Connecticut Quality Council
2024 Aligned Measure Set
Measure Specifications

Asthma Medication Ratio (AMR)

SUMMARY OF CHANGES TO HEDIS MY 2023

- Added instructions to report rates stratified by race and ethnicity for each product line.
- Clarified in the "Event/diagnosis" criteria that required exclusions are not a step.
- Added a required exclusion for members who died during the measurement year.
- Removed "Dyphylline Guaifenesin Medications Lists" from the Asthma Controller Medications table.
- Added new data elements tables for race and ethnicity stratification reporting.
- Revised the "Other" criteria in the Nonclinical Components table under *Rules for Allowable Adjustments of HEDIS.*
- Revised the "Required exclusions" criteria in the Clinical Components table under *Rules for Allowable Adjustments of HEDIS*.
- Removed the *Note* from the "Event/diagnosis" criteria in the Clinical Components table under *Rules for Allowable Adjustments of HEDIS*.

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 indicates 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:*
  - White.
  - Black or African American.
  - American Indian or Alaska Native.
  - Asian.
  - Native Hawaiian or Other Pacific Islander.
  - 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 (ED Value Set), with a principal diagnosis of asthma (Asthma Value Set).
- At least one acute inpatient encounter (Acute Inpatient Value Set), with a principal diagnosis of asthma (Asthma Value Set) ***without*** telehealth (Telehealth Modifier Value Set; Telehealth POS Value Set).
- At least one acute inpatient discharge with a principal diagnosis of asthma (Asthma Value Set) on the discharge claim. To identify an acute inpatient discharge:
  1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
  2. Exclude nonacute inpatient stays (Nonacute Inpatient Stay Value Set).
  3. Identify the discharge date for the stay.
- At least four outpatient visits (Outpatient Value Set), observation visits (Observation Value Set), telephone visits (Telephone Visits Value Set) or e-visits or virtual check-ins (Online Assessments Value Set), on different dates of service, with any diagnosis of asthma (Asthma Value Set) ***and*** at least two asthma medication dispensing events for any controller or reliever medication. Visit type need not be the same for the four visits. Use all the medication lists in the tables below to identify asthma controller and reliever medications.
- At least four asthma medication dispensing events for any controller or reliever medication. Use all the medication lists in the tables below to identify asthma controller and reliever medications.

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

Required exclusions

Exclude members who met any of the following criteria:

- Members who had any diagnosis from any of the following value sets, any time during the member's history through December 31 of the measurement year:
  - Emphysema Value Set.
  - Other Emphysema Value Set.
  - COPD Value Set.
  - Obstructive Chronic Bronchitis Value Set.
  - Chronic Respiratory Conditions Due to Fumes or Vapors Value Set.
  - Cystic Fibrosis Value Set.
  - Acute Respiratory Failure Value Set.
- Members who had no asthma controller or reliever medications dispensed during the measurement year. Use all the medication lists in the tables below to identify asthma controller and reliever medications.
- Members in hospice or using hospice services any time during the measurement year. Refer to *General Guideline 15: Members in Hospice.*
- Members who died any time during the measurement year. Refer to *General Guideline 16: Deceased Members.*

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 .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
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	White	Direct	EligiblePopulation	For each Stratification
	BlackOrAfricanAmerican	Indirect	Numerator	For each Stratification
	AmericanIndianOrAlaskaNative	Total	Rate	(Percent)
	Asian			
	NativeHawaiianOrOtherPacificIslander			
	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*	Total	Rate	(Percent)
	Unknown**			

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

**Unknown is only reported for Source='Indirect.'

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.

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

Importance of the Quality Measure

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

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

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

Quality Measure Description

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

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

Required Medical Record Documentation

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

*Code for Behavioral Health Screening

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

Quality Improvement Opportunities

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

Tools & Resources for Healthcare Professionals

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

Resources for Patients and Families

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

Additional Information on HUSKY Health

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

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

References:

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

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

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

Breast Cancer Screening (BCS-E)

SUMMARY OF CHANGES TO HEDIS MY 2023

- Refer to the Technical Release Notes file in the Digital Measures Package for a comprehensive list of changes.
- Added new data elements tables for race and ethnicity stratification reporting.
- Revised the "other" criteria of the Nonclinical Components in the *Rules for Allowable Adjustments.*

Description	The percentage of women 50–74 years of age who 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)
Citations	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.
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—White. ▪ Race—Black or African American. ▪ Race—American Indian or Alaska Native. ▪ Race—Asian.

	▪ Race—Native Hawaiian or Other Pacific Islander. ▪ 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	• For Medicare plans, I-SNP and LTI exclusions are not included in the measure calculation logic and need to be programmed manually. Administrative data must be used for these exclusions. • Non-administrative data may be used for the frailty and advanced illness exclusion. **Allocation:** The member was enrolled with a medical benefit throughout the participation period. No more than one gap in enrollment of up to 45 days for each full calendar year of the participation period (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. When identifying members in hospice, the requirements described in *General Guideline 15* for identification of hospice members using the monthly membership detail data files are not included in the measure calculation logic and need to be programmed manually. **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. SES and product line stratifications are not included in the measure calculation logic and need to be programmed manually. The race and ethnicity stratifications are reported by data source—direct or indirect.

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	Women 52–74 years of age by the end of the measurement period who also meet the criteria for participation.
Exclusions	• Members in hospice or using hospice services 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 (Bilateral Modifier Value Set) (same procedure). – Unilateral mastectomy found in clinical data (Clinical Unilateral Mastectomy Value Set) with a bilateral modifier (Clinical Bilateral Modifier Value Set) (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 or different dates of service.

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

	• 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 of the following frailty and advanced illness criteria to be excluded: – 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. – Any of the following during the measurement period or the year prior to the measurement period (count services that occur over both years): ▪ At least two outpatient visits (Outpatient Value Set), observation visits (Observation Value Set), ED visits (ED Value Set), telephone visits (Telephone Visits Value Set), e-visits or virtual check-ins (Online Assessments Value Set), nonacute inpatient encounters (Nonacute Inpatient Value Set) or nonacute inpatient discharges (instructions below; the diagnosis must be on the discharge claim) on different dates of service, with an advanced illness diagnosis (Advanced Illness Value Set). Visit type need not be the same for the two visits. To identify a nonacute inpatient discharge: 1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set). 2. Confirm the stay was for nonacute care based on the presence of a nonacute code (Nonacute Inpatient Stay Value Set) on the claim. 3. Identify the discharge date for the stay. ▪ At least one acute inpatient encounter (Acute Inpatient Value Set) with an advanced illness diagnosis (Advanced Illness Value Set). ▪ At least one acute inpatient discharge with an advanced illness diagnosis (Advanced Illness Value Set) on the discharge claim. To identify an acute inpatient discharge: 1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set). 2. Exclude nonacute inpatient stays (Nonacute Inpatient Stay Value Set). 3. Identify the discharge date for the stay. ▪ A dispensed dementia medication (Dementia Medications List). • Members receiving palliative care (Palliative Care Assessment Value Set; Palliative Care Encounter Value Set; Palliative Care Intervention Value Set; ICD-10-CM code Z51.5) any time during the measurement period.
Denominator	The initial population, minus exclusions.

Numerator	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.

Data criteria (element level)

Value Sets:

- **BCSE_HEDIS_MY2023-2.0.0**
  - 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)
  - Bilateral Modifier (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1043)
  - Clinical Bilateral Modifier (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1951)
  - Clinical Left Modifier (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1949)
  - Clinical Right Modifier (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1950)
  - 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)
  - Left Modifier (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1148)
  - Mammography (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1168)
  - Right Modifier (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1230)
  - 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-2.0.0**
  - 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)
  - Observation (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1191)
  - 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-2.0.0**
  - 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-2.0.0**
  - 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-2.0.0**
  - 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-1.0.0**
  - American Indian or Alaska Native Detailed Race (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.2365)
  - Asian Detailed Race (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.2366)
  - Black or African American Detailed Race (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.2367)
  - Hispanic or Latino Detailed Ethnicity (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.2368)
  - Native Hawaiian or Other Pacific Islander Detailed Race (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.2369)
  - White Detailed Race (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.2370)

Direct reference codes and codesystems:

- **NCQA_PalliativeCare-2.0.0**
  - 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-2.0.0**
  - 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
White	Direct	InitialPopulation	For each Stratification
BlackOrAfricanAmerican	Indirect	Exclusions	For each Stratification
AmericanIndianOrAlaskaNative	Total	Denominator	For each Stratification
Asian		Numerator	For each Stratification
NativeHawaiianOrOtherPacificIslander		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*	Total	Denominator	For each Stratification
Unknown**		Numerator	For each Stratification
		Rate	(Percent)

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

**Unknown is only reported for Source='Indirect.'

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		
Eligible Population	**Adjustments Allowed (Yes/No)**	**Notes**
Event/diagnosis	NA	There is no event/diagnosis for this measure.
Denominator Exclusions	**Adjustments Allowed (Yes/No)**	**Notes**
Exclusions	No	Only specified exclusions may be applied. Value sets may not be changed.
Exclusions: Hospice, palliative care, I-SNP, LTI, frailty or advanced illness	Yes	These exclusions are not required. Refer to *Exclusions* in the *Guidelines for the Rules for Allowable Adjustments.*
Numerator Criteria	**Adjustments Allowed (Yes/No)**	**Notes**
Mammogram	No	Value sets and logic may not be changed.

Cervical Cancer Screening (CCS)

SUMMARY OF CHANGES TO HEDIS MY 2023

- Revised the optional exclusions for hysterectomy with no residual cervix, cervical agenesis or acquired absence of cervix to be required exclusions.
- Added a required exclusion for members who died during the measurement year.
- Added a direct reference code for palliative care.
- Revised the "Other" criteria in the Nonclinical Components table under *Rules for Allowable Adjustments of HEDIS.*
- Revised the "Exclusions" criteria in the Clinical Components table under *Rules for Allowable Adjustments of HEDIS*.

Description

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

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

Eligible Population

Product lines	Commercial, Medicaid (report each product line separately).
Ages	Women 24–64 years as of December 31 of the measurement year.
Continuous enrollment	*Commercial:* The measurement year and the 2 years prior to the measurement year. *Medicaid:* The measurement year.
Allowable gap	No more than one gap in enrollment of up to 45 days during each year of continuous enrollment. To determine continuous enrollment for a Medicaid beneficiary for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage (e.g., a member whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).
Anchor date	December 31 of the measurement year.
Benefit	Medical.
Event/diagnosis	None.
Required exclusions	Exclude members who meet any of the following criteria: • Hysterectomy with no residual cervix, cervical agenesis or acquired absence of cervix (Absence of Cervix Diagnosis Value Set; Hysterectomy

With No Residual Cervix Value Set) any time during the member's history through December 31 of the measurement year.

- Members in hospice or using hospice services any time during the measurement year. Refer to *General Guideline 15: Members in Hospice*.
- Members who died any time during the measurement year. Refer to *General Guideline 16: Deceased Members.*
- Members receiving palliative care (Palliative Care Assessment Value Set; Palliative Care Encounter Value Set; Palliative Care Intervention Value Set; ICD-10-CM code Z51.5) any time during the measurement year.

Administrative Specification

Denominator The eligible population.

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

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

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

Hybrid Specification

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

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

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

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

- Women 24–64 years of age as of December 31 of the measurement year who had cervical cytology during the measurement year or the 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.

– Count any cervical cancer screening method that includes collection and microscopic analysis of cervical cells. Do not count lab results that explicitly state the sample was inadequate or that "no cervical cells were present"; this is not considered appropriate screening.

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

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

- Women 30–64 years of age as of December 31 of the measurement year who had cervical high-risk human papillomavirus (hrHPV) testing during the measurement year or the 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.

– 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	
	Denominator	Report once	
	NumeratorByAdmin	Report once	✓
	NumeratorByMedicalRecords	Report once	
	NumeratorBySupplemental	Report once	✓
	Rate	(Percent)	✓

Rules for Allowable Adjustments of HEDIS

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

Rules for Allowable Adjustments of 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, 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, 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.

Child and Adolescent Well-Care Visits (WCV)

SUMMARY OF CHANGES TO HEDIS MY 2023

- Added a required exclusion for members who died during the measurement year.
- Revised the "Required exclusions" criteria in the Clinical Components table under *Rules for Allowable Adjustments of HEDIS.*
- Revised the "Other" criteria in the Nonclinical Components table under *Rules for Allowable Adjustments of HEDIS.*

Description

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

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

Eligible Population

Product lines

Commercial, Medicaid (report each product line separately).

