population 2. **Step 1:** Identify all members from initial population 1. **Step 2:** Calculate participation. The member must be enrolled throughout Participation period 2. **Step 3:** Calculate treatment days (covered days) to determine continuous medication treatment. Using the members in step 2, determine if the member was dispensed a sufficient number of prescriptions to provide continuous medication treatment beginning on the IPSD through 300 days after the IPSD. The definition of "continuous medication treatment" allows gaps in medication treatment, up to a total of 91 days during the 301-day period. **Step 4:** Remove members who had an acute inpatient encounter for a mental, behavioral or neurodevelopmental disorder during the C&M phase. Either of the following meets criteria: • An acute inpatient encounter (Acute Inpatient Value Set) with a principal diagnosis of mental, behavioral or neurodevelopmental disorder (Mental, Behavioral and Neurodevelopmental Disorders Value Set). • An acute inpatient admission with a principal diagnosis of mental, behavioral or neurodevelopmental disorder (Mental, Behavioral and Neurodevelopmental Disorders Value Set) on the discharge claim. To identify an acute inpatient admission: 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.
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. • Members with a diagnosis of narcolepsy (Narcolepsy Value Set) any time during the member's history through the end of the measurement period. Do not include laboratory claims (claims with POS 81). **Exclusions 2** Same as exclusions 1.
Denominator	**Denominator 1** The initial population 1, minus exclusions. **Denominator 2** The initial population 2, minus exclusions.

Numerator	**Numerator 1—Initiation Phase** Members who had a follow-up visit with a practitioner with prescribing authority, within 30 days after the IPSD (do not include visits on the IPSD). Any of the following code combinations meet criteria for a visit; the visit must be with a provider with prescribing authority. • An outpatient visit (Visit Setting Unspecified Value Set ***with*** Outpatient POS Value Set). • An outpatient visit (BH Outpatient Value Set). • A health and behavior assessment or intervention (Health and Behavior Assessment or Intervention Value Set). • An intensive outpatient encounter or partial hospitalization (Visit Setting Unspecified Value Set ***with*** 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 ***with*** POS Code 53). • A telehealth visit (Visit Setting Unspecified Value Set ***with*** Telehealth POS Value Set). • A telephone visit (Telephone Visits Value Set). **Numerator 2—C&M Phase** Members who meet the following criteria: • Numerator compliant for Rate 1—Initiation Phase, ***and*** • At least two follow-up visits on different dates of service with any practitioner, from 31–300 days after the IPSD. Any of the following code combinations meet criteria for follow-up visits: • An outpatient visit (Visit Setting Unspecified Value Set ***with*** Outpatient POS Value Set). • An outpatient visit (BH Outpatient Value Set). • A health and behavior assessment or intervention (Health and Behavior Assessment or Intervention Value Set). • An intensive outpatient encounter or partial hospitalization (Visit Setting Unspecified Value Set ***with*** 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 ***with*** POS Code 53). • A telehealth visit (Visit Setting Unspecified Value Set ***with*** Telehealth POS Value Set). • A telephone visit (Telephone Visits Value Set). • An e-visit or virtual check-in (Online Assessments Value Set). Only one of the two visits (during the 31–300 days after the IPSD) may be an e-visit or virtual check-in (Online Assessments Value Set).

Data criteria (element level)

Value Sets:

- **ADDE_HEDIS_MY2024-3.0.0**
  - Acute Inpatient (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1810)
  - ADHD Medications (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1736)
  - BH Outpatient (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1481)
  - Health and Behavior Assessment or Intervention (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1487)
  - Mental, Behavioral and Neurodevelopmental Disorders (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1961)
  - Narcolepsy (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1182)
  - Online Assessments (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1446)
  - Partial Hospitalization or Intensive Outpatient (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1492)
  - Telephone Visits (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1246)
  - Visit Setting Unspecified (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1493)
- **NCQA_Claims-3.0.0**
  - Inpatient Stay (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1395)
  - Nonacute Inpatient Stay (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1398)
- **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_Medication-3.0.0**
  - Atomoxetine Medications (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.2400)
  - Clonidine Medications (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.2398)
  - Dexmethylphenidate Medications (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.2393)
  - Dextroamphetamine Medications (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.2394)
  - Guanfacine Medications (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1854)
  - Lisdexamfetamine Medications (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.2395)
  - Methamphetamine Medications (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.2397)
  - Methylphenidate Medications (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.2396)

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'
  - codesystem "ConditionClinicalStatusCodes": 'http://terminology.hl7.org/CodeSystem/condition-clinical'
  - code "active": 'active' from "ConditionClinicalStatusCodes"
  - code "ambulatory": 'AMB' from "ActCode"
  - code "drug policy": 'DRUGPOL' from "ActCode"
  - code "home health": 'HH' from "ActCode"
  - code "Institutional": 'institutional' from "ClaimTypeCodes"
  - code "managed care policy": 'MCPOL' from "ActCode"
  - code "Pharmacy": 'pharmacy' from "ClaimTypeCodes"
  - code "Professional": 'professional' from "ClaimTypeCodes"
  - code "retiree health program": 'RETIRE' from "ActCode"
  - code "subsidized health program": 'SUBSIDIZ' from "ActCode"
  - code "virtual": 'VR' from "ActCode"

Data Elements for Reporting

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

Table ADD-E-1/2: Data Elements for Follow-Up Care for Children Prescribed ADHD Medication

Metric	Data Element	Reporting Instructions
Initiation	Benefit	Metadata
Continuation	InitialPopulationByEHR	For each Metric
	InitialPopulationByCaseManagement	For each Metric
	InitialPopulationByHIERegistry	For each Metric
	InitialPopulationByAdmin	For each Metric
	InitialPopulation	(Sum over SSoRs)
	ExclusionsByEHR	For each Metric
	ExclusionsByCaseManagement	For each Metric
	ExclusionsByHIERegistry	For each Metric
	ExclusionsByAdmin	For each 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)

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 Care for Children Prescribed ADHD Medication—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	The age determination dates may be changed (e.g., select, "age as of June 30"). Changing the denominator age range is allowed.
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 medication lists and value sets may be used to identify visits. Medication lists, value sets and logic may not be changed.
Exclusions	**Adjustments Allowed (Yes/No)**	**Notes**
Exclusions	No	Only the specified exclusions may be applied and the value sets may not be changed.
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**
• Initiation Phase • C&M Phase	No	Value sets, direct reference codes and logic may not be changed.

Health Equity Measure Specifications

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

SUMMARY OF CHANGES FOR 2024

- No substantive changes.

Background

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

Description

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

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

General Guidelines

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

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

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

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

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

Measure Specifications Table of Contents

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

Measure #1 – Description

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

Measure #1 – Denominator

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

Measure #1 – Numerator

Numerator Statement	Patients who received one or more well-care visits during the measurement year. The well-care visit must occur with a PCP or an OB/GYN practitioner, but the practitioner does not have to be the practitioner assigned to the patient.
Numerator Exclusions	None
Guidance	This measure requires use of administrative data to identify well-care visits. ANs should leverage payer-provided data for measure performance. For example, payers could share a spreadsheet with information on which patients meet the numerator for the measure. ANs could use this information to update data in their

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

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

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

Measure #2 – Description

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

Measure #2 – Denominator

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

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

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

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

Measure #2 – Numerator

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

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

Measure #3 – Description

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

Measure #3 – Denominator

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

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

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

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

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

Measure #3 – Numerator

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

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

Measure #4 – Description

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

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

Measure #4 – Denominator

Initial Population	Delivered a live birth on or between October 8 of the year prior to the measurement year and October 7 of the measurement year. Include women who delivered in any setting. Multiple births. Women who had two separate deliveries (different dates of service) between October 8 of the year prior to the measurement year and October 7 of the measurement year count twice. Women who had multiple live births during one pregnancy count once. Follow the steps below to identify the initial population, which is the denominator for both rates:[8] 1. Identify deliveries. Identify all women with a delivery (Deliveries Value Set) on or between October 8 of the year prior to the measurement year and October 7 of the measurement year. a. Note: The intent is to identify the date of delivery (the date of the "procedure"). If the date of delivery cannot be interpreted on the claim, use the date of service or, for inpatient claims, the date of discharge. 2. Exclude non-live births (Non-live Births Value Set).
Denominator Statement	Equals Initial Population
Denominator Exclusions	Patients in hospice or using hospice services anytime during the measurement year.
Denominator Exceptions	None
Guidance	This measure requires use of administrative data to identify well-care visits. ANs should leverage payer-provided data for measure performance. For example, payers

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

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

Measure #4 – *Timeliness of Prenatal Care* Numerator

Numerator Statement	A prenatal care visit to an OB/GYN or other prenatal care practitioner, or PCP during the required time frame. Follow the steps below to identify numerator compliance: 1. Identify women attributed to the AN with a delivery during the measurement year. 2. Identify prenatal visits that occurred during the required timeframe. The practitioner type must be an OB/GYN or other prenatal care practitioner or PCP to meet criteria for a prenatal visit. For visits to a PCP, a diagnosis of pregnancy must be present. Documentation in the medical record must include a note indicating the date when the prenatal care visit occurred, and evidence of one of the following: a. Documentation indicating the woman is pregnant or references to the pregnancy; for example: i. Documentation in a standardized prenatal flow sheet, or ii. Documentation of LMP, EDD or gestational age, or iii. A positive pregnancy test result, or iv. Documentation of gravidity and parity, or v. Documentation of complete obstetrical history, or vi. Documentation of prenatal risk assessment and counseling/education. b. A basic physical obstetrical examination that includes auscultation for fetal heart tone, or pelvic exam with obstetric observations, or measurement of fundus height (a standardized prenatal flow sheet may be used).

	c. Evidence that a prenatal care procedure was performed, such as: i. Screening test in the form of an obstetric panel (must include all of the following: hematocrit, differential WBC count, platelet count, hepatitis B surface antigen, rubella antibody, syphilis test, RBC antibody screen, Rh and ABO blood typing), or ii. TORCH antibody panel alone, or iii. A rubella antibody test/titer with an Rh incompatibility (ABO/Rh) blood typing, or iv. Ultrasound of a pregnant uterus.
Numerator Exclusions	Not applicable
Guidance	Services that occur over multiple visits count toward this measure if all services are within the time frame established in the measure. Ultrasound and lab results alone are not considered a visit; they must be combined with an office visit with an appropriate practitioner in order to count for this measure. For each patient, the organization must use one date (date of delivery or EDD) to define the start and end of the first trimester. If multiple EDDs are documented, the organization must define a method to determine which EDD to use, and use that date consistently. If the organization elects to use EDD, and the EDD is not on or between October 8 of the year prior to the measurement year and October 7 of the measurement year, the member is excluded as a valid data error and replaced by the next member of the oversample. The LMP may not be used to determine the first trimester. The organization may use EDD to identify the first trimester for the Timeliness of Prenatal Care rate and use the date of delivery for the Postpartum Care rate. A Pap test does not count as a prenatal care visit for the administrative and hybrid specification of the Timeliness of Prenatal Care rate, but is acceptable for the Postpartum Care rate as evidence of a pelvic exam. A colposcopy alone is not numerator compliant for either rate. The intent is that a prenatal visit is with a PCP or OB/GYN or other prenatal care practitioner. Ancillary services (lab, ultrasound) may be delivered by an ancillary provider. Nonancillary services (e.g., fetal heart tone, prenatal risk assessment) must be delivered by the required provider type. The intent is to assess whether prenatal and preventive care was rendered on a routine, outpatient basis rather than assessing treatment for emergent events. Services provided during a telephone visit, e-visit or virtual check-in are eligible for use in reporting.
Rate 1	The numerator statement.
Rate 2	The numerator statement, stratified by race.
Rate 3	The numerator statement, stratified by ethnicity.

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

Measure #4 – *Postpartum Care* Numerator

Numerator Statement	A postpartum visit to an OB/GYN or other prenatal care practitioner, or PCP on or between 7 and 84 days after delivery. Documentation in the medical record must include a note indicating the date when a postpartum visit occurred and one of the following:
	• Pelvic exam.
	• Evaluation of weight, BP, breasts and abdomen.
	  ○ Notation of "breastfeeding" is acceptable for the "evaluation of breasts" component.
	• Notation of postpartum care, including, but not limited to:
	  ○ Notation of "postpartum care," "PP care," "PP check," "6-week check."
	  ○ A preprinted "Postpartum Care" form in which information was documented during the visit.
	• Perineal or cesarean incision/wound check.
	• Screening for depression, anxiety, tobacco use, substance use disorder, or preexisting mental health disorders.
	• Glucose screening for women with gestational diabetes.
	• Documentation of any of the following topics:
	  ○ Infant care or breastfeeding.
	  ○ Resumption of intercourse, birth spacing or family planning.
	  ○ Sleep/fatigue.
	  ○ Resumption of physical activity.
	  ○ Attainment of healthy weight.

Numerator Exclusions	Services provided in an acute inpatient setting (Acute Inpatient Value Set; Acute Inpatient POS Value Set).
Guidance	Services that occur over multiple visits count toward this measure if all services are within the time frame established in the measure. Ultrasound and lab results alone are not considered a visit; they must be combined with an office visit with an appropriate practitioner in order to count for this measure. For each patient, the organization must use one date (date of delivery or EDD) to define the start and end of the first trimester. If multiple EDDs are documented, the organization must define a method to determine which EDD to use, and use that date consistently. If the organization elects to use EDD, and the EDD is not on or between October 8 of the year prior to the measurement year and October 7 of the measurement year, the member is excluded as a valid data error and replaced by the next member of the oversample. The LMP may not be used to determine the first trimester. The organization may use EDD to identify the first trimester for the Timeliness of Prenatal Care rate and use the date of delivery for the Postpartum Care rate.

	A Pap test does not count as a prenatal care visit for the administrative and hybrid specification of the Timeliness of Prenatal Care rate, but is acceptable for the Postpartum Care rate as evidence of a pelvic exam. A colposcopy alone is not numerator compliant for either rate. Services provided during a telephone visit, e-visit or virtual check-in are eligible for use in reporting.
Rate 1	The numerator statement.
Rate 2	The numerator statement, stratified by race.
Rate 3	The numerator statement, stratified by ethnicity.
Rate 4	The numerator statement, stratified by language.
Rate 5	The numerator statement, stratified by disability status.

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

Measure #5 – Description

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

Measure #5 – Denominator

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

Measure #5 – Numerator

Numerator Statement	Patients screened for depression on the date of the encounter or up to 14 days prior to the date of the encounter using an age-appropriate standardized tool AND if positive, a follow-up plan is documented on the date of the eligible encounter.
Numerator	None

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

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

	• Referral to a practitioner or program for further evaluation for depression, for example, referral to a psychiatrist, psychologist, social worker, mental health counselor, or other mental health service such as family or group therapy, support group, depression management program, or other service for treatment of depression. • Other interventions designed to treat depression such as behavioral health evaluation, psychotherapy, pharmacological interventions, or additional treatment options. Should a patient screen positive for depression, a clinician should: • Only order pharmacological intervention when appropriate and after sufficient diagnostic evaluation. However, for the purposes of this measure, additional screening and assessment during the qualifying encounter will not qualify as a follow-up plan. • Opt to complete a suicide risk assessment when appropriate and based on individual patient characteristics. However, for the purposes of this measure, a suicide risk assessment or additional screening using a standardized tool will not qualify as a follow-up plan.
Rate 1	The numerator statement.
Rate 2	The numerator statement, stratified by race.
Rate 3	The numerator statement, stratified by ethnicity.
Rate 4	The numerator statement, stratified by language.

Immunizations for Adolescents (IMA)*

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

SUMMARY OF CHANGES TO HEDIS MY 2024

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

Description

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

Eligible Population

Product lines

Commercial, Medicaid (report each product line separately).

Stratifications

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

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

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

Age

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

Continuous enrollment

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

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

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

Benefit Medical.

Event/diagnosis None.

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

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

Administrative Specification

Denominator The eligible population.

Numerators

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

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

Tdap Any of the following meet criteria:

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

HPV Any of the following meet criteria:

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

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

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

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

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

Hybrid Specification

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

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

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

For Tdap, count any of the following:

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

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

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

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

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

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

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

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

Note

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

Data Elements for Reporting

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

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

Metric	Data Element	Reporting Instructions	A
Meningococcal	CollectionMethod	Repeat per Metric	✓
Tdap	EligiblePopulation	Repeat per Metric	✓
HPV	ExclusionAdminRequired	Repeat per Metric	✓
Combo1	NumeratorByAdminElig	For each Metric	
Combo2	CYAR	(Percent)	
	MinReqSampleSize	Repeat per Metric	
	OversampleRate	Repeat per Metric	
	OversampleRecordsNumber	(Count)	
	ExclusionValidDataErrors	Repeat per Metric	
	ExclusionEmployeeOrDep	Repeat per Metric	
	OversampleRecsAdded	Repeat per Metric	
	Denominator	Repeat per Metric	
	NumeratorByAdmin	For each Metric	✓
	NumeratorByMedicalRecords	For each Metric	
	NumeratorBySupplemental	For each Metric	✓
	Rate	(Percent)	✓

Table IMA-B-1/2: Data Elements for Immunizations for Adolescents: Stratifications by Race

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

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

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

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

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

Rules for Allowable Adjustments of HEDIS

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

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

Rules for Allowable Adjustments of Immunizations for Adolescents

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

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

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

SUMMARY OF CHANGES TO HEDIS MY 2024

- Added instructions to report rates stratified by race and ethnicity for each product line.
- Updated the age stratifications to align with the National Kidney Foundation.
- Updated the event/diagnosis criteria.
- Updated the Diabetes Medications table.
- Removed the required exclusion for members who did not have a diagnosis of diabetes.
- Added a laboratory claim exclusion to value sets for which laboratory claims should not be used.
- Moved previously listed *Exclusions* to *Required exclusions.*
- Revised the method for identifying advanced illness.
- Revised the "Denominator Exclusions" criteria in the Clinical Components table under *Rules for Allowable Adjustments of HEDIS.*

Description

The percentage of members 18–85 years of age with diabetes (type 1 and type 2) who received a kidney health evaluation, defined by an estimated glomerular filtration rate (eGFR) ***and*** a urine albumin-creatinine ratio (uACR), during the measurement year.

Eligible Population

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

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

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

- Unknown.
- Total.

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

Ages

18–85 years as of December 31 of the measurement year. Report three age stratifications and a total rate:

- 18–64.
- 65–75.
- 76–85.
- Total.

The total is the sum of the age stratifications.

Continuous enrollment

The measurement year.

Allowable gap

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

Anchor date

December 31 of the measurement year.

Benefit

Medical.

Event/diagnosis

There are two ways to identify members with diabetes: by claim/encounter data and by pharmacy data. The organization must use both methods to identify the eligible population, but a member only needs to be identified by one method to be included in the measure. Members may be identified as having diabetes during the measurement year or the year prior to the measurement year.

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

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

Diabetes Medications

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

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

Required exclusions

Exclude members who meet any of the following criteria:

- Members with a diagnosis of ESRD (ESRD Diagnosis Value Set) any time during the member's history on or prior to December 31 of the measurement year. Do not include laboratory claims (claims with POS code 81).
- Members who had dialysis (Dialysis Procedure Value Set) any time during the member's history on or prior to December 31 of the measurement year.
- Members who use hospice services (Hospice Encounter Value Set; Hospice Intervention Value Set) or elect to use a hospice benefit any time during the measurement year. Organizations that use the Monthly Membership Detail Data File to identify these members must use only the run date of the file to determine if the member elected to use a hospice benefit during the measurement year.
- Members who die any time during the measurement year.