Stratifications

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

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

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

Ages	3–21 years as of December 31 of the measurement year. Report three age stratifications and total rate: • 3–11 years. • 12–17 years. • 18–21 years. • Total. The total is the sum of the age stratifications for each product line.
Continuous enrollment	The measurement year.
Allowable gap	No more than one gap in enrollment of up to 45 days during the continuous enrollment period. To determine continuous enrollment for a Medicaid member for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage (e.g., a member whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).
Anchor date	December 31 of the measurement year.
Benefit	Medical.
Event/diagnosis	None.
Required exclusions	Exclude members who meet either of the following criteria: • Members in hospice or using hospice services any time during the measurement year. Refer to *General Guideline 15: Members in Hospice.* • Members who died any time during the measurement year. *Refer to General Guideline 16: Deceased Members.*

Administrative Specification

Denominator	The eligible population.
Numerator	One or more well-care visits (Well-Care Value Set) during the measurement year. The well-care visit must occur with a PCP or an OB/GYN practitioner, but the practitioner does not have to be the practitioner assigned to the member.

Note

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

Data Elements for Reporting

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

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

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

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

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

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

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

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

**Unknown is only reported for Source='Indirect.'

Rules for Allowable Adjustments of HEDIS

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

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

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

Chlamydia Screening in Women (CHL)

SUMMARY OF CHANGES TO HEDIS MY 2023

- Revised the optional exclusions for pregnancy test to be step 3 of the event/diagnosis criteria.
- Added a required exclusion for members who died during the measurement year.
- Revised the "Other" criteria in the Nonclinical Components table under *Rules for Allowable Adjustments of HEDIS.*
- Revised the "Exclusions" criteria in the Clinical Components table under *Rules for Allowable Adjustments of HEDIS*.

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. A code from any of the following meets criteria:

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

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

Contraceptive Medications

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

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 in hospice or using hospice services any time during the measurement year. Refer to *General Guideline 15: Members in Hospice*.
- Members who died any time during the measurement year. Refer to *General Guideline 16: Deceased Members*.

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

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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, 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 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)

SUMMARY OF CHANGES TO HEDIS MY 2023

- Revised the optional exclusions for colorectal cancer and total colectomy to be required exclusions.
- Added a required exclusion for members who died during the measurement year.
- Updated the number of occurrences required for the frailty cross-cutting exclusion.
- Added a direct reference code for palliative care.
- Updated the Hybrid Specification to indicate that sample size reduction is allowed.
- Revised the medical record criteria for a completed colonoscopy.
- Revised the "Other" criteria in the Nonclinical Components table under *Rules for Allowable Adjustments of HEDIS.*
- Revised the "Exclusions" criteria in the Clinical Components table under *Rules for Allowable Adjustments of HEDIS*.

Description

The percentage of members 45–75 years of age who had appropriate screening for colorectal cancer.

Note

- *Only the administrative data collection method may be used when reporting this measure for the Medicaid product line.*

Eligible Population

Product lines

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

Stratifications

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.*

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

- *Race:*
  - White.
  - Black or African American.
  - American Indian or Alaska Native.

  - Asian.
  - Native Hawaiian or Other Pacific Islander.
  - 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

46–75 years as of December 31 of the measurement year. Report two age stratifications and a total rate:

- 46–49 years.
- 50–75 years.
- Total.

The total is the sum of the age stratifications.

Continuous enrollment

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

Allowable gap

No more than one gap in continuous enrollment of up to 45 days during each year of continuous enrollment.

Anchor date

December 31 of the measurement year.

Benefit

Medical.

Event/diagnosis

None.

Required exclusions

Exclude members who meet any of the following criteria:

- Members who had colorectal cancer (Colorectal Cancer Value Set) or a total colectomy (Total Colectomy Value Set; History of Total Colectomy Value Set) any time during the member's history through December 31 of the measurement year.
- Members in hospice or using hospice services anytime during the measurement year. Refer to *General Guideline 15: Members in Hospice*.
- Members who died any time during the measurement year. Refer to *General Guideline 16: Deceased Members.*
- Members receiving palliative care (Palliative Care Assessment Value Set; Palliative Care Encounter Value Set; Palliative Care Intervention Value Set; ICD-10-CM code Z51.5) any time during the measurement year.

Exclusions

Exclude members who meet any of the following criteria:

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

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

Dementia Medications

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

Administrative Specification

Denominator The eligible population.

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

- Fecal occult blood test (FOBT Lab Test Value Set; FOBT Test Result or Finding Value Set) during the measurement year. For administrative data, assume the required number of samples were returned, regardless of FOBT type.
- Flexible sigmoidoscopy (Flexible Sigmoidoscopy Value Set; History of Flexible Sigmoidoscopy Value Set) during the measurement year or the 4 years prior to the measurement year.
- Colonoscopy (Colonoscopy Value Set; History of Colonoscopy Value Set) during the measurement year or the 9 years prior to the measurement year.
- CT colonography (CT Colonography Value Set) during the measurement year or the 4 years prior to the measurement year.
- Stool DNA (sDNA) with FIT test (sDNA FIT Lab Test Value Set; sDNA FIT Test Result or Finding Value Set) during the measurement year or the 2 years prior to the measurement year.

Hybrid Specification

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

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

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

- FOBT during the measurement year.
- Flexible sigmoidoscopy during the measurement year or the 4 years prior to the measurement year.
- Colonoscopy during the measurement year or the 9 years prior to the measurement year.

- CT colonography during the measurement year or the 4 years prior to the measurement year.
- Stool DNA (sDNA) with FIT test during the measurement year or the 2 years prior to the measurement year.

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

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

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

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

- Evidence that the scope advanced to the cecum meets criteria for a completed colonoscopy.
- Evidence that the scope advanced into the sigmoid colon meets criteria for a completed flexible sigmoidoscopy.

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

- If the medical record does not indicate the type of test and there is no indication of how many samples were returned, assume the required number was returned. The member meets the screening criteria for inclusion in the numerator.
- If the medical record does not indicate the type of test and the number of returned samples is specified, the member meets the screening criteria only if the number of samples specified is greater than or equal to three samples. If there are fewer than three samples, the member does not meet the screening criteria for inclusion.
- FIT tests may require fewer than three samples. If the medical record indicates that an FIT was done, the member meets the screening criteria, regardless of how many samples were returned.
- If the medical record indicates that a gFOBT was done, follow the scenarios below.
  - *If the medical record does not indicate the number of returned samples,* assume the required number was returned. The member meets the screening criteria for inclusion in the numerator.
  - *If the medical record indicates that three or more samples were returned,* the member meets the screening criteria for inclusion in the numerator.
  - *If the medical record indicates that fewer than three samples were returned,* the member does not meet the screening criteria.

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

Data Elements for Reporting

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

Table COL-A-1: Data Elements for Colorectal Cancer Screening

Metric	Age	Data Element	Reporting Instructions
ColorectalCancerScreening	46-49	EligiblePopulation	For each Stratification
	50-75	ExclusionAdminRequired	For each Stratification
	Total	NumeratorByAdmin	For each Stratification
		NumeratorBySupplemental	For each Stratification
		Rate	(Percent)

Table COL-A-2: Data Elements for Colorectal Cancer Screening

Metric	Age	Data Element	Reporting Instructions	A
ColorectalCancerScreening	46-49	CollectionMethod	Repeat per Stratification	✓
	50-75	EligiblePopulation	For each Stratification	✓
	Total	ExclusionAdminRequired	For each Stratification	✓
		NumeratorByAdminElig	For each Stratification	
		CYAR	Only for Total (Percent)	
		MinReqSampleSize	Repeat per Stratification	
		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 COL-A-3: Data Elements for Colorectal Cancer Screening

Metric	Age	SES Stratification	Data Element	Reporting Instructions	A
ColorectalCancerScreening	46-49	NonLisDeNondisability	CollectionMethod	Repeat per Stratification	✓
	50-75	LisDe	EligiblePopulation	For each Stratification	✓
	Total	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 COL-B-1/2/3: Data Elements for Colorectal Cancer Screening: Stratifications by Race

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

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

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

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

**Unknown is only reported for Source='Indirect.'

***The CollectionMethod and Denominator data elements are not available for Medicaid reporting.

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

NONCLINICAL COMPONENTS		
Eligible Population	**Adjustments Allowed (Yes/No)**	**Notes**
Product lines	Yes	Organizations are not required to use product line criteria; product lines may be combined and all (or no) product line criteria may be used.
Ages	Yes, with limits	The age determination dates may be changed (e.g., select, "age as of June 30"). The denominator age may not be expanded.
Continuous enrollment, allowable gap, anchor date	Yes	Organizations are not required to use enrollment criteria; adjustments are allowed.
Benefit	Yes	Organizations are not required to use a benefit; adjustments are allowed.
Other	Yes	Organizations may use additional eligible population criteria to focus on 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, 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*
Exclusions: I-SNP, LTI, frailty or advanced illness	Yes	These exclusions are not required. Refer to *Exclusions* in the *Guidelines for the Rules for Allowable Adjustments*.
Numerator Criteria	**Adjustments Allowed (Yes/No)**	**Notes**
Colorectal Cancer Screening	No	The value sets and the logic may not be changed.

Data Update Freeze

CMIT will undergo system updates requiring a data update freeze starting July 14, 2023 at 11:59 PM. Data is current as of that date and will undergo any pending updates after the system updates are complete. Please reach out to MMSsupport@battelle.org with any specific questions.

Concurrent Use of Opioids and Benzodiazepines (COB-AD)

CMIT Measure ID: 150 | **CMIT ID:** 00150-01-C-MACS | **Measure Type:** Process

Date of Information: 01/17/2023 | **Revision:** 4 | **Program:** Medicaid: Adult Core Set

View Description +

Properties

Date of Information	01/17/2023
Abbreviated Measure Title	Not Available
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.
Numerator	The number of beneficiaries from the denominator with: * Two or more prescription claims for any benzodiazepine with different dates of service, AND * Concurrent use of opioids and benzodiazepines for 30 or more cumulative days
Denominator	Age 18 and older as of January 1 of the measurement year. Step 1 Identify beneficiaries with 2 or more prescription claims for opioid medications 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. Step 2 * Identify beneficiaries with an IPSD on January 1 through December 2 of the measurement year.

Denominator Exclusions	Beneficiaries with a cancer diagnosis, sickle cell disease diagnosis, or in hospice or palliative care are excluded. The cancer exclusion criterion is for beneficiaries with a diagnosis code for cancer during the measurement year. Their initial diagnosis may have occurred previously; however, the diagnosis code for cancer must be present during the measurement year for the individual to be excluded.
Rationale	Not Available
Evidence	Not Available
Denominator Exceptions	Not applicable
Numerator Exceptions	Not applicable
Risk Adjusted	No
Program Name Abbreviation	MACS
Program Status	Active

Controlling High Blood Pressure (CBP)

SUMMARY OF CHANGES TO HEDIS MY 2023

- Added a required exclusion for members who died during the measurement year.
- Replaced the reference of "female members" to "members" in the required exclusions.
- Added a direct reference code for palliative care.
- Revised the optional exclusions to be required exclusions.
- Updated the number of occurrences required for the frailty cross-cutting exclusion.
- Revised the "Other" criteria in the Nonclinical Components table under *Rules for Allowable Adjustments of HEDIS.*
- Revised the "Exclusions" criteria in the Clinical Components table under *Rules for Allowable Adjustments of HEDIS*.

Description

The percentage of members 18–85 years of age who had a diagnosis of hypertension (HTN) and whose blood pressure (BP) was adequately controlled (<140/90 mm Hg) during the measurement year.

Definitions

Adequate control Both a representative systolic BP <140 mm Hg and a representative diastolic BP of <90 mm Hg.

Representative BP The most recent BP reading during the measurement year on or after the second diagnosis of hypertension. If multiple BP measurements occur on the same date, or are noted in the chart on the same date, use the lowest systolic and lowest diastolic BP reading. If no BP is recorded during the measurement year, assume that the member is "not controlled."

Eligible Population

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

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

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

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

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

Ages 18–85 years as of December 31 of the measurement year.

Continuous enrollment The measurement year.

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

Anchor date December 31 of the measurement year.

Benefit Medical.

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

Step 1 Identify members who had at least two visits on different dates of service with a diagnosis of hypertension on or between January 1 of the year prior to the measurement year and June 30 of the measurement year. Visit type need not be the same for the two visits. Any of the following code combinations meet criteria:

- Outpatient visit (Outpatient Without UBREV Value Set) with any diagnosis of hypertension (Essential Hypertension Value Set).
- A telephone visit (Telephone Visits Value Set) with any diagnosis of hypertension (Essential Hypertension Value Set).
- An e-visit or virtual check-in (Online Assessments Value Set) with any diagnosis of hypertension (Essential Hypertension Value Set).

Step 2 Remove members who had a nonacute inpatient admission during the measurement year. To identify nonacute inpatient admissions:

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

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

- Members in hospice or using hospice services any time during the measurement year. Refer to *General Guideline 15: Members in Hospice.*
- Members who died any time during the measurement year. Refer to *General Guideline 16: Deceased Members.*

- Members receiving palliative care (Palliative Care Assessment Value Set; Palliative Care Encounter Value Set; Palliative Care Intervention Value Set; ICD-10-CM code Z51.5) any time during the measurement year.
- Members with evidence of end-stage renal disease (ESRD) (ESRD Diagnosis Value Set), dialysis (Dialysis Procedure Value Set), nephrectomy (Total Nephrectomy Value Set; Partial Nephrectomy Value Set) or kidney transplant (Kidney Transplant Value Set; History of Kidney Transplant Value Set) any time during the member's history on or prior to December 31 of the measurement year.
- Members with a diagnosis of pregnancy (Pregnancy Value Set) any time during the measurement year.

Exclusions

Exclude members who meet any of the following criteria:

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

- Medicare members 66 years of age and older as of December 31 of the measurement year who meet either of the following:
  - Enrolled in an Institutional SNP (I-SNP) any time during the measurement year.
  - Living long-term in an institution any time during the measurement year as identified by the LTI flag in the Monthly Membership Detail Data File. Use the run date of the file to determine if a member had an LTI flag during the measurement year.
- Members 66–80 years of age as of December 31 of the measurement year (all product lines) with frailty ***and*** advanced illness. Members must meet *both* of the following frailty and advanced illness criteria to be excluded:
  1. At least 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.
  2. Any of the following during the measurement year or the year prior to the measurement year (count services that occur over both years):
     - At least two outpatient visits (Outpatient Value Set), observation visits (Observation Value Set), ED visits (ED Value Set), telephone visits (Telephone Visits Value Set), e-visits or virtual check-ins (Online Assessments Value Set), nonacute inpatient encounters (Nonacute Inpatient Value Set) or nonacute inpatient discharges (instructions below; the diagnosis must be on the discharge claim) on different dates of service, with an advanced illness diagnosis (Advanced Illness Value Set). Visit type need not be the same for the two visits. To identify a nonacute inpatient discharge:
       1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
       2. Confirm the stay was for nonacute care based on the presence of a nonacute code (Nonacute Inpatient Stay Value Set) on the claim.
       3. Identify the discharge date for the stay.
     - At least one acute inpatient encounter (Acute Inpatient Value Set) with an advanced illness diagnosis (Advanced Illness Value Set).

  - At least one acute inpatient discharge with an advanced illness diagnosis (Advanced Illness Value Set) on the discharge claim. To identify an acute inpatient discharge:
    1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
    2. Exclude nonacute inpatient stays (Nonacute Inpatient Stay Value Set).
    3. Identify the discharge date for the stay.
  - A dispensed dementia medication (Dementia Medications List).
- Members 81 years of age and older as of December 31 of the measurement year (all product lines) with 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.

Dementia Medications

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

Administrative Specification

Denominator The eligible population.

Numerator Identify the most recent BP reading (Systolic Blood Pressure Value Set; Diastolic Blood Pressure Value Set) taken during the measurement year. Exclude BPs taken in an acute inpatient setting (Acute Inpatient Value Set; Acute Inpatient POS Value Set) or during an ED visit (ED Value Set; ED POS Value Set).

The BP reading must occur *on or after* the date of the second diagnosis of hypertension (identified using the event/diagnosis criteria).

The member is numerator compliant if the BP is <140/90 mm Hg. The member is not compliant if the BP is ≥140/90 mm Hg, if there is no BP reading during the measurement year or if the reading is incomplete (e.g., the systolic or diastolic level is missing). If there are multiple BPs on the same date of service, use the lowest systolic and lowest diastolic BP on that date as the representative BP.

Organizations that use CPT Category II codes to identify numerator compliance for this indicator must search for all codes in the following value sets and use the most recent codes during the measurement year to determine numerator compliance for both systolic and diastolic levels.

Value Set	Numerator Compliance
Systolic Less Than 140 Value Set	Systolic compliant
Systolic Greater Than or Equal To 140 Value Set	Systolic not compliant
Diastolic Less Than 80 Value Set	Diastolic compliant
Diastolic 80–89 Value Set	Diastolic compliant
Diastolic Greater Than or Equal To 90 Value Set	Diastolic not compliant

Hybrid Specification

Denominator

A systematic sample drawn from the eligible population.

The organization may reduce the sample size using the current year's administrative rate or the prior year's audited, product line specific rate. Refer to the *Guidelines for Calculations and Sampling* for information on reducing the sample size.

Identifying the medical record

All eligible BP measurements recorded in the record must be considered. If an organization cannot find the medical record, the member remains in the measure denominator and is considered noncompliant for the numerator.

Use the following guidance to find the appropriate medical record to review.

- Identify the member's PCP.
- If the member had more than one PCP for the time period, identify the PCP who most recently provided care to the member.
- If the member did not visit a PCP for the time period or does not have a PCP, identify the practitioner who most recently provided care to the member.
- If a practitioner other than the member's PCP manages the hypertension, the organization may use the medical record of that practitioner.

Numerator

The number of members in the denominator whose most recent BP (both systolic and diastolic) is adequately controlled during the measurement year. For a member's BP to be controlled, the systolic and diastolic BP must be <140/90 mm Hg (adequate control). To determine if a member's BP is adequately controlled, the representative BP must be identified.

Administrative

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

Medical record

Identify the most recent BP reading noted during the measurement year.

The BP reading must occur on or after the date when the second diagnosis of hypertension (identified using the event/diagnosis criteria) occurred.

Do not include BP readings:

- Taken during an acute inpatient stay or an ED visit.
- Taken on the same day as a diagnostic test or diagnostic or therapeutic procedure that requires a change in diet or change in medication on or one day before the day of the test or procedure, with the exception of fasting blood tests.

- Taken by the member using a non-digital device such as with a manual blood pressure cuff and a stethoscope.

Identify the lowest systolic and lowest diastolic BP reading from the most recent BP notation in the medical record. If multiple readings were recorded for a single date, use the lowest systolic and lowest diastolic BP on that date as the representative BP. The systolic and diastolic results do not need to be from the same reading.

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

The member is not compliant if the BP reading is ≥140/90 mm Hg or is missing, or if there is no BP reading during the measurement year or if the reading is incomplete (e.g., the systolic or diastolic level is missing).

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

Note

- *When identifying the most recent BP reading, all eligible BP readings in the appropriate medical record should be considered, regardless of practitioner type and setting (excluding acute inpatient and ED visit settings).*
- *An EMR can be used to identify the most recent BP reading if it meets the criteria for appropriate medical record.*
- *When excluding BP readings from the numerator, the intent is to identify diagnostic or therapeutic procedures that require a medication regimen, a change in diet or a change in medication. For example (this list is for reference only and is not exhaustive):*
  - *A colonoscopy requires a change in diet (NPO on the day of the procedure) and a medication change (a medication is taken to prep the colon).*
  - *Dialysis, infusions and chemotherapy (including oral chemotherapy) are all therapeutic procedures that require a medication regimen.*
  - *A nebulizer treatment with albuterol is considered a therapeutic procedure that requires a medication regimen (the albuterol).*
  - *A patient forgetting to take regular medications on the day of the procedure is not considered a required change in medication and therefore the BP reading is eligible.*
- *BP readings taken on the same day that the member receives a common low-intensity or preventive procedure are eligible for use. For example, the following procedures are considered common low-intensity or preventive (this list is for reference only and is not exhaustive):*
  - *Vaccinations.*
  - *Injections (e.g., allergy, vitamin B-12, insulin, steroid, toradol, Depo-Provera, testosterone, lidocaine).*
  - *TB test.*
  - *IUD insertion.*
  - *Eye exam with dilating agents.*
  - *Wart or mole removal.*

Data Elements for Reporting

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

Table CBP-A-1/2/3: Data Elements for Controlling High Blood Pressure

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

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

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

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

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

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

**Unknown is only reported for Source='Indirect.'

Rules for Allowable Adjustments of HEDIS

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

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

Rules for Allowable Adjustments of Controlling High Blood Pressure

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

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 2023

- Added a required exclusion for members who died during the measurement year.
- Added a direct reference code for palliative care.
- Updated the number of occurrences required for the frailty cross-cutting exclusion.
- Added a *Note* to clarify that an eye exam result documented as "unknown" does not meet criteria.
- Revised the "Other" criteria in the Nonclinical Components table under *Rules for Allowable Adjustments of HEDIS.*
- Revised the "Required 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).

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: *The 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 met any of the following criteria during the measurement year or the year prior to the measurement year (count services that occur over both years):

- At least one acute inpatient encounter (Acute Inpatient Value Set) with a diagnosis of diabetes (Diabetes Value Set) ***without*** telehealth (Telehealth Modifier Value Set; Telehealth POS Value Set).
- At least one acute inpatient discharge with a diagnosis of diabetes (Diabetes Value Set) on the discharge claim. To identify an acute inpatient discharge:
  1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
  2. Exclude nonacute inpatient stays (Nonacute Inpatient Stay Value Set).
  3. Identify the discharge date for the stay.
- At least two outpatient visits (Outpatient Value Set), observation visits (Observation Value Set), telephone visits (Telephone Visits Value Set), e-visits or virtual check-ins (Online Assessments Value Set), ED visits (ED Value Set), nonacute inpatient encounters (Nonacute Inpatient Value Set) or nonacute inpatient discharges (instructions below; the diagnosis must be on the discharge claim), on different dates of service, with a diagnosis of diabetes (Diabetes Value Set). Visit type need not be the same for the two encounters. To identify a nonacute inpatient discharge:
  1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
  2. Confirm the stay was for nonacute care based on the presence of a nonacute code (Nonacute Inpatient Stay Value Set) on the claim.
  3. Identify the discharge date for the stay.

  Only include nonacute inpatient encounters (Nonacute Inpatient Value Set) ***without*** telehealth (Telehealth Modifier Value Set; Telehealth POS Value Set).
- *Pharmacy data*. Members who were dispensed insulin or hypoglycemics/ antihyperglycemics during the measurement year or the year prior to the measurement year (Diabetes Medications List).

Diabetes Medications

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

Description	Prescription		
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	
Glucagon-like peptide-1 (GLP1) agonists	• Albiglutide • Dulaglutide • Exenatide	• Liraglutide (excluding Saxenda®) • Lixisenatide • Semaglutide	
Sodium glucose cotransporter 2 (SGLT2) inhibitor	• Canagliflozin	• Dapagliflozin (excluding Farxiga®)	• Empagliflozin • Ertugliflozin
Sulfonylureas	• Chlorpropamide • Glimepiride	• Glipizide • Glyburide	• Tolazamide • Tolbutamide
Thiazolidinediones	• Pioglitazone	• Rosiglitazone	
Dipeptidyl peptidase-4 (DDP-4) inhibitors	• Alogliptin • Linagliptin	• Saxagliptin • Sitagliptin	

Note: *Glucophage/metformin as a solo agent is not included because it is used to treat conditions other than diabetes; members with diabetes on these medications are identified through diagnosis codes only.*

Required exclusions

Exclude members who meet any of the following criteria:

- Members who did not have a diagnosis of diabetes (Diabetes Value Set), in any setting, during the measurement year or the year prior to the measurement year ***and*** who had a diagnosis of polycystic ovarian syndrome, gestational diabetes or steroid-induced diabetes (Diabetes Exclusions Value Set), in any setting, during the measurement year or the year prior to the measurement year.
- Members in hospice or using hospice services any time during the measurement year. Refer to *General Guideline 15: Members in Hospice.*
- Members who died any time during the measurement year. Refer to *General Guideline 16: Deceased Members.*
- Members receiving palliative care (Palliative Care Assessment Value Set; Palliative Care Encounter Value Set; Palliative Care Intervention Value Set; ICD-10-CM code Z51.5) any time during the measurement year.

Exclusions

Exclude members who meet any of the following criteria:

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

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

Dementia Medications

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

Administrative Specification

Denominator The eligible population.

Numerator 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 or Automated Eye Exam Value Set billed by any provider type during the measurement year.
- Any code in the Eye Exam Without Evidence of Retinopathy Value Set billed by any provider type during the year prior to the measurement year.
- Any code in the Diabetic Retinal Screening Negative In Prior Year Value Set billed by any provider type during the measurement year.
- Unilateral eye enucleation (Unilateral Eye Enucleation Value Set) ***with*** a bilateral modifier (Bilateral Modifier Value Set).
- Two unilateral eye enucleations (Unilateral Eye Enucleation Value Set) with service dates 14 days or more apart. For example, if the service date for the first unilateral eye enucleation was February 1 of the measurement year, the service date for the second unilateral eye enucleation must be on or after February 15.
- Left unilateral eye enucleation (Unilateral Eye Enucleation Left Value Set) ***and*** right unilateral eye enucleation (Unilateral Eye Enucleation Right Value Set) on the same or different dates of service.