- Members receiving palliative care (Palliative Care Assessment Value Set; Palliative Care Encounter Value Set; Palliative Care Intervention Value Set) any time during the measurement year.
- Members who had an encounter for palliative care (ICD-10-CM code Z51.5) any time during the measurement year. Do not include laboratory claims (claims with POS code 81).
- Medicare members 66 years of age and older as of December 31 of the measurement year who meet either of the following:
- Enrolled in an Institutional SNP (I-SNP) any time during the measurement year.
- Living long-term in an institution any time during the measurement year as identified by the LTI flag in the Monthly Membership Detail Data File. Use the run date of the file to determine if a member had an LTI flag during the measurement year.
- Members 66-80 years of age as of December 31 of the measurement year (all product lines) with frailty **and** advanced illness. Members must meet **both** frailty and advanced illness criteria to be excluded:
  1. **Frailty.** At least two indications of frailty (Frailty Device Value Set; Frailty Diagnosis Value Set; Frailty Encounter Value Set; Frailty Symptom Value Set) with different dates of service during the measurement year. Do not include laboratory claims (claims with POS code 81).
  2. **Advanced Illness.** Either of the following during the measurement year or the year prior to the measurement year:
- Advanced illness (Advanced Illness Value Set) on at least two different dates of service. Do not include laboratory claims (claims with POS code 81).
- Dispensed dementia medication (Dementia Medications List).
- Members 81 years of age and older as of December 31 of the measurement year (all product lines) with at least two indications of frailty (Frailty Device Value Set; Frailty Diagnosis Value Set; Frailty Encounter Value Set; Frailty Symptom Value Set) with different dates of service during the measurement year. Do not include laboratory claims (claims with POS code 81).

Dementia Medications

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

Administrative Specification

Denominator The eligible population.

Numerator

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

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

Data Elements for Reporting

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

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

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

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

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

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

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

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

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

Rules for Allowable Adjustments of HEDIS

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

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

Rules for Allowable Adjustments of Kidney Health Evaluation for Patients With Diabetes

NONCLINICAL COMPONENTS		
Eligible Population	**Adjustments Allowed (Yes/No)**	**Notes**
Product lines	Yes	Organizations are not required to use product line criteria; product lines may be combined and all (or no) product line criteria may be used.
Ages	Yes, with limits	Age determination dates may be changed (e.g., select, "age as of June 30"). The denominator age may be changed if the range is within the specified age range (18–85 years).
Continuous enrollment, allowable gap, anchor date	Yes	Organizations are not required to use enrollment criteria; adjustments are allowed.
Benefit	Yes	Organizations are not required to use a benefit; adjustments are allowed.
Other	Yes	Organizations may use additional eligible population criteria to focus on an area of interest defined by gender, race, ethnicity, socioeconomic or sociodemographic characteristics, geographic region or another characteristic.
CLINICAL COMPONENTS		
Eligible Population	**Adjustments Allowed (Yes/No)**	**Notes**
Event/diagnosis	No	Only events or diagnoses that contain (or map to) codes in the medication lists and value sets may be used to identify visits. Medication lists, value sets and logic may not be changed.
Denominator Exclusions	**Adjustments Allowed (Yes/No)**	**Notes**
Required exclusions	Yes, with limits	Apply required exclusions according to specified value sets. The hospice, deceased member, palliative care, I-SNP, LTI, frailty and advanced illness exclusions are not required. Refer to *Exclusions* in the *Guidelines for the Rules for Allowable Adjustments*.
Numerator Criteria	**Adjustments Allowed (Yes/No)**	**Notes**
Kidney Health Evaluation	No	Value sets and logic may not be changed.

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

2024 COLLECTION TYPE:
MIPS CLINICAL QUALITY MEASURES (CQMS)

MEASURE TYPE:
Process – High Priority

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

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

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

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

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

NUMERATOR:
Patients receiving the following at a postpartum visit:

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

- Healthy lifestyle behavioral advice
- Immunization review and update

Definitions:

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

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

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

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

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

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

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

Numerator Instructions:

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

NUMERATOR OPTIONS:

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

RATIONALE:

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

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

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

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

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

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

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

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

References

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

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

CLINICAL RECOMMENDATION STATEMENTS:

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

Postpartum Care

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

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

Breastfeeding Evaluation and Education

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

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

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

Postpartum Depression Screening

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

Postpartum Glucose Screening for Gestational Diabetes Patients

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

Family and Contraceptive Planning Counseling

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

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

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

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

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

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

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

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

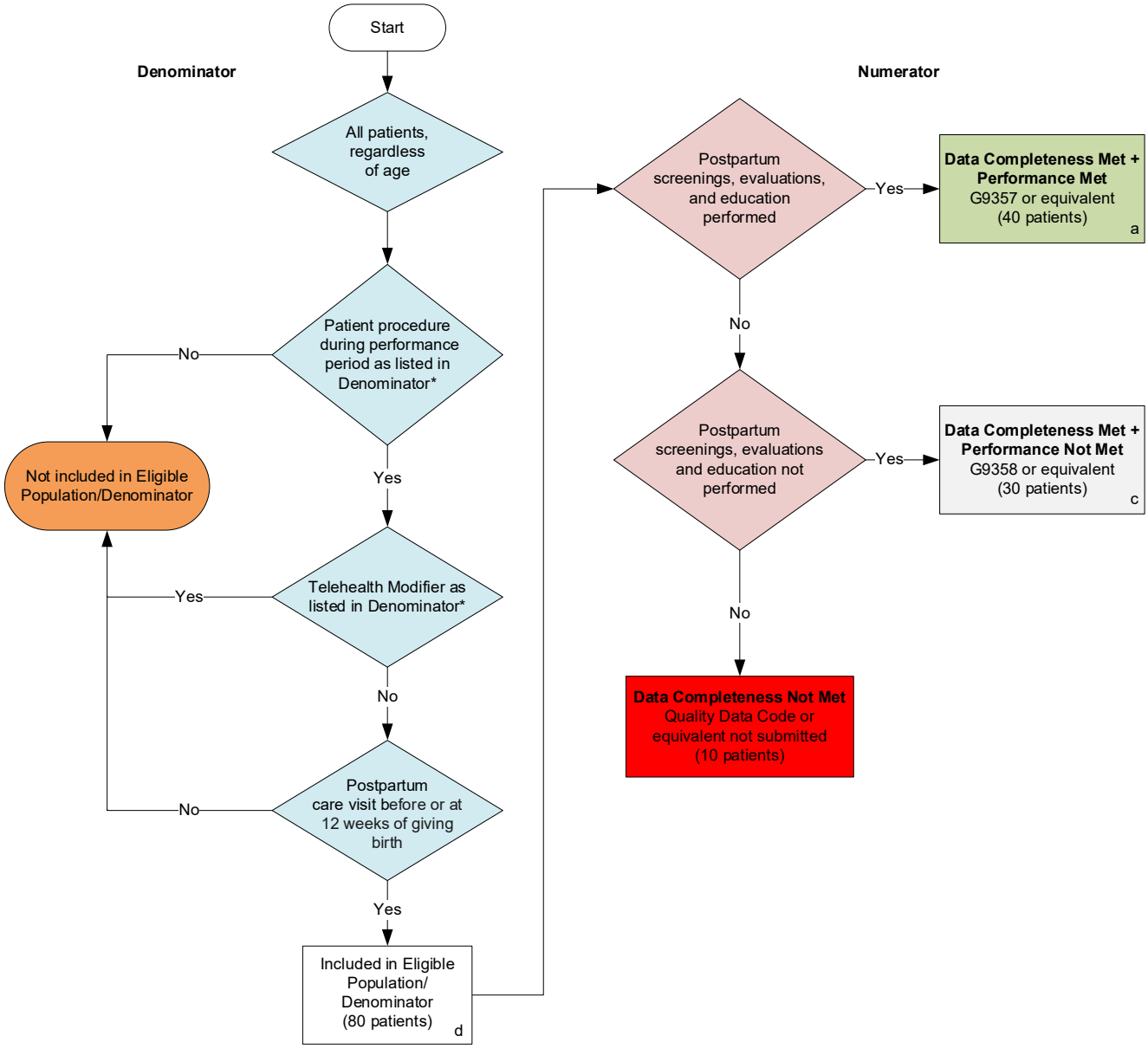
References

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

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

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

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



SAMPLE CALCULATIONS

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

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

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

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

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

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

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

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

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

10. Check *Data Completeness Not Met*:

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

Sample Calculations:

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

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

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

NOTE: Submission Frequency: Patient-Process

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

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

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

SUMMARY OF CHANGES TO HEDIS MY 2024

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

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

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

	Reporting: The total is the sum of the age stratifications. **Programming Guidance:** The requirements for identifying members in hospice using the monthly membership detail data files are not included in the measure calculation logic, and must be programmed manually. Product line stratifications are not included in the measure calculation logic, and must be programmed manually. Refer to the HEDIS Implementation Guide in the digital measure package for additional programming guidance.
Definitions	
Participation **Participation period**	The identifiers and descriptors for each organization's coverage used to define members' eligibility for measure reporting. Allocation for reporting is based on eligibility during the participation period. The measurement period.
Initial population	**Initial population 1** Members 1–17 years by the end of the measurement period with at least two antipsychotic medication dispensing events (APM Antipsychotic Medications List) of the same or different medications on different dates of service during the measurement period, and who also meet criteria for participation. **Initial population 2** Same as the initial population 1. **Initial population 3** Same as the initial population 1.
Exclusions	**Exclusions 1** • Members who use hospice services (Hospice Encounter Value Set; Hospice Intervention Value Set) or elect to use a hospice benefit any time during the measurement period. Organizations that use the Monthly Membership Detail Data File to identify these members must use only the run date of the file to determine if the member elected to use a hospice benefit during the measurement period. • Members who die any time during the measurement period. **Exclusions 2** Same as exclusions 1. **Exclusions 3** Same as exclusions 1.