- A unilateral eye enucleation (Unilateral Eye Enucleation Value Set) and a left unilateral eye enucleation (Unilateral Eye Enucleation Left Value Set) with service dates 14 days or more apart.
- A unilateral eye enucleation (Unilateral Eye Enucleation Value Set) and a right unilateral eye enucleation (Unilateral Eye Enucleation Right Value Set) with service dates 14 days or more apart.

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 Hemoglobin A1c Control for Patients With Diabetes (HBD), 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 HbA1c poor control >9.0% rate (100 minus the HbA1c poor control rate) before reducing the sample.

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

If separate samples are used for the HBD, 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.*

Data Elements for Reporting

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

Table EED-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-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)	✓

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, 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*.
Exclusions: I-SNP, LTI, frailty or advanced illness	Yes	These exclusions are not required. Refer to *Exclusions* in the *Guidelines for the Rules for Allowable Adjustments*.
Numerator Criteria	**Adjustments Allowed (Yes/No)**	**Notes**
Eye Exam for Patients With Diabetes	No	Value sets and logic may not be changed.

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

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

SUMMARY OF CHANGES TO HEDIS MY 2023

- Added a required exclusion for members who died during the measurement year.
- Revised the "Other" criteria in the Nonclinical Components table under *Rules for Allowable Adjustments of HEDIS.*
- Revised the "Required exclusions" criteria in the Clinical Components table under *Rules for Allowable Adjustments of HEDIS*.

Description

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

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

Eligible Population

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

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

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

The total is the sum of the age stratifications.

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

Allowable gap None.

Anchor date None.

Benefit Medical and mental health.

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

The denominator for this measure is based on ED visits, not on members. If a member has more than one ED visit, identify all eligible ED visits between

January 1 and December 1 of the measurement year and do not include more than one visit per 31-day period as described below.

Multiple visits in a 31-day period

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

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

ED visits followed by inpatient admission

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

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

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

Required exclusions

Exclude members who meet either of the following criteria:

- Members in hospice or using hospice services anytime during the measurement year. Refer to *General Guideline 15: Members in Hospice*.
- Members who died any time during the measurement year. Refer to *General Guideline 16: Deceased Members.*

Administrative Specification

Denominator

The eligible population.

Numerators

30-Day Follow-Up

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

7-Day Follow-Up

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

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

- An outpatient visit (Visit Setting Unspecified Value Set ***with*** Outpatient POS Value Set) ***with*** a principal diagnosis of a mental health disorder (Mental Health Diagnosis Value Set).

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

- A community mental health center visit (Visit Setting Unspecified Value Set ***with*** Community Mental Health Center POS Value Set), ***with*** a principal diagnosis of intentional self-harm (Intentional Self-Harm Value Set), ***with*** any diagnosis of a mental health disorder (Mental Health Diagnosis Value Set).
- Electroconvulsive therapy (Electroconvulsive Therapy Value Set) ***with*** (Ambulatory Surgical Center POS Value Set; Community Mental Health Center POS Value Set; Outpatient POS Value Set; Partial Hospitalization POS Value Set) ***with*** a principal diagnosis of intentional self-harm (Intentional Self-Harm Value Set), ***with*** any diagnosis of a mental health disorder (Mental Health Diagnosis Value Set).
- A telehealth visit (Visit Setting Unspecified Value Set ***with*** Telehealth POS Value Set), ***with*** a principal diagnosis of intentional self-harm (Intentional Self-Harm Value Set), ***with*** any diagnosis of a mental health disorder (Mental Health Diagnosis Value Set).
- An observation visit (Observation Value Set) ***with*** a principal diagnosis of intentional self-harm (Intentional Self-Harm Value Set), ***with*** any diagnosis of a mental health disorder (Mental Health Diagnosis Value Set).
- A telephone visit (Telephone Visits Value Set) ***with*** a principal diagnosis of intentional self-harm (Intentional Self-Harm Value Set), ***with*** any diagnosis of a mental health disorder (Mental Health Diagnosis Value Set).
- An e-visit or virtual check-in (Online Assessments Value Set) ***with*** a principal diagnosis of intentional self-harm (Intentional Self-Harm Value Set), ***with*** any diagnosis of a mental health disorder (Mental Health Diagnosis Value Set).

Note

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

Data Elements for Reporting

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

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

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

Rules for Allowable Adjustments of HEDIS

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

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

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

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

Follow-Up After Hospitalization for Mental Illness (FUH)

SUMMARY OF CHANGES TO HEDIS MY 2023

- Added a required exclusion for members who died during the measurement year.
- Revised the "Other" criteria in the Nonclinical Components table under *Rules for Allowable Adjustments of HEDIS.*
- Revised the "Required exclusions" criteria in the Clinical Components table under *Rules for Allowable Adjustments of HEDIS*.

Description

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

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

Eligible Population

Product lines	Commercial, Medicaid, Medicare (report each product line separately).
Ages	6 years and older as of the date of discharge. Report three age stratifications and a total rate: • 6–17 years. • 18–64 years. • 65 years and older. • Total. The total is the sum of the age stratifications.
Continuous enrollment	Date of discharge through 30 days after discharge.
Allowable gap	None.
Anchor date	None.
Benefits	Medical and mental health (inpatient and outpatient).
Event/diagnosis	An acute inpatient discharge with a principal diagnosis of mental illness or intentional self-harm (Mental Illness Value Set; Intentional Self-Harm Value Set) on the discharge claim on or between January 1 and December 1 of the measurement year. To identify acute inpatient discharges: 1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set). 2. Exclude nonacute inpatient stays (Nonacute Inpatient Stay Value Set). 3. Identify the discharge date for the stay.

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

Acute readmission or direct transfer

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

1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
2. Exclude nonacute inpatient stays (Nonacute Inpatient Stay Value Set).
3. Identify the admission date for the stay (the admission date must occur during the 30-day follow-up period).
4. Identify the discharge date for the stay.

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

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

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

Nonacute readmission or direct transfer

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

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

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

Required exclusions

Exclude members who meet either of the following criteria:

- Members in hospice or using hospice services anytime during the measurement year. Refer to *General Guideline 15: Members in Hospice*.
- Members who died any time during the measurement year. Refer to *General Guideline 16: Deceased Members*.

Administrative Specification

Denominator

The eligible population.

Numerators

30-Day Follow-Up

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

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

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

- An outpatient visit (Visit Setting Unspecified Value Set) ***with*** (Outpatient POS Value Set) ***with*** a mental health provider.
- An outpatient visit (BH Outpatient Value Set) ***with*** a mental health provider.
- An intensive outpatient encounter or partial hospitalization (Visit Setting Unspecified Value Set) ***with*** (Partial Hospitalization POS Value Set).
- An intensive outpatient encounter or partial hospitalization (Partial Hospitalization or Intensive Outpatient Value Set).
- A community mental health center visit (Visit Setting Unspecified Value Set; BH Outpatient Value Set; Observation Value Set; Transitional Care Management Services Value Set) ***with*** (Community Mental Health Center POS Value Set).
- Electroconvulsive therapy (Electroconvulsive Therapy Value Set) ***with*** (Ambulatory Surgical Center POS Value Set; Community Mental Health Center POS Value Set; Outpatient POS Value Set; Partial Hospitalization POS Value Set).
- A telehealth visit: (Visit Setting Unspecified Value Set) ***with*** (Telehealth POS Value Set) ***with*** a mental health provider.
- An observation visit (Observation Value Set) ***with*** a mental health provider.
- Transitional care management services (Transitional Care Management Services Value Set), ***with*** a mental health provider.
- A visit in a behavioral healthcare setting (Behavioral Healthcare Setting Value Set).
- A telephone visit (Telephone Visits Value Set) ***with*** a mental health provider.
- Psychiatric collaborative care management (Psychiatric Collaborative Care Management Value Set).

Note

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

Data Elements for Reporting

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

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

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

Rules for Allowable Adjustments of HEDIS

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

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

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

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

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.

Hemoglobin A1c Control for Patients With Diabetes (HBD)

SUMMARY OF CHANGES TO HEDIS MY 2023

- Added a required exclusion for members who died during the measurement year.
- Added a direct reference code for palliative care.
- Updated the number of occurrences required for the frailty cross-cutting exclusion.
- Revised the "Other" criteria in the Nonclinical Components table under *Rules for Allowable Adjustments of HEDIS.*
- Revised the "Required exclusions" criteria in the Clinical Components table under *Rules for Allowable Adjustments of HEDIS*.

Description

The percentage of members 18–75 years of age with diabetes (types 1 and 2) whose hemoglobin A1c (HbA1c) was at the following levels during the measurement year:

- HbA1c Control (<8.0%).
- HbA1c Poor Control (>9.0%).

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

Eligible Population

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

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

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

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

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

Continuous enrollment The measurement year.

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

Anchor date December 31 of the measurement year.

Benefit Medical.

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

Claim/encounter data. Members who met any of the following criteria during the measurement year or the year prior to the measurement year (count services that occur over both years):

- At least one acute inpatient encounter (Acute Inpatient Value Set) with a diagnosis of diabetes (Diabetes Value Set) ***without*** telehealth (Telehealth Modifier Value Set; Telehealth POS Value Set).
- At least one acute inpatient discharge with a diagnosis of diabetes (Diabetes Value Set) on the discharge claim. To identify an acute inpatient discharge:
  1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
  2. Exclude nonacute inpatient stays (Nonacute Inpatient Stay Value Set).
  3. Identify the discharge date for the stay.
- At least two outpatient visits (Outpatient Value Set), observation visits (Observation Value Set), telephone visits (Telephone Visits Value Set), e-visits or virtual check-ins (Online Assessments Value Set), ED visits (ED Value Set), nonacute inpatient encounters (Nonacute Inpatient Value Set) or nonacute inpatient discharges (instructions below; the diagnosis must be on the discharge claim), on different dates of service, with a diagnosis of diabetes (Diabetes Value Set). Visit type need not be the same for the two encounters. To identify a nonacute inpatient discharge:
  1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
  2. Confirm the stay was for nonacute care based on the presence of a nonacute code (Nonacute Inpatient Stay Value Set) on the claim.

3. Identify the discharge date for the stay.

Only include nonacute inpatient encounters (Nonacute Inpatient Value Set) ***without*** telehealth (Telehealth Modifier Value Set; Telehealth POS Value Set).

Pharmacy data. Members who were dispensed insulin or hypoglycemics/ antihyperglycemics during the measurement year or the year prior to the measurement year (Diabetes Medications List).

Diabetes Medications

Description	Prescription		
Alpha-glucosidase inhibitors	• Acarbose	• Miglitol	
Amylin analogs	• Pramlintide		
Antidiabetic combinations	• Alogliptin-metformin • Alogliptin-pioglitazone • Canagliflozin-metformin • Dapagliflozin-metformin • Dapagliflozin-saxagliptin • Empagliflozin-linagliptin • Empagliflozin-linagliptin-metformin	• Empagliflozin-metformin • Ertugliflozin-metformin • Ertugliflozin-sitagliptin • Glimepiride-pioglitazone • Glipizide-metformin • Glyburide-metformin	• Linagliptin-metformin • Metformin-pioglitazone • Metformin-repaglinide • Metformin-rosiglitazone • Metformin-saxagliptin • Metformin-sitagliptin
Insulin	• Insulin aspart • Insulin aspart-insulin aspart protamine • Insulin degludec • Insulin 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	
Glucagon-like peptide-1 (GLP1) agonists	• Albiglutide • Dulaglutide • Exenatide	• Liraglutide (excluding Saxenda®) • Lixisenatide • Semaglutide	
Sodium glucose cotransporter 2 (SGLT2) inhibitor	• Canagliflozin • Dapagliflozin (excluding Farxiga®)	• Ertugliflozin • Empagliflozin	
Sulfonylureas	• Chlorpropamide • Glimepiride	• Glipizide • Glyburide	• Tolazamide • Tolbutamide
Thiazolidinediones	• Pioglitazone	• Rosiglitazone	
Dipeptidyl peptidase-4 (DDP-4) inhibitors	• Alogliptin • Linagliptin	• Saxagliptin • Sitagliptin	

Note: *Glucophage/metformin as a solo agent is not included because it is used to treat conditions other than diabetes; members with diabetes on these medications are identified through diagnosis codes only.*

Required exclusions

Exclude members who meet any of the following criteria:

- Members who did not have a diagnosis of diabetes (Diabetes Value Set), in any setting, during the measurement year or the year prior to the measurement year ***and*** who had a diagnosis of polycystic ovarian syndrome, gestational diabetes or steroid-induced diabetes (Diabetes Exclusions Value Set), in any setting, during the measurement year or the year prior to the measurement year.
- Members in hospice or using hospice services any time during the measurement year. Refer to *General Guideline 15: Members in Hospice.*
- Members who died any time during the measurement year. Refer to *General Guideline 16: Deceased Members.*
- Members receiving palliative care (Palliative Care Assessment Value Set; Palliative Care Encounter Value Set; Palliative Care Intervention Value Set; ICD-10-CM code Z51.5) any time during the measurement year.

Exclusions

Exclude members who meet any of the following criteria:

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

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

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

Dementia Medications

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

Administrative Specification

Denominator The eligible population.

Numerators

HbA1c Control <8% Use codes (HbA1c Lab Test Value Set; HbA1c Test Result or Finding Value Set) to identify the most recent HbA1c test during the measurement year. The member is numerator compliant if the most recent HbA1c level is <8.0%. The member is not numerator compliant if the result for the most recent HbA1c test is ≥8.0% or is missing a result, or if an HbA1c test was not done during the measurement year.

Organizations that use CPT Category II codes to identify numerator compliance for this indicator must search for all codes in the following value sets and use the most recent code during the measurement year to evaluate whether the member is numerator compliant.

Value Set	Numerator Compliance
HbA1c Level Less Than 7.0 Value Set	Compliant
HbA1c Level Greater Than or Equal To 7.0 and Less Than 8.0 Value Set	Compliant
HbA1c Level Greater Than or Equal To 8.0 and Less Than or Equal To 9.0 Value Set	Not compliant
HbA1c Level Greater Than 9.0 Value Set	Not compliant

HbA1c Poor Control >9%

Use codes (HbA1c Lab Test Value Set; HbA1c Test Result or Finding Value Set) to identify the *most recent* HbA1c test during the measurement year. The member is numerator compliant if the most recent HbA1c level is >9.0% or is missing a result, or if an HbA1c test was not done during the measurement year. The member is not numerator compliant if the result for the most recent HbA1c test during the measurement year is ≤9.0%.

Organizations that use CPT Category II codes to identify numerator compliance for this indicator must search for all codes in the following value sets and use the most recent code during the measurement year to evaluate whether the member is numerator compliant.

Value Set	Numerator Compliance
HbA1c Level Less Than 7.0 Value Set	Not compliant
HbA1c Level Greater Than or Equal To 7.0 and Less Than 8.0 Value Set	Not compliant
HbA1c Level Greater Than or Equal To 8.0 and Less Than or Equal To 9.0 Value Set	Not compliant
HbA1c Level Greater Than 9.0 Value Set	Compliant

Note: *A lower rate indicates better performance for this indicator (i.e., low rates of poor control indicate better care).*

Hybrid Specification

Denominator

A systematic sample drawn from the eligible population.

Organizations that use the Hybrid Method to report the Hemoglobin A1c Control for Patients With Diabetes (HBD), 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 HbA1c poor control >9.0% rate (100 minus the HbA1c poor control rate) before reducing the sample.

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

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

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

Numerators

HbA1c Control <8% The *most recent* HbA1c level (performed during the measurement year) is <8.0% as identified by laboratory data or medical record review.

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

Medical record At a minimum, documentation in the medical record must include a note indicating the date when the HbA1c test was performed and the result. The member is numerator compliant if the most recent HbA1c level during the measurement year is <8.0%. The member is not numerator compliant if the result for the most recent HbA1c level during the measurement year is ≥8.0% or is missing, or if an HbA1c test was not performed during the measurement year.

Ranges and thresholds do not meet criteria for this indicator. A distinct numeric result is required for numerator compliance.

HbA1c Poor Control >9% The *most recent* HbA1c level (performed during the measurement year) is >9.0% or is missing, or was not done during the measurement year, as documented through laboratory data or medical record review.

Note: *A lower rate indicates better performance for this indicator (i.e., low rates of poor control indicate better care).*

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

Medical record At a minimum, documentation in the medical record must include a note indicating the date when the HbA1c test was performed and the result. The member is numerator compliant if the result for the most recent HbA1c level during the measurement year is >9.0% or is missing, or if an HbA1c test was not done during the measurement year. The member is not numerator compliant if the most recent HbA1c level during the measurement year is ≤9.0%.

Ranges and thresholds do not meet criteria for this indicator. A distinct numeric result is required for numerator compliance.

Note

- *If a combination of administrative, supplemental or hybrid data are used, the most recent HbA1c result must be used, regardless of data source.*

Data Elements for Reporting

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

Table HBD-A-1/2/3: Data Elements for Hemoglobin A1c Control for Patients With Diabetes

Metric	Data Element	Reporting Instructions	A
AdequateHbA1cControl	CollectionMethod	Repeat per Metric	✓
PoorHbA1cControl	EligiblePopulation*	For each Metric	✓
	ExclusionAdminRequired*	For each Metric	✓
	NumeratorByAdminElig	For each Metric	
	CYAR	(Percent)	
	MinReqSampleSize	Repeat per Metric	
	OversampleRate	Repeat per Metric	
	OversampleRecordsNumber	(Count)	
	ExclusionValidDataErrors	Repeat per Metric	
	ExclusionEmployeeOrDep	Repeat per Metric	
	OversampleRecsAdded	Repeat per Metric	
	Denominator	Repeat per Metric	
	NumeratorByAdmin	For each Metric	✓
	NumeratorByMedicalRecords	For each Metric	
	NumeratorBySupplemental	For each Metric	✓
	Rate	(Percent)	✓

Table HBD-B-1/2/3: Data Elements for Hemoglobin A1c Control for Patients With Diabetes: Stratifications by Race

Metric
AdequateHbA1cControl
PoorHbA1cControl

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

Table HBD-C-1/2/3: Data Elements for Hemoglobin A1c Control for Patients With Diabetes: Stratifications by Ethnicity

Metric
AdequateHbA1cControl
PoorHbA1cControl

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

***Unknown is only reported for Source='Indirect.'

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 Hemoglobin A1c Control 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, 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*.
Exclusions: I-SNP, LTI, frailty or advanced illness	Yes	These exclusions are not required. Refer to *Exclusions* in the *Guidelines for the Rules for Allowable Adjustments*.
Numerator Criteria	**Adjustments Allowed (Yes/No)**	**Notes**
• HbA1c Control (<8.0%) • HbA1c Poor Control (>9.0%)	No	Value sets and logic may not be changed.

*Immunizations for Adolescents (IMA)**

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

SUMMARY OF CHANGES TO HEDIS MY 2023

- Added instructions to report rates stratified by race and ethnicity for each product line.
- Added a required exclusion for members who died during the measurement year.
- Added new data elements tables for race and ethnicity stratification reporting.
- Revised the "Other" criteria in the Nonclinical Components table under *Rules for Allowable Adjustments of HEDIS.*
- Revised the "Required exclusions" criteria in the Clinical Components table under *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:*
  - White.
  - Black or African American.
  - American Indian or Alaska Native.
  - Asian.
  - Native Hawaiian or Other Pacific Islander.
  - 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 12 months prior to the member's 13th birthday.

Allowable gap No more than one gap in enrollment of up to 45 days during the 12 months prior to the 13th birthday. To determine continuous enrollment for a Medicaid beneficiary for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage (e.g., a member whose coverage lapses for 2 months [60 days] is not continuously enrolled).

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

Benefit Medical.

Event/diagnosis None.

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

- Members in hospice or using hospice services any time during the measurement year. Refer to *General Guideline 15: Members in Hospice.*
- Members who died any time during the measurement year. Refer to *General Guideline 16: Deceased Members.*

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 (Tdap Immunization Value Set; 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, Tdap and HPV, count *either:*

- Evidence of the antigen or combination vaccine.
- Anaphylaxis 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 (5 months), with a 4-day grace period (146 days).*

Data Elements for Reporting

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

Table IMA-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	White	Direct	CollectionMethod	Repeat per Metric and Stratification	✓
Tdap	BlackOrAfricanAmerican	Indirect	EligiblePopulation	For each Stratification, repeat per Metric	✓
HPV	AmericanIndianOrAlaskaNative	Total	Denominator	For each Stratification, repeat per Metric	
Combo1	Asian		Numerator	For each Metric and Stratification	✓
Combo2	NativeHawaiianOrOtherPacificIslander		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*	Total	Denominator	For each Stratification, repeat per Metric	
Combo1	Unknown**		Numerator	For each Metric and Stratification	✓
Combo2			Rate	(Percent)	✓

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

**Unknown is only reported for Source='Indirect.'

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"). 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, 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 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 2023

- Revised the optional exclusions for polycystic ovarian syndrome, gestational diabetes or steroid-induced diabetes to be required exclusions.
- Added a required exclusion for members who died during the measurement year.
- Added a direct reference code for palliative care.
- Updated the number of occurrences required for the frailty cross-cutting exclusion.
- Revised the "Other" criteria in the Nonclinical Components table under *Rules for Allowable Adjustments of HEDIS.*
- Revised the "Required 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).
Ages	18–85 years as of December 31 of the measurement year. Report three age stratifications and a total rate: • 18–64. • 65–74. • 75–85. • Total. The total is the sum of the age stratifications.
Continuous enrollment	The measurement year.
Allowable gap	No more than one gap in enrollment of up to 45 days during the measurement year. To determine continuous enrollment for a Medicaid beneficiary for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage (e.g., a member whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).
Anchor date	December 31 of the measurement year.
Benefit	Medical.
Event/diagnosis	There are two ways to identify members with diabetes: by claim/encounter data and by pharmacy data. The organization must use both methods to identify the eligible population, but a member only needs to be identified by one method to be included in the measure. Members may be identified as having diabetes during the measurement year or the year prior to the measurement year.

Claim/encounter data. Members who met any of the following criteria during the measurement year or the year prior to the measurement year (count services that occur over both years):

- At least one acute inpatient encounter (Acute Inpatient Value Set) with a diagnosis of diabetes (Diabetes Value Set) ***without*** telehealth (Telehealth Modifier Value Set; Telehealth POS Value Set).
- At least one acute inpatient discharge with a diagnosis of diabetes (Diabetes Value Set) on the discharge claim. To identify an acute inpatient discharge:
  1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
  2. Exclude nonacute inpatient stays (Nonacute Inpatient Stay Value Set).
  3. Identify the discharge date for the stay.
- At least two outpatient visits (Outpatient Value Set), observation visits (Observation Value Set), telephone visits (Telephone Visits Value Set), e-visits or virtual check-ins (Online Assessments Value Set), ED visits (ED Value Set), nonacute inpatient encounters (Nonacute Inpatient Value Set) or nonacute inpatient discharges (instructions below; the diagnosis must be on the discharge claim), on different dates of service, with a diagnosis of diabetes (Diabetes Value Set). Visit type need not be the same for the two encounters. To identify a nonacute inpatient discharge:
  1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
  2. Confirm the stay was for nonacute care based on the presence of a nonacute code (Nonacute Inpatient Stay Value Set) on the claim.
  3. Identify the discharge date for the stay.

  Only include nonacute inpatient encounters (Nonacute Inpatient Value Set) ***without*** telehealth (Telehealth Modifier Value Set; Telehealth POS Value Set).

Pharmacy data. Members who were dispensed insulin or hypoglycemics/ antihyperglycemics during the measurement year or the year prior to the measurement year (Diabetes Medications List).

Diabetes Medications

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

Description	Prescription		
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	
Glucagon-like peptide-1 (GLP1) agonists	• Albiglutide • Dulaglutide • Exenatide	• Liraglutide (excluding Saxenda®) • Lixisenatide • Semaglutide	
Sodium glucose cotransporter 2 (SGLT2) inhibitor	• Canagliflozin • Dapagliflozin (excluding Farxiga®)	• Ertugliflozin • Empagliflozin	
Sulfonylureas	• Chlorpropamide • Glimepiride	• Glipizide • Glyburide	• Tolazamide • Tolbutamide
Thiazolidinediones	• Pioglitazone	• Rosiglitazone	
Dipeptidyl peptidase-4 (DDP-4) inhibitors	• Alogliptin • Linagliptin	• Saxagliptin • Sitagliptin	

Note: *Glucophage/metformin as a solo agent is not included because it is used to treat conditions other than diabetes; members with diabetes on these medications are identified through diagnosis codes only.*

Required exclusions

Exclude members who meet any of the following criteria:

- Members who did not have a diagnosis of diabetes (Diabetes Value Set), in any setting, during the measurement year or the year prior to the measurement year ***and*** who had a diagnosis of polycystic ovarian syndrome, gestational diabetes or steroid-induced diabetes (Diabetes Exclusions Value Set), in any setting, during the measurement year or the year prior to the measurement year.
- Members with evidence of ESRD (ESRD Diagnosis Value Set) or dialysis (Dialysis Procedure Value Set) any time during the member's history on or prior to December 31 of the measurement year.
- Members in hospice or using hospice services any time during the measurement year. Refer to *General Guideline 15: Members in Hospice.*
- Members who died any time during the measurement year. Refer to *General Guideline 16: Deceased Members.*
- Members receiving palliative care (Palliative Care Assessment Value Set; Palliative Care Encounter Value Set; Palliative Care Intervention Value Set; ICD-10-CM code Z51.5) any time during the measurement year.