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

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

Direct reference codes and codesystems:

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

Data Elements for Reporting

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

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

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

Rules for Allowable Adjustments of HEDIS

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

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

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

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

Prenatal and Postpartum Care (PPC)

SUMMARY OF CHANGES TO HEDIS MY 2024

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

Description

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

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

Definitions

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

Eligible Population

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

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

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

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

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

Age None specified.

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

Allowable gap None.

Anchor date Date of delivery.

Benefit Medical.

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

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

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

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

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

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

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

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

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

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

Administrative Specification

Denominator The eligible population.

Numerator

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

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

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

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

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

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

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

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

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

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

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

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

Hybrid Specification

Denominator

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

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

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

Numerator

Timeliness of Prenatal Care

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

Administrative

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

Medical record

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

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

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

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

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

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

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

Note

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

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

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

Data Elements for Reporting

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

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

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

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

Metric
TimelinessPrenatalCare
PostpartumCare

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

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

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

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

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

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

Rules for Allowable Adjustments of HEDIS

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

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

Rules for Allowable Adjustments of Prenatal and Postpartum Care

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

SDOH Screening Measure Specifications

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

Description

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

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

Eligible Population

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

Product lines	Medicaid, Commercial
Stratification	None
Ages	All ages
Continuous enrollment	Measurement year
Allowable gap	No more than one gap in enrollment of up to 45 days during the measurement year. To determine continuous enrollment for a Medicaid member for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage (e.g., a member whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).
Anchor date	December 31 of the measurement year.
Lookback period	12 months
Benefit	Medical
Event/diagnosis	• The patient has been seen by an Advanced Network-affiliated primary care clinician anytime within the last 12 months • For the purpose of this measure "primary care clinician" is any provider defined by the reporting payer as a primary care clinician and holding a patient panel. • Follow the below to determine a primary care visit: ○ The following are the eligible CPT/HCPCS office visit codes for determining a primary care visit: 98970-98972; 99201-99205; 99212-99215; 99324-99337; 99341-99350; 99381 – 99387; 99391-99397; 99417;

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

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

Electronic Data Specifications

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

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

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

Code List

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

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

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

Transitions of Care (TRC)

SUMMARY OF CHANGES TO HEDIS MY 2024

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

Description

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

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

Definitions

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

Eligible Population

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

Event/diagnosis

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

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

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

Observation stays that precede the inpatient stay

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

Readmission or direct transfer

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

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

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

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

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

To identify nonacute inpatient discharges:

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

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

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

Required exclusions

Members who meet either of the following criteria:

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

Administrative Specification

Denominator

The eligible population.

Numerators

Notification of Inpatient Admission

Administrative reporting is not available for this indicator.

Receipt of Discharge Information

Administrative reporting is not available for this indicator.

Patient Engagement After Inpatient Discharge

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

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

Medication Reconciliation Post-Discharge

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

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

Hybrid Specification

Denominator

A systematic sample drawn from the eligible population.

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

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

Identifying the medical record

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

Numerators

Notification of Inpatient Admission

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

Administrative

Administrative reporting is not available for this indicator.

Medical record

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

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

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

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

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

Receipt of Discharge Information

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

Administrative

Administrative reporting is not available for this indicator.

Medical record

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

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

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

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

Patient Engagement After Inpatient Discharge

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

Administrative

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

Medical record

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

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

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

Medication Reconciliation Post-Discharge

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

Administrative

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

Medical record

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

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

Note

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

Data Elements for Reporting

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

Table TRC-3: Data Elements for Transitions of Care

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

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

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

Rules for Allowable Adjustments of HEDIS

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

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

Rules for Allowable Adjustments of Transitions of Care

NONCLINICAL COMPONENTS		
Eligible Population	**Adjustments Allowed (Yes/No)**	**Notes**
Product lines	Yes	Organizations are not required to use product line criteria; product lines may be combined and all (or no) product line criteria may be used.
Ages	Yes	Age determination dates may be changed (e.g., select, "age as of June 30"). Changing the denominator age range is allowed.
Continuous enrollment, allowable gap, anchor date	Yes	Organizations are not required to use enrollment criteria; adjustments are allowed.
Benefits	Yes	Organizations are not required to use a benefit; adjustments are allowed.
Other	Yes	Organizations may use additional eligible population criteria to focus on an area of interest defined by gender, race, ethnicity, socioeconomic or sociodemographic characteristics, geographic region or another characteristic.
CLINICAL COMPONENTS		
Eligible Population	**Adjustments Allowed (Yes/No)**	**Notes**
Event/diagnosis	Yes, with limits	Only events that contain (or map to) codes in the value sets may be used to identify the eligible population for each rate. The value sets and logic may not be changed. ***Note:*** *Organizations may choose alternate measurement-period date ranges.* *Organizations may assess at the member level (vs. discharge level) by applying measure logic appropriately (i.e., percentage of members with documentation of medication reconciliation after each discharge).*
Denominator Exclusions	**Adjustments Allowed (Yes/No)**	**Notes**
Required exclusions	Yes	The hospice and deceased member exclusions are not required. Refer to *Exclusions* in the *Guidelines for the Rules for Allowable Adjustments*.

Numerator Criteria	Adjustments Allowed (Yes/No)	Notes
• Notification of Inpatient Admission • Receipt of Discharge Information	No	Allowable adjustments are not permitted for these components of the Transitions of Care measure.
• Patient Engagement After Inpatient Discharge • Medication Reconciliation Post-Discharge	No	Value sets and logic may not be changed.

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

SUMMARY OF CHANGES TO HEDIS MY 2024

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

Description

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

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

Note

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

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

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

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

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

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

Ages	Children who turn 15 months old during the measurement year. Calculate the 15-month birthday as the child's first birthday plus 90 days.
Continuous enrollment	31 days–15 months of age. Calculate 31 days of age by adding 31 days to the date of birth.
Allowable gap	No more than one gap in enrollment of up to 45 days during the continuous enrollment period. To determine continuous enrollment for a Medicaid member for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage (e.g., a member whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).
Anchor date	The date when the child turns 15 months old.
Benefit	Medical.
Event/diagnosis	None.
Required exclusions	Exclude members who meet either of the following criteria: • Members who use hospice services (Hospice Encounter Value Set; Hospice Intervention Value Set) or elect to use a hospice benefit any time during the measurement year. Organizations that use the Monthly Membership Detail Data File to identify these members must use only the run date of the file to determine if the member elected to use a hospice benefit during the measurement year. • Members who die any time during the measurement year.

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

Denominator	The Rate 1 eligible population.
Numerator	Six or more well-child visits on different dates of service on or before the 15-month birthday. Either of the following meet criteria: • A well-care visit (Well Care Visit Value Set). • An encounter for well-care (Encounter for Well Care Value Set). Do not include laboratory claims (claims with POS code 81). The well-child visit must occur with a PCP, but the PCP does not have to be the practitioner assigned to the child.

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

Product lines	Commercial, Medicaid (report each product line separately).
Stratifications	For each product line, report the following stratifications by race and total, and stratifications by ethnicity and total: • *Race:* – American Indian or Alaska Native. – Asian. – Black or African American. – Native Hawaiian or Other Pacific Islander. – White.

  - Some Other Race.
  - Two or More Races.
  - Asked But No Answer.
  - Unknown.
  - Total.
- *Ethnicity:*
  - Hispanic or Latino.
  - Not Hispanic or Latino.
  - Asked But No Answer.
  - Unknown.
  - Total.

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

Ages	Children who turn 30 months old during the measurement year. Calculate the 30-month birthday as the second birthday plus 180 days.
Continuous enrollment	15 months plus 1 day–30 months of age. Calculate the 15-month birthday plus 1 day as the first birthday plus 91 days.
Allowable gap	No more than one gap in enrollment of up to 45 days during the continuous enrollment period. To determine continuous enrollment for a Medicaid member for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage (e.g., a member whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).
Anchor date	The date when the child turns 30 months old.
Benefit	Medical.
Event/diagnosis	None.
Required exclusions	Exclude members who meet either of the following criteria: • Members who use hospice services (Hospice Encounter Value Set; Hospice Intervention Value Set) or elect to use a hospice benefit any time during the measurement year. Organizations that use the Monthly Membership Detail Data File to identify these members must use only the run date of the file to determine if the member elected to use a hospice benefit during the measurement year. • Members who die any time during the measurement year.

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

Denominator The Rate 2 eligible population.

Numerator Two or more well-child visits on different dates of service between the child's 15-month birthday plus 1 day and the 30-month birthday. Either of the following meet criteria:

- A well-care visit (Well Care Visit Value Set).
- An encounter for well-care (Encounter for Well Care Value Set). Do not include laboratory claims (claims with POS code 81).

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

Note

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

Data Elements for Reporting

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

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

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

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

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

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

Metric	Ethnicity	Source	Data Element	Reporting Instructions
Age15Months	HispanicOrLatino	Direct	EligiblePopulation	For each Metric and Stratification
Age15To30Months	NotHispanicOrLatino	Indirect	Numerator	For each Metric and Stratification
	AskedButNoAnswer*	Unknown**	Rate	(Percent)
	Unknown**	Total		

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

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

Rules for Allowable Adjustments of HEDIS

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

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

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

NONCLINICAL COMPONENTS		
Eligible Population	**Adjustments Allowed (Yes/No)**	**Notes**
Product lines	Yes	Organizations are not required to use product line criteria; product lines may be combined and all (or no) product line criteria may be used.
Ages	Yes, with limits	The age determination dates may be changed (e.g., select, "age 15 months as of June 30"). The denominator age may not be expanded.
Continuous enrollment, allowable gap, anchor date	Yes	Organizations are not required to use enrollment criteria; adjustments are allowed.
Benefits	Yes	Organizations are not required to use a benefit; adjustments are allowed.
Other	Yes	Organizations may use additional eligible population criteria to focus on an area of interest defined by gender, race, ethnicity, socioeconomic or sociodemographic characteristics, geographic region or another characteristic.
CLINICAL COMPONENTS		
Eligible Population	**Adjustments Allowed (Yes/No)**	**Notes**
Event/diagnosis	NA	There is no event/diagnosis for this measure.
Denominator Exclusions	**Adjustments Allowed (Yes/No)**	**Notes**
Required exclusions	Yes	The hospice and deceased member exclusion are not required. Refer to *Exclusions* in the *Guidelines for the Rules for Allowable Adjustments*.
Numerator Criteria	**Adjustments Allowed (Yes/No)**	**Notes**
• Well-Care Visits in the First 15 Months • Well-Care Visits for Age 15 Months–30 Months	No	Value sets and logic may not be changed.
Stratifications	**Adjustments Allowed (Yes/No)**	**Notes**
Well-Care Visits	Yes, with limits	Organizations may stratify the count of visits for the numerator of both rates. Value sets and logic may not be changed.