Exclusions

Exclude members who meet any of the following criteria:

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

- Medicare members 66 years of age and older as of December 31 of the measurement year who meet either of the following:
  - Enrolled in an Institutional SNP (I-SNP) any time during the measurement year.
  - Living long-term in an institution any time during the measurement year as identified by the LTI flag in the Monthly Membership Detail Data File. Use the run date of the file to determine if a member had an LTI flag during the measurement year.
- Members 66-80 years of age as of December 31 of the measurement year (all product lines) with frailty ***and*** advanced illness. Members must meet **BOTH** of the following frailty and advanced illness criteria to be excluded:
  1. At least 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.
  2. Any of the following during the measurement year or the year prior to the measurement year (count services that occur over both years):
     - At least two outpatient visits (Outpatient Value Set), observation visits (Observation Value Set), ED visits (ED Value Set), telephone visits (Telephone Visits Value Set), e-visits or virtual check-ins (Online Assessments Value Set), nonacute inpatient encounters (Nonacute Inpatient Value Set) or nonacute inpatient discharges (instructions below; the diagnosis must be on the discharge claim) on different dates of service, with an advanced illness diagnosis (Advanced Illness Value Set). Visit type need not be the same for the two visits. To identify a nonacute inpatient discharge:
       1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
       2. Confirm the stay was for nonacute care based on the presence of a nonacute code (Nonacute Inpatient Stay Value Set) on the claim.
       3. Identify the discharge date for the stay.
     - At least one acute inpatient encounter (Acute Inpatient Value Set) with an advanced illness diagnosis (Advanced Illness Value Set).
     - At least one acute inpatient discharge with an advanced illness diagnosis (Advanced Illness Value Set) on the discharge claim. To identify an acute inpatient discharge:
       1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
       2. Exclude nonacute inpatient stays (Nonacute Inpatient Stay Value Set).
       3. Identify the discharge date for the stay.
     - A dispensed dementia medication (Dementia Medications List).
- Members 81 years of age and older as of December 31 of the measurement year (all product lines) with 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.

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-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
	65-74	ExclusionAdminRequired	For each Stratification
	75-85	NumeratorByAdmin	For each Stratification
	Total	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 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 and palliative care exclusions are not required. Refer to Exclusions in the Guidelines for the Rules for Allowable Adjustments.
Exclusions: I-SNP, LTI, frailty or advanced illness	Yes	These exclusions are not required. Refer to *Exclusions* in the *Guidelines for the Rules for Allowable Adjustments*.
Numerator Criteria	**Adjustments Allowed (Yes/No)**	**Notes**
Kidney Health Evaluation	No	Value sets and logic may not be changed.

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

2023 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: breast-feeding 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
AND
Postpartum care visit before or at 12 weeks of giving birth

NUMERATOR:
Patients receiving the following at a postpartum visit:

- Breast-feeding evaluation and education, including patient-reported breast-feeding
- 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:

Breast-Feeding Evaluation and Education – Patients who were evaluated for and educated about breast-feeding 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 breast-feeding, 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 (breast-feeding 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, breast-feeding 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 breast-feeding 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

Breast-Feeding Evaluation and Education

The USPSTF recommends interventions during pregnancy and after birth to support breast-feeding (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, breast-feeding may be contraindicated, and interventions to promote breast-feeding may not be appropriate.

Interventions to promote and support breast-feeding 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 Vacciation 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)

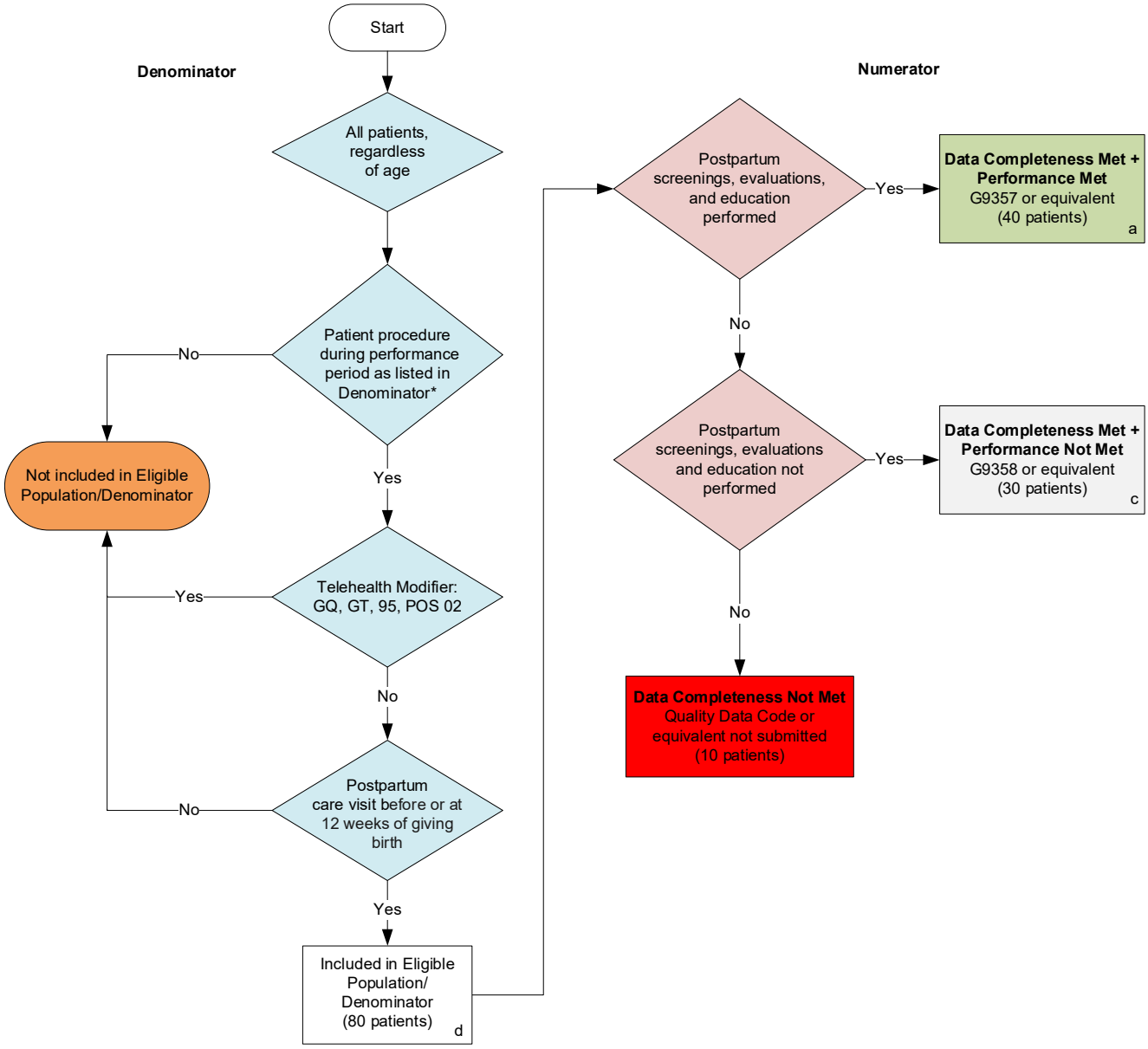
7. ACOG Postpartum Toolkit (2018)

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)

2023 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
NOTE: Telehealth modifiers include **but are not limited to**: GQ, GT, 95, POS 02

2023 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. 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*.
4. Check *Telehealth Modifier*:
    a. If *Telehealth Modifier* equals Yes, do not include in *Eligible Population/Denominator*. Stop processing.
    b. If *Telehealth Modifier* 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:
    a. Denominator Population is all Eligible Patients in the Denominator. Denominator is represented as Denominator in the Sample Calculation listed at the end of this document. Letter d equals 80 patients in the Sample Calculation.
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

NOTE: Telehealth modifiers include **but are not limited to:** GQ, GT, 95, POS 02

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)**

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

SUMMARY OF CHANGES TO HEDIS MY 2023

- Added a required exclusion for members who died during the measurement year.
- Revised the "Other" criteria in the Nonclinical Components table under *Rules for Allowable Adjustments of HEDIS.*
- Revised the "Exclusions" criteria in the Clinical Components table under *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:

1. The percentage of children and adolescents on antipsychotics who received blood glucose testing.
2. The percentage of children and adolescents on antipsychotics who received cholesterol testing.
3. The percentage of children and adolescents on antipsychotics who received blood glucose and cholesterol testing.

Eligible Population

Product lines	Commercial, Medicaid (report each product line separately).
Ages	1–17 years as of December 31 of the measurement year. Report two age stratifications and a total rate for each of the three indicators: • 1–11 years. • 12–17 years. • Total. The total is the sum of the age stratifications.
Continuous enrollment	The measurement year.
Allowable gap	No more than one gap in enrollment of up to 45 days during the measurement year.
Anchor date	December 31 of the measurement year.
Benefit	Medical and pharmacy.
Event/diagnosis	At least two antipsychotic medication dispensing events (Antipsychotic Medications List; Antipsychotic Combination Medications List; Prochlorperazine Medications List) of the same or different medications, on different dates of service during the measurement year.

Required exclusions

Exclude members who meet either of the following criteria:

- Members in hospice or using hospice services any time during the measurement year. Refer to *General Guideline 15: Members in Hospice*.
- Members who died any time during the measurement year. Refer to *General Guideline 16: Deceased Members.*

Antipsychotic Medications

Description	Prescription		
Miscellaneous antipsychotic agents	• Aripiprazole • Asenapine • Brexpiprazole • Cariprazine • Clozapine • Haloperidol	• Iloperidone • Loxapine • Lurasidone • Molindone • Olanzapine • Paliperidone	• Pimozide • Quetiapine • Risperidone • Ziprasidone
Phenothiazine antipsychotics	• Chlorpromazine • Fluphenazine • Perphenazine	• Thioridazine • Trifluoperazine	
Thioxanthenes	• Thiothixene		
Long-acting injections	• Aripiprazole • Aripiprazole lauroxil • Fluphenazine decanoate • Haloperidol decanoate	• Olanzapine • Paliperidone palmitate • Risperidone	

Antipsychotic Combination Medications

Description	Prescription	
Psychotherapeutic combinations	• Fluoxetine-olanzapine	• Perphenazine-amitriptyline

Prochlorperazine Medications

Description	Prescription
Phenothiazine antipsychotics	• Prochlorperazine

Administrative Specification

Denominator

The eligible population.

Numerator

Blood Glucose

Members who received at least one test for blood glucose (Glucose Lab Test Value Set; Glucose Test Result or Finding Value Set) or HbA1c (HbA1c Lab Test Value Set; HbA1c Test Result or Finding Value Set) during the measurement year.

Cholesterol Members who received at least one test for LDL-C (LDL-C Lab Test Value Set; LDL-C Test Result or Finding Value Set) or cholesterol (Cholesterol Lab Test Value Set; Cholesterol Test Result or Finding Value Set) during the measurement year.

Blood Glucose and Cholesterol Members who received both of the following during the measurement year on the same or different dates of service.

- At least one test for blood glucose (Glucose Lab Test Value Set, Glucose Test Result or Finding Value Set) or HbA1c (HbA1c Lab Test Value Set, HbA1c Test Result or Finding Value Set).
- At least one test for LDL-C (LDL-C Lab Test Value Set; LDL-C Test Result or Finding Value Set) or cholesterol (Cholesterol Lab Test Value Set; Cholesterol Test Result or Finding Value Set).

Data Elements for Reporting

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

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

Metric	Age	Data Element	Reporting Instructions
BloodGlucoseTesting	1-11	Benefit	Metadata
CholesterolTesting	12-17	EligiblePopulation	For each Stratification, repeat per Metric
BloodGlucoseCholesterolTesting	Total	ExclusionAdminRequired	For each Stratification, repeat per Metric
		NumeratorByAdmin	For each Metric and Stratification
		NumeratorBySupplemental	For each Metric and Stratification
		Rate	(Percent)

Rules for Allowable Adjustments of HEDIS

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

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

Guidance for Allowable Adjustments of Metabolic Monitoring for Children and Adolescents on Antipsychotics

NONCLINICAL COMPONENTS		
Eligible Population	**Adjustments Allowed (Yes/No)**	**Notes**
Product lines	Yes	Organizations are not required to use product line criteria; product lines may be combined and all (or no) product line criteria may be used.
Ages	Yes	The age determination dates may be changed (e.g., select, "age as of June 30"). Changing the denominator age range is allowed within a specified age range (ages 1–17+ years). Additionally, the upper age range may be expanded, or no upper age limit may be used.
Continuous enrollment, allowable gap, anchor date	Yes	Organizations are not required to use enrollment criteria; adjustments are allowed.
Benefits	Yes	Organizations are not required to use a benefit; adjustments are allowed.
Other	Yes	Organizations may use additional eligible population criteria to focus on 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 dispensing events that contain (or map to) codes in the medication lists and value sets may be used to identify antipsychotic medication events. Medication lists, value sets and logic may not be changed.
Denominator Exclusions	**Adjustments Allowed (Yes/No)**	**Notes**
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**
Metabolic Monitoring	No	Value sets and logic may not be changed.

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

Population Version: Adult
Language: English

Read about the Patient-Centered Medical Home Item Set.

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

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

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

Population Version: Child
Language: English

Read about the Patient-Centered Medical Home Item Set.

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

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

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

Plan All-Cause Readmissions (PCR)

SUMMARY OF CHANGES TO HEDIS MY 2023

- Replaced “female members” with “members” in the pregnancy exclusion.
- Clarified truncating and rounding rules in steps 6 and 8 of the *Risk Adjustment Weighting* section.
- Revised the “Other” criteria in the Nonclinical Components table under *Rules for Allowable Adjustments of HEDIS* for Observed Measurement.

Description

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

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

Definitions

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

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

Eligible Population

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

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

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

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

Required exclusions Members in hospice or using hospice services any time during the measurement year. Refer to *General Guideline 15: Members in Hospice.*

Administrative Specification

Denominator The eligible population.

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

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

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

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

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

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

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

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

Step 4 Exclude hospital stays for the following reasons:

- The member died during the stay.
- Members with a principal diagnosis of pregnancy (Pregnancy Value Set) on the discharge claim.
- A principal diagnosis of a condition originating in the perinatal period (Perinatal Conditions Value Set) on the discharge claim.

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

Step 5 Calculate continuous enrollment.

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

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

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

Risk Adjustment Determination

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

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

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

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

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

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

Risk Adjustment Weighting

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

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

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

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

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

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

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

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

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

OR

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Reporting: Number of Members in Plan Population

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

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

Reporting: Number of Outliers

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

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

Calculated: Outlier Rate

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

Reporting: Denominator

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

Reporting: SES Stratification (Medicare only)

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

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

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

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

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

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

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

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

Reporting: Numerator

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

Calculated: Observed Readmission Rate

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

Reporting: Count of Expected 30-Day Readmissions

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

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

Calculated: Expected Readmission Rate

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

Reporting: Variance

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

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

Calculated: O/E Ratio

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

Note

- *Supplemental data may not be used for this measure.*

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

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

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

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

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

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

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

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

Rules for Allowable Adjustments of HEDIS

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

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

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

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

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

Rules for Allowable Adjustments of HEDIS

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

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

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

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

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

Prenatal and Postpartum Care (PPC)

SUMMARY OF CHANGES TO HEDIS MY 2023

- Replaced all references of "women" to "member" throughout the measure specification.
- Added a required exclusion for members who died during the measurement year.
- Clarified continuous enrollment requirements for step 2 of the Timeliness of Prenatal Care numerator.
- Revised the "Other" criteria in the Nonclinical Components table under *Rules for Allowable Adjustments of HEDIS.*
- Revised the "Required exclusions" criteria in the Clinical Components table under *Rules for Allowable Adjustments of HEDIS*.

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:*
  - White.
  - Black or African American.
  - American Indian or Alaska Native.
  - Asian.
  - Native Hawaiian or Other Pacific Islander.
  - 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 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 members who delivered in any setting.

Multiple births. Members 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. Members who had multiple live births during one pregnancy count once.

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

Step 1 Identify deliveries. Identify all 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.

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

- Members in hospice or using hospice services any time during the measurement year. Refer to *General Guideline 15: Members in Hospice*.
- Members who died any time during the measurement year. Refer to *General Guideline 16: Deceased Members.*

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).
- A prenatal visit (Prenatal Visits Value Set; Telephone Visits Value Set; Online Assessments Value Set) ***with*** a pregnancy-related diagnosis code (Pregnancy Diagnosis Value Set).

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

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

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

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

Hybrid Specification

Denominator

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

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
White	Direct	CollectionMethod	For each Metric, repeat per Stratification	✓
BlackOrAfricanAmerican	Indirect	EligiblePopulation*	For each Stratification, repeat per Metric	✓
AmericanIndianOrAlaskaNative	Total	Denominator	For each Stratification, repeat per Metric	
Asian		Numerator	For each Metric and Stratification	✓
NativeHawaiianOrOtherPacificIslander		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**	Total	Denominator	For each Stratification, repeat per Metric	
	Unknown***		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.'

***Unknown is only reported for Source='Indirect.'

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.

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

2023 COLLECTION TYPE:
MIPS CLINICAL QUALITY MEASURES (CQMS)

MEASURE TYPE:
Process

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

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

NOTE: *Patient encounters for this measure conducted via telehealth (e.g., encounters coded with GQ, GT, 95, or POS 02 modifiers) are allowable.*

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

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

Definition:
Not Eligible for Depression Screening or Follow-Up Plan (Denominator Exclusions) –

- **Patients who have been diagnosed with depression**
    - The following codes would be sufficient to define the Denominator Exclusion of depression: F01.51, F01.511, F01.518, F01.52, F01.53, F01.54, F01.A0, F01.A11, F01.A18, F01.A2, F01.A3, F01.A4, F01.B0, F01.B11, F01.B18, F01.B2, F01.B3, F01.B4, F01.C0, F01.C11, F01.C18, F01.C2, F01.C3, F01.C4, F32.A, F32.0, F32.1, F32.2, F32.3, F32.4, F32.5, F32.89, F32.9, F33.0, F33.1, F33.2, F33.3, F33.40, F33.41, F33.42, F33.8, F33.9, F34.1, F34.81, F34.89, F43.21, F43.23, F53.0, F53.1, O90.6, O99.340, O99.341, O99.342, O99.343, O99.345
    - For historical reference purposes these ICD-9 codes if documented would be sufficient to define the Denominator Exclusion of depression: 290.13, 290.21, 290.43, 296.20, 296.21, 296.22, 296.23, 296.24, 296.25, 296.26, 296.30, 296.31, 296.32, 296.33,

296.34, 296.35, 296.36, 296.81, 296.82, 298.0, 300.4, 301.12, 309.0, 309.1, 309.28, 311

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

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

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

Denominator Criteria (Eligible Cases):
Patients aged ≥ 12 years at the beginning of the measurement period
AND
Patient encounter during the performance period (CPT or HCPCS): 59400, 59510, 59610, 59618, 90791, 90792, 90832, 90834, 90837, 92625, 96105, 96110*, 96112, 96116, 96125, 96136, 96138, 96156, 96158, 97161, 97162, 97163, 97164, 97165, 97166, 97167, 98966, 98967, 98968, 99078, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99315, 99316, 99341, 99342, 99344, 99345, 99347, 99348, 99349, 99350, 99401*, 99402*, 99403*, 99424, 99441, 99442, 99443, 99483, 99484, 99491, 99492, 99493, 99384*, 99385*, 99386*, 99387*, 99394*, 99395*, 99396*, 99397*, G0101, G0402, G0438, G0439, G0444
WITHOUT
Place of Service (POS): 12
AND NOT
DENOMINATOR EXCLUSION:
Documentation stating the patient has had a diagnosis of depression or has had a diagnosis of bipolar disorder: G9717

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

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

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

- **Adolescent Screening Tools (12-17 years)**
  Patient Health Questionnaire for Adolescents (PHQ-A), Beck Depression Inventory-Primary Care

Version (BDI-PC), Mood Feeling Questionnaire (MFQ), Center for Epidemiologic Studies Depression Scale (CES-D), Patient Health Questionnaire (PHQ-9), Pediatric Symptom Checklist (PSC-17), and PRIME MD-PHQ-2

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

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

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

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

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

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

Patient Reason(s):

Patient refuses to participate

OR

Medical Reason(s):

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

Numerator Instructions:

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

This is a patient-based measure. Depression screening is required once per measurement period, not at all

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

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

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

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

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

Numerator Options:

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

RATIONALE:

Depression is a serious medical illness associated with higher rates of chronic disease, increased health care utilization, and impaired functioning [1]. Results from a 2016 U.S. survey data indicated that 12.8 percent of adolescents (3.1 million adolescents) had a major depressive episode (MDE) in the past year, with nine percent of adolescents (2.2 million adolescents) having one MDE with severe impairment [2]. The odds of a diagnosis of depression are believed to be 2.6 times

greater for children and adolescents exposed to trauma as compared to those unexposed or less exposed [3]. Children and teens with major depressive disorder (MDD) have been found to have difficulty carrying out their daily activities, relating to others, growing up healthy, and are at an increased risk of suicide [4].

The same 2016 study indicated that 6.7 percent of adults aged 18 or older (16.2 million adults) had at least one MDE with 4.3 percent of adults (10.3 million adults) having one MDE with severe impairment in the past year [2]. Moreover, it is estimated 22.9 percent of adult patients with chronic pain (2.2 million adults) were diagnosed with comorbid depression from 2011 to 2015, with an upward trend of prevalence among Black Americans, patients aged 65 to 84 years old, Medicare and Medicaid insured patients, and patients from zip code areas with low annual household incomes [5].

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

Negative outcomes associated with depression make it crucial to screen in order to identify and treat depression in its early stages. Data indicates that as the severity of depressive symptoms increase, rates of having difficulty with work, home, or social activities related to depressive symptoms increase. For those twelve and older with mild depressive symptoms, 45.7 percent reported difficulty with activities, and for those with severe depressive symptoms, 88 percent reported difficulty [1]. Depression also imposes significant economic burden through direct and indirect costs, supporting the need for regular depression screening. "In the United States, an estimated $22.8 billion was spent on depression treatment in 2009, and lost productivity cost an additional estimated $23 billion in 2011" [9].

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

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

This measure seeks to align with clinical guideline recommendations as well as the Healthy People 2020 recommendation for routine screening for mental health problems as a part of primary care for both children and adults and makes an important contribution to the quality domain of community and population health [14].

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CLINICAL RECOMMENDATION STATEMENTS:

Adolescent Recommendation (12-18 years):

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

Adult Recommendation (18 years and older):

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

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

The American College of Obstetricians and Gynecologists (ACOG) provides the following recommendation: "All obstetrician–

gynecologists and other obstetric care providers should complete a full assessment of mood and emotional well-being (including screening for postpartum depression and anxiety with a validated instrument) during the comprehensive postpartum visit for each patient." [4].