*Follow-Up After Abnormal Breast Cancer Assessment (BCF-E)**

***Developed with support from the Centers for Disease Control and Prevention (CDC) through Cooperative Agreement NU380T000303 with the National Network of Public Health Institutes (NNPHI).**

SUMMARY OF CHANGES TO HEDIS MY 2025

- This is a first-year measure.

Description	The percentage of inconclusive or high-risk BI-RADS assessments that received appropriate follow-up within 90 days of the assessment for members 40–74 years of age.
Measurement period	January 1–December 31.
Clinical recommendation statement	The National Comprehensive Cancer Network recommends breast cancer screening follow-up, in alignment with the Breast Imaging Reporting and Data System (BI-RADS) scoring categories, which offer recommendations for different findings: Category 1 (negative finding) or Category 2 (benign) advises resuming routine screening; Category 3 (probably benign), the recommendation is for diagnostic mammograms at 6 months, followed by repeat screenings every 6–12 months for 1–2 years, if appropriate; Categories 4 and 5 (suspicious or highly suggestive of malignancy), the recommendation is for tissue diagnosis using core needle biopsy (preferred) or needle localization excisional biopsy with specimen radiograph. For Category 6 (proven malignancy), the recommendation depends on the primary tumor, size of the invasive component, estimated disease volume, histological grade and other relevant characteristics. All recommendations are Category 2A recommendations—based on lower-level evidence, there is uniform NCCN consensus that the intervention is appropriate.
Citations	Breast Imaging Reporting & Data System. American College of Radiology. https://www.acr.org/Clinical-Resources/Reporting-and-Data-Systems/Bi-Rads Gradishar, W.J., M.S. Moran, J. Abraham, et al. 2022. “Breast Cancer, Version 3. NCCN Clinical Practice Guidelines in Oncology.” *J Natl Compr Canc Netw* 20(6):691–722. doi:10.6004/jnccn.2022.0030
Characteristics	
Scoring **Type**	Proportion. Process.
Stratification	• Follow-Up after Abnormal Breast Cancer Screening. – Product line: ▪ Commercial.

	▪ Medicaid. ▪ Medicare.
Risk adjustment	None.
Improvement notation	A higher rate indicates better performance.
Guidance	**General Rules:** The denominator for this measure is based on episodes, not on members. **Allocation:** The member was enrolled with a medical benefit on the date of the episode through 90 days after the episode date with no gaps in enrollment. **Reporting:** Commercial, Medicaid, Medicare (report each product line separately).
Definitions	
Participation	The identifiers and descriptors for each organization's coverage used to define members' eligibility for measure reporting. Allocation for HEDIS reporting is based on eligibility during the participation period.
Participation period	The episode date through 90 days after the episode date.
Intake period	October 3 of the year prior to the measurement period to October 2 of the measurement period. The intake period is used to capture the episode date.
Episode date	The date of service for an eligible encounter during the intake period with a recorded abnormal or high-risk BI-RADS assessment.
BI-RADS assessment	Clinically documented BI-RADS score. BI-RADS is a standardized classification system proposed by the American College of Radiology, used for the imaging of mammography, ultrasound and MRI of the breast. Acceptable values include all categories of BI-RADS 0–6.
Initial population	Mammography episodes during the Intake Period that resulted in a BI-RADS assessment for members 40–74 years of age by the end of the measurement period. Either of the following meet criteria: • A high-risk BI-RADS assessment (High Risk BIRADS Value Set) result of 4–5. • An inconclusive BI-RADS assessment (SNOMED CT code 397138000) result of 0.
Exclusions	**Exclusions** • Members who die any time during the measurement period. • 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.
Denominator	The initial population, minus exclusions.
Numerator	Mammography episodes during the Intake Period that received appropriate follow-up. Appropriate follow-up is defined as either of the following: • A high-risk BI-RADS assessment (High Risk BIRADS Value Set) result of 4–5 that received a breast biopsy (Breast Biopsy Value Set) on or within 90 days after the episode date (91 days total). • An inconclusive BI-RADS assessment (BI-RADS 0) (SNOMED CT code 397138000) that received a mammogram (Mammography Value Set) or ultrasound (Breast Ultrasound Value Set) on or within 90 days after the episode date (91 days total).

Data Elements for Reporting

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

Table BCF-E-A-1/2/3: Data Elements for Follow-Up after Abnormal Breast Cancer Assessment

Metric	Data Element	Reporting Instructions
FollowUpBreastCancerAssessment	InitialPopulation	Report once
	ExclusionsByEHR	Report once
	ExclusionsByCaseManagement	Report once
	ExclusionsByHIERegistry	Report once
	ExclusionsByAdmin	Report once
	Exclusions	(Sum over SsoRs)
	Denominator	Report once
	NumeratorByEHR	Report once
	NumeratorByCaseManagement	Report once
	NumeratorByHIERegistry	Report once
	NumeratorByAdmin	Report once
	Numerator	(Sum over SsoRs)
	Rate	(Percent)

Breast Cancer Screening and Follow-Up

Measure Workup

Evidence Overview

Importance and Prevalence

Health importance

Breast cancer is one of the most common types of cancers, accounting for 15% of all new cancer diagnoses in the U.S.[1] In 2020, over 3 million women were estimated to be living with breast cancer in the U.S., and it is estimated that 13% of women will be diagnosed with breast cancer at some point during their lifetime.[1] Breast cancer ranks as the second leading cause of cancer-related deaths among women in the U.S., after lung cancer; there were 42,273 deaths related to female breast cancer in the U.S. in 2020.[2] Although breast cancer incidence rates are slightly higher in non-Hispanic White women than in non-Hispanic Black women, breast cancer mortality rates are higher for non-Hispanic Black women.[1]

Advancing age is a primary risk factor: Breast cancer is most frequently diagnosed among women 55–64; the median age at diagnosis is 63.[1] The likelihood of a woman receiving a breast cancer diagnosis within the next 10 years is as follows: At 40, the chances are 1 in 65; at 50, the chances are 1 in 42; at age 60, the chances are 1 in 28.[3]

Financial importance and cost-effectiveness

In the U.S., costs associated with a diagnosis of breast cancer range from $451 to $2,520, factoring in continued testing, multiple office visits and procedures. The total costs related to breast cancer add up to nearly $7B per year in the U.S., including $2B spent on late-stage treatment.[4] If breast cancer is detected through mammography screening and diagnosed in its earliest stages, treatment may be less expensive.[5]

Evidence Supporting Screening for People at Average Risk for Breast Cancer

National guidelines recommend that women 40 and older who are at average risk for breast cancer be screened for breast cancer using mammography, but guidelines vary over which age to begin and end regular screening, and over frequency of screening. Table 2 lists specific recommendations and frequencies for women at average risk of breast cancer, by age group.

Age for beginning/ending screening

Advancing age is the most important breast cancer risk factor for most women. Major guideline organizations that interpret the evidence differ over when to begin and end regular screening.

40–49 years: The U.S. Preventive Services Task Force (USPSTF),* the National Comprehensive Cancer Network (NCCN) and the American College of Radiology (ACR) recommend that women 40–49 years be routinely screened for breast cancer.[6–8] The American College of Obstetricians and Gynecologists (ACOG) and the American College of Physicians (ACP) recommend that women 40–49 be offered screening for breast cancer, based on clinical shared decision making and a discussion of the potential harms and benefits.[9,10] The

*Based on 2023 USPSTF Draft Recommendation Statement published in May 2023; final recommendation was expected to be published in fall 2023.

American Cancer Society (ACS) recommends screening based on shared decision making for women 40–44 and routine screening for women 45–50. [11]

50–74 years: All national guidelines described above recommend routine screening for breast cancer for women 50–74.[7,9–13]

75 and older: ACP recommends against screening average-risk women 75 years and older.[10] The USPSTF indicates that current evidence is insufficient to assess the balance of benefits and harms of screening mammography for women 75 and older.[7] ACOG recommends screening for women 75 years and older based on shared decision making, while ACR, NCCN and ACS recommend continuing screening unless comorbidities limit life expectancy.[6,8,9,11]

Screening frequency

The USPSTF and ACP recommend biennial screening.[7,10] ACR and NCCN recommend annual screening.[6,8] ACOG recommends either annual or biennial screening based the patient's values and preferences.[9] ACS recommends annual screening for women 40–54, then switching to biennial screening.[11]

Screening methods

Mammography: The recommended method for primary screening of breast cancer, mammography is a low-dose x-ray that allows visualization of the internal structure of the breast. Studies have established that mammograms are the best method to detect early breast cancer, before it is big enough to feel or cause symptoms, and when it is easier to treat.[9,11,14,15]

Detecting early breast cancer via mammography can provide women with a greater range of treatment options, such as less aggressive surgery (e.g., lumpectomy vs. mastectomy), less toxic chemotherapy or the option to forgo chemotherapy.[11] Numerous randomized controlled trials have shown that early detection of breast cancer by mammography can reduce the risk of dying from breast cancer by 20%.[11]

However, mammography can lead women to be diagnosed and treated for noninvasive or invasive breast cancer that would otherwise not have become a health threat during their lifetime. Mammography can also produce false-positive results, which may lead to invasive follow-up examinations like biopsies, and cause women to experience anxiety, or false-negative results in which cancer is missed.[14] Mammography exposes women to radiation, but the risk of radiation-induced breast cancer is minimal.[16] The USPSTF and other national organizations recommend the use of digital mammography or digital breast tomosynthesis (DBT), both effective mammographic screening modalities.[17] The Task Force notes that DBT must be accompanied by traditional or synthetic digital mammography, which is a two-dimensional image constructed from DBT data.[7]

Magnetic Resonance Imaging (MRI): The USPSTF concludes that current evidence is insufficient to assess the balance of benefits and harms of supplemental screening for breast cancer using breast ultrasonography or MRI in women identified to have dense breasts on an otherwise negative screening mammogram.[7] No other guidelines recommend breast ultrasonography or MRI as first-line screening methods in asymptomatic, average-risk women. Studies of MRI screening have shown that MRI yields many more false-positive results than mammography, and has the potential to be associated with a greater degree of over-diagnosis than mammography.[14]

Screening in transgender individuals

Additional research is needed on the prevalence of breast cancer among transgender patients. Breast cancer rates for transgender men are not well described in the literature. Transgender women have a lower incidence of breast cancer than cisgender women, but a higher incidence than cisgender men,[18] given the potential increased risk from gender-affirming hormone exposure.[19,20] The duration of estrogen exposure at which risk increases is variable across studies. In a nationwide retrospective study in the Netherlands, Blok et al. observed a median of 18 years of estrogen exposure at breast cancer diagnosis among transgender women.[18] Though not limited to transgender patients, the Nurse's Health Study found a statistically significant increase in breast cancer risk after 15 years of exposure to estrogen.[21] In addition, the median age for breast cancer diagnosis in transgender women is younger than observed in cisgender women, with some studies finding a median age of diagnosis at around 50 years of age (compared to 60+ in cisgender women).[22]

Evidence indicates that breast cancer screening rates are lower among transgender adults recommended for screening compared to their cisgender counterparts.[23] Missed preventive screenings may result in poorer outcomes, such as more advanced disease at diagnosis. Few studies have been conducted on the impact of missed breast cancer screening specifically among transgender patients, but studies have shown that absence of breast cancer screening in the general population can result in more advanced stage at diagnosis.[24] A study of survivorship among transgender and gender-diverse cancer survivors found that this population experiences complex challenges and higher rates of risk factors for poor survival than cisgender cancer survivors.[25]

Breast cancer screening gaps for transgender individuals are influenced by barriers to access, as well as lack of provider knowledge of screening guidelines for transgender patients.[26] Organizations focused on care of gender-diverse patients have released guidelines recommending breast cancer screening for transgender and gender-diverse patients assigned female at birth, or with breasts from natal puberty, as well as transgender and gender-diverse patients assigned male at birth, with at least 5–10 years of exposure to gender-affirming estrogen therapy, excluding those with bilateral mastectomy or chest reconstruction.[27–29] These guidelines are mostly based on weak evidence, or are consensus-based. (Refer to *Appendix,* Table 5.)

Interventions, Management and Follow-Up

Diagnostic mammograms are performed to assess women who present with a symptom or other sign of breast cancer, to evaluate changes found during a screening mammogram.[30,31] Diagnostic mammograms can include diagnostic mammography, breast ultrasonography and diagnostic breast MRI.[32] Diagnostic mammography takes longer than conventional screening mammography because more x-rays are needed to obtain views of the breast from several angles, and the technician may magnify a suspicious area to produce a detailed picture that can help the physician make an accurate diagnosis.[31] Diagnostic mammography is associated with higher sensitivity, but lower specificity, compared to screening mammography.[30]

In a diagnostic evaluation, mammograms and ultrasounds may include positive or negative outcomes. A combined imaging assessment across the modalities is developed. Final mammographic assessments are mandated by the Mammography Quality Standards Act to be reported using ACR's breast imaging reporting and data system (BI-RADS) assessment categories.[33,34] BI-RADS standardizes reporting of findings into six

assessment categories for further management. Concordance between imaging methods (e.g., imaging and pathology) should be obtained. If findings are discordant, additional imaging or sampling should occur.

NCCN recommends BI-RADS 0 as needing additional imaging; categories 1 and 2 recommended for continued routine screening; category 3 recommended for mammography surveillance or tissue biopsies; categories 4 and 5 recommended for core needle biopsy (also called percutaneous core breast biopsy).[13,32] As noted, negative or benign BI-RADS assessments rely on concordance with clinical findings; thus, BI-RADS 2 or lower, accompanied by symptomology, may indicate a need for biopsy. Patients with BI-RADS category 6 are diagnosed with breast cancer; treatment depends on the stage and biological characteristics of the cancer, the patient's age and preferences and the risks and benefits associated with treatment. Women often have surgery, combined with other treatments such as radiation therapy, chemotherapy and/or hormone therapy; women with specific subtypes of breast cancer may also receive targeted therapy.[11]

Opportunity for Improvement

Screening

There is opportunity for improvement. National data collected by the Centers for Disease Control and Prevention (CDC) indicate that 68% of women 40 and older who were surveyed in 2019 reported having a mammogram within the past 2 years.[35] Performance rates on the HEDIS® *Breast Cancer Screening* measure (assessing biennial screening rates among health plan members 50–74) were around 70% for commercial and Medicare health plans, and 50% for Medicaid health plans in 2021.[36]

There are also significant racial and ethnic disparities in breast cancer mortality and screening rates. A systematic review and meta-analysis on racial disparities in screening mammography showed that African American women had lower odds of receiving screening mammography than White women.[37] In addition, studies suggest that women with a lower level of education, who lack health insurance coverage or have lower socioeconomic status are less likely to have had a mammogram.[38] One study found that between 2011 and 2015, breast cancer mortality for African American women was 42% higher than for White women.[39]

Follow-Up

There are gaps in care related to follow-up of positive results. It is estimated that up to 30% of women fail to attend recommended immediate follow-up for high-risk mammograms.[40] Additionally, some populations experience greater delays than others. For example, women in minority groups and those with underlying health conditions or previous clinical diagnoses tend to experience delays in follow-up care for abnormal mammograms.[41–43] It is believed that delayed follow-up after abnormal mammography plays a role in decreased survival rates among underserved minority women.[42]

Data Standards

Capturing the clinical information needed to track follow-up of abnormal results has historically been a challenge at the health-plan level.[44] Data systems use different methods to capture and store clinical data, which can result in incomplete records. This is changing, due to Health Level (HL7®†) standards such as Fast Healthcare Interoperability Resources (FHIR®‡), which provide the infrastructure to allow exchange, integration and retrieval of health data standards. "Data standards" refers to a common set of agreed-on data elements and definitions that can be implemented in a standardized, structured and interoperable way. Data standards can support

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quality measurement by providing a common understanding of how data are defined, represented and shared. Measures will require standardized data concepts and terms across providers, health systems and plans. Data currently support documentation and exchange of mammography BI-RADS assessment using SNOMED terminology and codes (Table 1).

To streamline data exchange between stakeholders, the Office of National Coordinator for Health Information Technology (ONC) 21st Century Cures Act mandated that providers implement HL7 FHIR application programming interfaces.[45] According to the Certified Health IT product list, more than 95% of certified Health IT systems had been updated to the Cures update standards as of December 31, 2022.[46] Most hospitals and providers who have implemented EHR systems are using certified vendors. According to the ONC, as of 2021, 94% of general acute care hospitals and 78% of office-based physicians used certified health IT systems.[47] This suggests that the capabilities included in certification standards are being implemented by clinicians and hospitals across the country.

Table 1: Mammography BI-RADS SNOMED CT US Edition Codes

Code	Description
397138000	Mammography assessment (Category 0)—Need additional imaging evaluation (finding)
397140005	Mammography assessment (Category 1)—Negative (finding)
397141009	Mammography assessment (Category 2)—Benign finding (finding)
397143007	Mammography assessment (Category 3)—Probably benign finding, short interval follow-up (finding)
397144001	Mammography assessment (Category 4)—Suspicious abnormality, biopsy should be considered (finding)
6121000179106	Mammography assessment (Category 4A)—Suspicious abnormality, biopsy should be considered, low suspicion of malignancy (finding)
6131000179108	Mammography assessment (Category 4B)—Suspicious abnormality, biopsy should be considered, moderate suspicion of malignancy (finding)
6141000179100	Mammography assessment (Category 4C)—Suspicious abnormality, biopsy should be considered, high suspicion of malignancy (finding)
397145000	Mammography assessment (Category 5)—Highly suggestive of malignancy (finding)
6111000179101	Mammography assessment (Category 6)—known biopsy, proven malignancy (finding)
397144001	Mammography assessment (Category 4)—Suspicious abnormality, biopsy should be considered (finding)
6121000179106	Mammography assessment (Category 4A)—Suspicious abnormality, biopsy should be considered, low suspicion of malignancy (finding)
6131000179108	Mammography assessment (Category 4B)—Suspicious abnormality, biopsy should be considered, moderate suspicion of malignancy (finding)
6141000179100	Mammography assessment (Category 4C)—Suspicious abnormality, biopsy should be considered, high suspicion of malignancy (finding)
397145000	Mammography assessment (Category 5)—Highly suggestive of malignancy (finding)

Table 2: Guidelines for Primary Breast Cancer Screening Using Mammography for Women at Average Risk for Breast Cancer

Age	Frequency	Recommendation	Rating/Grade
US Preventive Services Task Force, Breast Cancer: Screening (2016 Recommendation)[48]			
40-49 years	Biennial	The decision to start screening mammography should be an individual one. Women who place a higher value on the potential benefit than the potential harms may choose to begin biennial screening	C Recommendation The USPSTF recommends selectively offering or providing this service to individual patients based on professional judgment and patient preferences. There is at least moderate certainty that the net benefit is small. Offer or provide this service for selected patients depending on individual circumstances.
50-74 years	Biennial	Recommends biennial screening mammography	B Recommendation Recommends the service. There is high certainty that the net benefit is moderate or there is moderate certainty that the net benefit is moderate to substantial. Offer or provide this service.
≥75 years		Current evidence is insufficient to assess the balance of benefits and harms of screening mammography	I Statement Current evidence is insufficient to assess the balance of benefits and harms of the service. Evidence is lacking, of poor quality, or conflicting, and the balance of benefits and harms cannot be determined. If the service is offered, patients should understand the uncertainty about the balance of benefits and harms.
US Preventive Services Task Force, Breast Cancer: Screening (2023 DRAFT Recommendation)[7] **IN PROGRESS**			
40-74 years	Biennial	Recommends biennial screening mammography. Both digital mammography (DM) and digital breast tomosynthesis (DBT) are effective mammographic screening modalities. DBT must be accompanied by traditional DM or synthetic DM, which is a two-dimensional image constructed from DBT data.	B Recommendation
≥75 years		Current evidence is insufficient to assess the balance of benefits and harms of screening mammography	I Statement
National Comprehensive Cancer Network, Breast Cancer Screening and Diagnosis (2023)[32]			
≥40 years	Annual	Recommends annual screening mammogram ages 40 and older, with the consideration of digital breast tomosynthesis. Does not recommend an upper age limit for screening; if a patient has severe comorbid conditions limiting life expectancy and no further intervention would occur based on the screening findings, then the patient should not undergo screening, regardless of age.	Category 1 Based upon high-level evidence, there is uniform consensus that the intervention is appropriate

Age	Frequency	Recommendation	Rating/Grade
American College of Radiology/Society of Breast Imaging, Breast Cancer Screening Recommendations Inclusive of All Women at Average Risk (2021)[49]			
≥40 years	Annual	Annual screening mammogram is indicated for women ages 40 and older. Screening should continue past age 74 unless comorbidities limit life expectancy.	9 Usually appropriate
American College of Obstetricians and Gynecologists (2017; reaffirmed in 2021)[9]			
40-49 years	Annual or Biennial	Offer mammography starting at age 40 years and no earlier than age 40 years. The decision about the age to begin mammography screening should be made through a shared decision-making process that includes information about the potential benefits and harms.	Level A Based on good and consistent scientific evidence
50-75 years	Annual or Biennial	Begin screening mammography no later than age 50 years if patient has not already initiated and continue until age 75 years.	Level A
>75 years		The decision to discontinue screening mammography should be based on a shared decision-making process that includes a discussion of the woman's health status and longevity.	Level C Based primarily on consensus and expert opinion
American College of Physicians, Screening for Breast Cancer in Average Risk Women: A Guidance Statement (2019)[10]			
40-49 years	Biennial	Clinicians should discuss whether to screen for breast cancer with mammography before age 50 years. Discussion should include the potential benefits and harms and a woman's preferences. The potential harms outweigh the benefits in most women aged 40 to 49 years.	Expert Consensus
50-74 years	Biennial	Clinicians should offer screening for breast cancer with biennial mammography.	Expert Consensus
≥75 years		Clinicians should not screen average-risk women 75 years and older or those with life expectancy of 10 years or less	Expert Consensus
American Cancer Society, Recommendations for the Early Detection of Breast Cancer (2015)[11]			
40-44 years	Annual	Women should have the choice to start annual screening mammography. The risks of screening as well as the potential benefits should be considered.	Expert Consensus
45-54 years	Annual	Women should have annual screening mammography that should continue as long as woman is in good health and is expected to live 10 more years or longer.	Expert Consensus

Age	Frequency	Recommendation	Rating/Grade
≥55 years	Annual or Biennial	Women should switch to biennial screening mammography or have the choice to continue annual screening mammography. Screening should continue as long as a woman is in good health and is expected to live 10 more years or longer.	Expert Consensus

Table 3: Breast Cancer Screening Follow-Up Guidelines

BI-RADS	Recommendation	Rating/Grade
National Comprehensive Cancer Network, Breast Cancer Screening (2022)[32]		
Category 1 (negative finding) or Category 2 (benign)	Recommend resuming routine screening	Category 2A Based upon lower-level evidence, there is uniform NCCN consensus that the intervention is appropriate.
Category 3 (probably benign)	Recommend diagnostic mammograms at 6 months, then every 6 to 12 months for 1 to 2 years as appropriate. If the lesion remains stable or resolves mammographically, the patient resumes routine screening intervals for mammography. If, in any of the interval mammograms, the lesion increases in size or changes its benign characteristics, a biopsy is then performed. The exception to this approach of short-term follow-up is when a return visit is uncertain or the patient strongly desires or has a strong family history of breast cancer. In those cases, initial biopsy with histologic sampling may be a reasonable option.	Category 2A
Categories 4 and 5 (suspicious or highly suggestive of malignancy)	Recommend tissue diagnosis using core needle biopsy (preferred) or needle localization excisional biopsy with specimen radiograph is necessary. When a needle biopsy (aspiration or core needle biopsy) is performed, concordance between the pathology report and the imaging finding must be obtained.	Category 2A
Category 6 (proven malignancy)	Recommendation depends on primary tumor, size of invasive component, estimated disease volume, histological grade, and other characteristics.	Category 2A
University of California San Francisco Guidelines for the Primary and Gender-Affirming Care of Transgender and Gender Nonbinary People (2016)[28]		
Transgender women	It is recommended that screening mammography be performed every 2 years, once the age of 50 and 5-10 years of feminizing hormone use criteria have been met. Screening mammography is the primary recommended modality for breast cancer screening in transgender women	Grading: T O W • T: At least some data in transgender population • O: Strongest available evidence is from observational studies • W: Weak

Table 4: Breast Cancer Screening Guidelines for Transgender Individuals

Population	Recommendation	Grade
Transgender men	Transgender men who have not undergone bilateral mastectomy, or who have only undergone breast reduction, should undergo screening according to current guidelines for non-transgender women.	No grading. Grading of guidelines for non-transgender women apply.
Fenway Medical Care of Transgender and Gender Diverse Adults (2021)[29]		
Transgender and gender-diverse patients assigned female at birth	In patients assigned female at birth (AFAB) who have not undergone chest reconstruction (including those who have had breast reduction), breast/chest screening recommendations are the same as for cisgender women of a similar age and medical history	Consensus-based
Transgender and gender-diverse patients on estrogen	In TGD patients on estrogen, consider initial screening mammography starting at age 50, and only once on estrogen therapy for greater than 5 years. Thereafter mammograms are recommended every two years, following screening guidelines for cisgender women.	Consensus-based
World Professional Association for Transgender Health (WPATH) Standards of Care Version 8 (2022)[27]		
Transgender and gender-diverse patients who have received estrogens	We recommend health care professionals follow local breast cancer screening guidelines developed for cisgender women in their care of transgender and gender diverse people who have received estrogens, taking into consideration the length of time of hormone use, dosing, current age, and the age at which hormones were initiated.	Strong recommendations ("we recommend") are for those interventions/therapy/strategies where: • The evidence is of high quality • Estimates of the effect of an intervention/therapy/ strategy (i.e., there is a high degree of certainty effects will be achieved in practice) • There are few downsides of therapy/intervention/ strategy • There is a high degree of acceptance among providers and patients or those for whom the recommendation applies.
Transgender and gender-diverse patients without chest surgery	We recommend health care professionals follow local breast cancer screening guidelines developed for cisgender women in their care of transgender and gender diverse people with breasts from natal puberty who have not had gender-affirming chest surgery.	Strong recommendations ("we recommend") are for those interventions/therapy/strategies where: • The evidence is of high quality • Estimates of the effect of an intervention/therapy/ strategy (i.e., there is a high degree of certainty effects will be achieved in practice)

Population	Recommendation	Grade
		• There are few downsides of therapy/intervention/ strategy • There is a high degree of acceptance among providers and patients or those for whom the recommendation applies.

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Overview	
Measure Name	Rate of Race Data Completeness – ACO/AE
Steward	Massachusetts EOHHS (Modified by the Rhode Island Office of the Health Insurance Commissioner)
NQF Number	N/A
Data Sources	Numerator source: ACO/AE Denominator source: Payer

Population Health Impact
Complete, beneficiary-reported race data are critically important for identifying, analyzing, and addressing disparities in health and health care access and quality.

Measure Summary	
Description	The percentage of ACO/AE attributed members with self-reported race data that was collected by an ACO/AE in the measurement year.
Numerator	ACO/AE attributed members with self-reported race data that was collected by an ACO/AE during the measurement year
Denominator	ACO/AE attributed members in the measurement year

Eligible Population	
Age	ACO/AE attributed members 0 to 64 years of age as of December 31 of the measurement year
Continuous Enrollment	The measurement year
Allowable Gap	No more than one gap in enrollment of up to 45 days during the measurement year
Anchor Date	December 1st of the measurement year
Event/Diagnosis	None

Definitions	
Complete Race Data	Complete race data is defined as: At least one (1) valid race value (valid race values are listed in Attachment 1). ○ If value is "UNK" it will not count toward the numerator. ○ If value is "ASKU," it will count toward the numerator. ○ If value is "DONTKNOW," it will count toward the numerator. ○ Each value must be self-reported.

Data Collection	Race data may be collected: • over the phone, electronically (e.g. a patient portal), in person, by mail, etc.; • from an acute hospital; • must include one or more values in Attachment 1
Measurement Year	Measurement Years correspond to Calendar Years
Rate of Race Data Completeness	(Numerator Population / Eligible Population) * 100
Self-Reported Data	Race data must be self-reported. Race data that derived using an imputation methodology must not be included. For the purposes of this measure specification, data is considered to be self-reported if it has been provided by either: (a) the individual, or (b) a person who can act on the individual's behalf (e.g., parent, spouse, authorized representative, guardian, conservator, holder of power of attorney, or health-care proxy). Self-reported race data that has been rolled-up or transformed for reporting purposes may be included. For example, if an ACO/AE's data systems include races that are included in HHS' data collection standards and an individual self-reports their race as "Samoan", then the ACO/AE can report the value of "Native Hawaiian or Other Pacific Islander" since the value of Samoan is not a valid value in Attachment 1.

Administrative Specification	
Denominator	The eligible population
Numerator	For members in the denominator, identify those with complete race data, defined as: At least one (1) valid race value (valid race values are listed in Attachment 1). o If value is "UNK," it will not count toward the numerator. o If value is "ASKU," it will count toward the numerator. o If value is "DONTKNOW," it will count toward the numerator. o Each value must be self-reported.
Exclusions	If value is UTC, the member is excluded from the denominator.

Additional Measure Information	
Completeness Calculations	Completeness is calculated for each individual ACO/AE.

Attachment 1. Race: Accepted Values

	Description	Valid Values	Notes
Race	American Indian/Alaska Native	1002-5	
	Asian	2028-9	
	Black/African American	2054-5	
	Native Hawaiian or other Pacific Islander	2076-8	
	White	2106-3	
	Other Race	OTH	
	Choose not to answer	ASKU	Member was asked to provide their race, and the member actively selected or indicated that they "choose not to answer."
	Don't know	DONTKNOW	Member was asked to provide their race, and the member actively selected or indicated that they did not know their race.
	Unable to collect this information on member due to lack of clinical capacity of member to respond (e.g. clinical condition that alters consciousness)	UTC	Unable to collect this information on member due to lack of clinical capacity of member to respond.
	Unknown	UNK	The race of the member is unknown since either: (a) the member was not asked to provide their race, or (b) the member was asked to provide their race, and a response was not given. Note that a member actively selecting or indicating the response "choose not to answer" is a valid response, and should be assigned the value of ASKU instead of UNK.

Overview	
Measure Name	Rate of Hispanic or Latino Ethnicity Data Completeness – ACO/AE
Steward	Massachusetts EOHHS (Modified by the Rhode Island Office of the Health Insurance Commissioner)
NQF Number	N/A
Data Sources	Numerator source: ACO/AE Denominator source: Payer

Population Health Impact
Complete, beneficiary-reported ethnicity data are critically important for identifying, analyzing, and addressing disparities in health and health care access and quality.

Measure Summary	
Description	The percentage of ACO/AE attributed members with self-reported Hispanic or Latino ethnicity data that was collected by an ACO/AE in the measurement year.
Numerator	ACO/AE attributed members with self-reported Hispanic or Latino ethnicity data that was collected by an ACO/AE during the measurement year
Denominator	ACO/AE attributed members in the measurement year

Eligible Population	
Age	ACO/AE attributed members 0 to 64 years of age as of December 31 of the measurement year
Continuous Enrollment	The measurement year
Allowable Gap	No more than one gap in enrollment of up to 45 days during the measurement year
Anchor Date	December 1st of the measurement year
Event/Diagnosis	None

Definitions	
Complete Hispanic or Latino Ethnicity Data	Complete Hispanic ethnicity data is defined as: One (1) valid Hispanic or Latino ethnicity value (valid Hispanic or Latino ethnicity values are listed in Attachment 2). o If value is "UNK," it will <u>not</u> count toward the numerator.

	○ If value is "ASKU it will count toward the numerator. ○ If value is "DONTKNOW" it will count toward the numerator. ○ Each value must be self-reported.
Data Collection	Hispanic or Latino ethnicity data may be collected • over the phone, electronically (e.g. a patient portal), in person, by mail, etc. • from an acute hospital; • must include one value in Attachment 2
Measurement Year	Measurement Years correspond to Calendar Years
Rate of Hispanic or Latino Ethnicity Data Completeness	(Numerator Population / Eligible Population) * 100
Self-Reported Data	Hispanic or Latino ethnicity data must be self-reported. Hispanic or Latino ethnicity data that is a result of an imputation methodology must not be included. For the purposes of this measure specification, data is considered to be self-reported if it has been provided by either: (a) the individual, or (b) a person who can act on the individual's behalf (e.g., parent, spouse, authorized representative, guardian, conservator, holder of power of attorney, or health-care proxy). Self-reported Hispanic or Latino ethnicity data that has been rolled-up or transformed for reporting purposes may be included. For example, if an ACO/AE's data systems include ethnicities that are included in HHS' data collection standards (i.e., Mexican; Puerto Rican; Cuban; Another Hispanic, Latino/a, or Spanish origin) and an individual self-reports their ethnicity as "Puerto Rican", then the ACO/AE can report the value of "Hispanic or Latino" since the value of Puerto Rican is not a valid value in Attachment 2.

Administrative Specification	
Denominator	The eligible population
Numerator	For members in the denominator, identify those with complete Hispanic or Latino ethnicity data, defined as: One (1) valid Hispanic or Latino ethnicity value (valid Hispanic or Latino ethnicity values are listed in Attachment 2). ○ If value is "UNK," it will not count toward the numerator. ○ If value is "ASKU," it will count toward the numerator. ○ If value is "DONTKNOW," it will count toward the numerator.

	○ Each value must be self-reported.
Exclusions	If value is UTC, the member is excluded from the denominator.

Additional Measure Information	
Completeness Calculations	Completeness is calculated for each individual ACO/AE.

Attachment 2. Hispanic Ethnicity: Accepted Values

	Description	Valid Values	Notes
Hispanic or Latino Ethnicity	Hispanic or Latino	2135-2	
	Not Hispanic or Latino	2186-5	
	Choose not to answer	ASKU	Member was asked to provide their ethnicity, and the member actively selected or indicated that they "choose not to answer".
	Don't know	DONTKNOW	Member was asked to provide their ethnicity, and the member actively selected or indicated that they did not know not know their ethnicity.
	Unable to collect this information on member due to lack of clinical capacity of member to respond (e.g. clinical condition that alters consciousness).	UTC	Unable to collect this information on member due to lack of clinical capacity of member to respond
	Unknown	UNK	The ethnicity of the member is unknown since either: (a) the member was not asked to provide their ethnicity, or (b) the member was asked to provide their ethnicity, and a response was not given. Note that a member actively selecting or indicating the response "choose not to answer" is a valid response, and should be

			assigned the value of ASKU instead of UNK.

Overview	
Measure Name	Rate of English Proficiency Data Completeness – ACO/AE
Steward	Massachusetts EOHHS (Modified by the Rhode Island Office of the Health Insurance Commissioner)
NQF Number	N/A
Data Sources	Numerator source: ACO/AE Denominator source: Payer

Population Health Impact
Complete, beneficiary-reported English proficiency data are critically important for identifying, analyzing, and addressing disparities in health and health care access and quality.

Measure Summary	
Description	The percentage of ACO/AE attributed members with self-reported English Proficiency data that was collected by an ACO/AE in the measurement year.
Numerator	ACO/AE attributed members with self-reported English Proficiency data that was collected by an ACO/AE in the measurement year
Denominator	ACO/AE attributed members in the measurement year

Eligible Population	
Age	ACO/AE attributed members 0 to 64 years of age as of December 31 of the measurement year
Continuous Enrollment	The measurement year
Allowable Gap	No more than one gap in enrollment of up to 45 days during the measurement year
Anchor Date	December 1st of the measurement year
Event/Diagnosis	None

Definitions	
Complete English Proficiency Data	Complete English Proficiency data is defined as: One (1) valid English Proficiency Value (valid English Proficiency values are listed in Attachment 3). o If value is "UNK," it will not count toward the numerator. o If value is "ASKU," it will count toward the numerator.

	○ If value is "DONTKNOW," it will count toward the numerator. ○ Each value must be self-reported.
Data Collection	English Proficiency data may be collected • over the phone, electronically (e.g. a patient portal), in person, by mail, etc. • from an acute hospital; • must include one value in Attachment 3.
Measurement Year	Measurement Years correspond to Calendar Years
Rate of English Proficiency Data Completeness	(Numerator Population / Eligible Population) * 100
Self-Reported data	English Proficiency data must be self-reported. For the purposes of this measure specification, data is considered to be self-reported if it has been provided by either: (a) the individual, or (b) a person who can act on the individual's behalf (e.g., parent, spouse, authorized representative, guardian, conservator, holder of power of attorney, or health-care proxy).

Administrative Specification	
Denominator	The eligible population.
Numerator	For members in the denominator, identify those with complete English Proficiency data, defined as: One (1) valid English Proficiency value (valid English Proficiency values are listed in Attachment 3). ○ If value is "UNK," it will not count toward the numerator. ○ If value is "ASKU," it will count toward the numerator. ○ If value is "DONTKNOW," it will count toward the numerator. ○ Each value must be self-reported.
Exclusions	If value is UTC, the member is excluded from the denominator.
Additional Measure Information	
Completeness Calculations	Completeness is calculated for: each individual ACO/AE.

Attachment 3. English Proficiency: Accepted Values

	Description	Valid Values	Notes
English proficiency	Very well	VERWELL	
	Well	WELL	
	Not well	NOTWELL	
	Not at all	NOTALL	
	Choose not to Answer	ASKU	Member was asked to provide their English Proficiency, and the member actively selected or indicated that they "choose not to answer."
	Don't know	DONTKNOW	Member was asked to provide their English proficiency, and the member actively selected or indicated that they did not know their English proficiency.
	Unable to collect this information on member due to lack of clinical capacity of member to respond (e.g. clinical condition that alters consciousness)	UTC	Unable to collect this information on member due to lack of clinical capacity of member to respond.
	Unknown	UNK	The English Proficiency of the member is unknown since either: (a) the member was not asked to provide their English Proficiency, or (b) the member was asked to provide their English Proficiency, and a response was not given. Note that a member actively selecting or indicating the response "choose not to answer" is a valid response, and should

			be assigned the value of ASKU instead of UNK.