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

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

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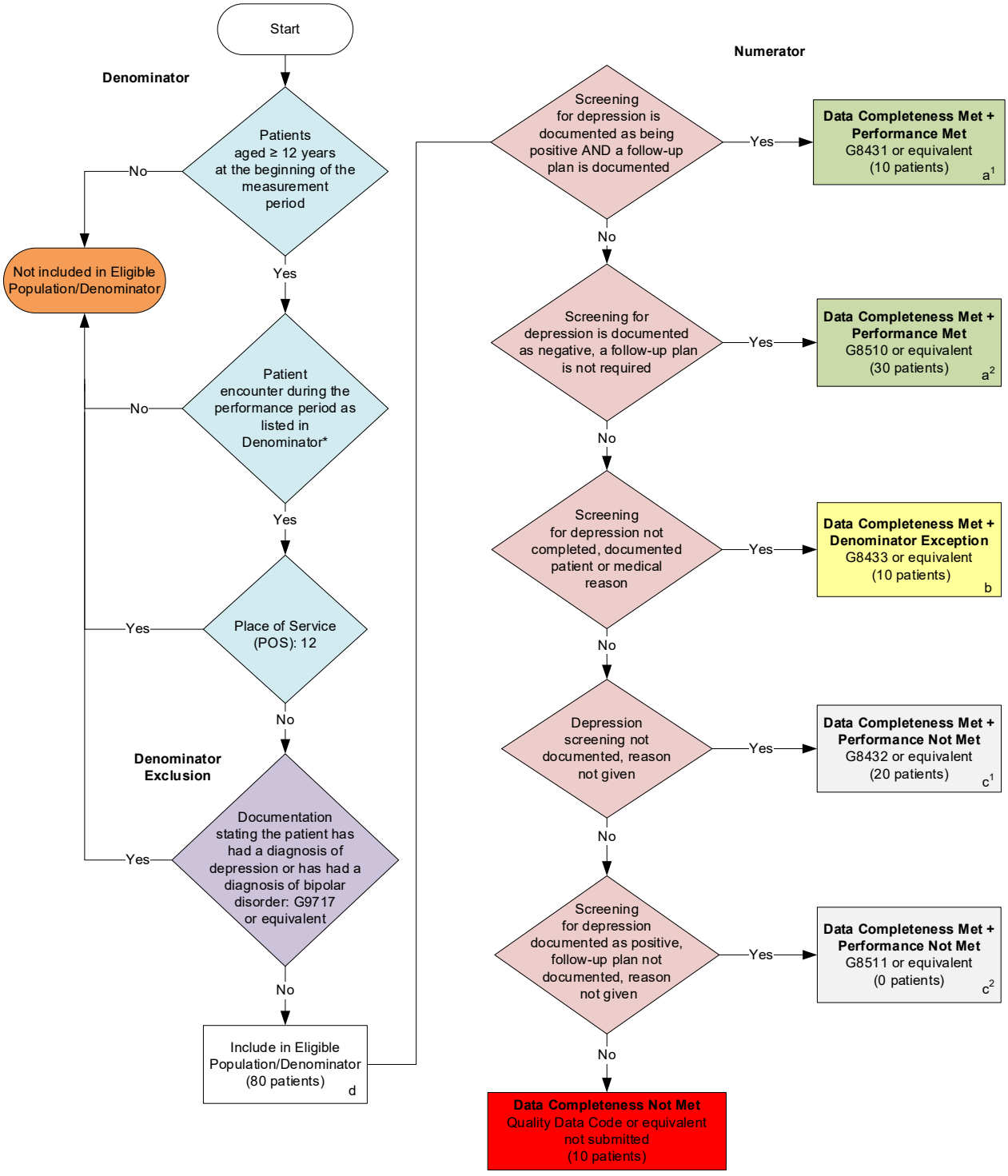
2023 Clinical Quality Measure Flow for Quality ID #134: Preventive Care and Screening: Screening for Depression and Follow-Up Plan

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



SAMPLE CALCULATIONS

Data Completeness Rate=

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

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

Performance Rate=

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

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

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

NOTE: Submission Frequency: Patient-Intermediate

2023 Clinical Quality Measure Flow Narrative for Quality ID #134: Preventative Care and Screening: Screening for Depression and Follow-Up Plan

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

1. Start with Denominator
2. Check *Patients aged greater than or equal to 12 years at the beginning of the measurement period*:
    a. If *Patients aged greater than or equal to 12 years at the beginning of the measurement period* equals No, do not include in *Eligible Population/Denominator*. Stop processing.
    b. If *Patients aged greater than or equal to 12 years at the beginning of the measurement period* equals Yes, proceed to check *Patient encounter during the performance period as listed in Denominator**.
3. Check *Patient encounter during the performance period as listed in Denominator**:
    a. If *Patient encounter during the performance period as listed in Denominator** equals No, do not include in *Eligible Population/Denominator*. Stop processing.
    b. If *Patient encounter during the performance period as listed in Denominator** equals Yes, proceed to check *Place of Service (POS).*
4. Check *Place of Service (POS):*
    a. If *Place of Service (POS)* equals Yes, do not include in *Eligible Population/Denominator*. Stop processing.
    b. If *Place of Service (POS)* equals No, proceed to check *Documentation stating the patient has had a diagnosis of depression or has had a diagnosis of bipolar disorder*.
5. Check *Documentation stating the patient has had a diagnosis of depression or has had a diagnosis of bipolar disorder:*
    a. If *Documentation stating the patient has had a diagnosis of depression or has had a diagnosis of bipolar disorder* equals Yes, do not include in *Eligible Population/Denominator*. Stop processing.
    b. If *Documentation stating the patient has had a diagnosis of depression or has had a diagnosis of bipolar disorder* equals No, 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 *Screening for depression is documented as being positive AND a follow-up plan is documented*:
    a. If *Screening for depression is documented as being positive AND a follow-up plan is documented* equals Yes, include in *Data Completeness Met and Performance Met*.
        - *Data Completeness Met and Performance Met* letter is represented in the Data Completeness and Performance Rate in the Sample Calculation listed at the end of this document. Letter a^1 equals 10 patients in the Sample Calculation.
    b. If *Screening for depression is documented as being positive AND a follow-up plan is documented* equals

No, proceed to check *Screening for depression is documented as negative, a follow-up plan is not required.*

9. Check *Screening for depression is documented as negative, a follow-up plan is not required*:

    a. If *Screening for depression is documented as negative, a follow-up plan is not required* equals Yes, include *in Data Completeness Met and Performance Met*.

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

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

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

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

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

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

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

    a. If *Depression screening not documented, reason not given* equals Yes, include in *Data Completeness Met and Performance Not Met.*

        - *Data Completeness Met and Performance Not Met* letter is represented in the Data Completeness in the Sample Calculation listed at the end of this document. Letter c^1 equals 20 patients in the Sample Calculation.

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

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

    a. If *Screening for depression documented as positive, follow-up plan not documented, reason not given* equals Yes, include in *Data Completeness Met and Performance Not Met*.

        - *Data Completeness Met and Performance Not Met letter* is represented in the Data Completeness in the Sample Calculation listed at the end of this document. Letter c^2 equals 0 patients in the Sample Calculation.

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

13. Check *Data Completeness Not Met*:

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

Sample Calculations:

Data Completeness Rate equals Performance Met (a^1 plus a^2 equals 40 patients) plus Denominator Exception (b equals 10 patients) plus Performance Not Met (c^1 plus c^2 equals 20 patients) divided by Eligible Population/Denominator (d equals 80 patients). All equals 70 patients divided by 80 patients. All equals 87.50 percent.

Performance Rate equals Performance Met (a^1 plus a^2 equals 40 patients) divided by Data Completeness Numerator (70 patients) minus Denominator Exception (b equals 10 patients). All equals 40 patients divided by 60 patients. All equals 66.67 percent.

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

NOTE: Submission Frequency: Patient-Intermediate

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

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

Substance Use Assessment in Primary Care

Steward: Inland Empire Health Plan

NQF #: N/A

SUMMARY OF CHANGES FOR 2023

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

Description

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

Definitions

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

Eligible Population

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

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

Specifications

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

Numerator Codes

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

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

Transitions of Care (TRC)

SUMMARY OF CHANGES TO HEDIS MY 2023

- Added a required exclusion for members who died during the measurement year.
- Revised the "Other" criteria in the Nonclinical Components table under *Rules for Allowable Adjustments of HEDIS.*
- Revised the "Required exclusions" criteria in the Clinical Components table under *Rules for Allowable Adjustments of HEDIS*.

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 visits 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 in hospice or using hospice services any time during the measurement year. Refer to *General Guideline 15: Members in Hospice*.
- Members who died any time during the measurement year. Refer to *General Guideline 16: Deceased Members.*

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 (Outpatient Value Set).
- A telephone visit (Telephone Visits Value Set).
- Transitional care management services (Transitional Care Management Services Value Set).
- An e-visit or virtual check-in (Online Assessments Value Set).

Medication Reconciliation Post-Discharge

Medication reconciliation (Medication Reconciliation Encounter Value Set; Medication Reconciliation Intervention Value Set) 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).

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 real-time, occurred between the member and provider).

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

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

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

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

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

Note

- *The following notations or examples of documentation do not count as numerator compliant:*
  - *Notification of Inpatient Admission and Notification of Inpatient Discharge:*
    - *Documentation that the member or the member's family notified the member's PCP or ongoing care provider of the admission or discharge.*
    - *Documentation of notification that does not include a time frame or date when the documentation was received.*
  - *Medication Reconciliation Post-Discharge:*
    - *Documentation of "post-op/surgery follow-up" without a reference to "hospitalization," "admission" or "inpatient stay" does not imply a hospitalization and is not considered evidence that the provider was aware of a hospitalization.*
- *The Medication Reconciliation Post-Discharge numerator assesses whether medication reconciliation occurred. It does not attempt to assess the quality of the medication list documented in the medical record or the process used to document the most recent medication list in the medical record.*

- *The denominator is based on the discharge date found in administrative/claims data, but organizations may use other systems (including data found during medical record review) to identify data errors and make corrections.*
  - *If a different discharge date is found in the medical record, and the organization chooses to use that date, the organization must assess all indicators using the updated discharge date, including those that were previously compliant based on administrative data.*
- *Organizations may have different methods for billing intensive outpatient visits and partial hospitalizations. Some methods may be comparable to outpatient billing, with separate claims for each date of service; others may be comparable to inpatient billing, with an admission date, a discharge date and units of service. Organizations whose billing methods are comparable to inpatient billing may count each unit of service as an individual visit. The unit of service must have occurred during the required period for the rate (i.e., within 30 days after discharge).*
- *Refer to Appendix 3 for the definition of* PCP *and* ongoing care provider*.*
- *A medication reconciliation performed without the member present meets criteria.*

Data Elements for Reporting

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

Table TRC-3: Data Elements for Transitions of Care

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

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

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

Rules for Allowable Adjustments of HEDIS

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

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

Rules for Allowable Adjustments of Transitions of Care

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

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

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

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

SUMMARY OF CHANGES TO HEDIS MY 2023

- Clarified that the measure is reported as the "percentage" of members.
- Added a direct reference code for palliative care.
- Added a required exclusion for members who died during the measurement year.
- Revised the "Other" criteria in the Nonclinical Components table under *Rules for Allowable Adjustments of HEDIS.*
- Revised the "Required exclusions" criteria in the Clinical Components table under *Rules for Allowable Adjustments of HEDIS*.

Description

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

Note: *A lower rate indicates better performance.*

Definitions

Calculating number of days covered for the denominator

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Eligible Population

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

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

Continuous enrollment The measurement year.

Allowable gap None.

Anchor date None.

Benefit Medical and pharmacy.

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

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

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

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

- Cancer (Malignant Neoplasms Value Set).
- Sickle cell disease (Sickle Cell Anemia and HB S Disease Value Set).
- Members receiving palliative care (Palliative Care Assessment Value Set; Palliative Care Encounter Value Set; Palliative Care Intervention Value Set; ICD-10-CM code Z51.5).
- Members in hospice or using hospice services. Refer to *General Guideline 15: Members in Hospice.*
- Members who died any time during the measurement year. Refer to *General Guideline 16: Deceased Members.*

Administrative Specification

Denominator The eligible population.

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

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

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

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

day, sum the MME daily doses for all dispensing events to determine the total daily MME for that day.

Step 4 Determine the treatment period.

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

Table HDO-A: Opioid Medications[1]

Type of Opioid	Medication Lists	Strength	MME Conversion Factor
Benzhydrocodone	Acetaminophen Benzhydrocodone 4.08 mg Medications List Acetaminophen Benzhydrocodone 6.12 mg Medications List Acetaminophen Benzhydrocodone 8.16 mg Medications List	4.08 mg 6.12 mg 8.16 mg	1.2
Butorphanol	Butorphanol 10 MGPML Medications List	10 mg	7
Codeine	Codeine Sulfate 15 mg Medications List Codeine Sulfate 30 mg Medications List Codeine Sulfate 60 mg Medications List	15 mg 30 mg 60 mg	0.15
Codeine	Acetaminophen Codeine 2.4 MGPML Medications List Acetaminophen Codeine 15 mg Medications List Acetaminophen Codeine 30 mg Medications List Acetaminophen Codeine 60 mg Medications List	2.4 mg 15 mg 30 mg 60 mg	0.15
Codeine	Acetaminophen Butalbital Caffeine Codeine 30 mg Medications List	30 mg	0.15
Codeine	Aspirin Butalbital Caffeine Codeine 30 mg Medications List	30 mg	0.15
Codeine	Aspirin Carisoprodol Codeine 16 mg Medications List	16 mg	0.15
Dihydrocodeine	Acetaminophen Caffeine Dihydrocodeine 16 mg Medications List	16 mg	0.25
Dihydrocodeine	Aspirin Caffeine Dihydrocodeine 16 mg Medications List	16 mg	0.25
Fentanyl buccal or sublingual tablet, transmucosal lozenge (mcg)[2]	Fentanyl 100 mcg Medications List Fentanyl 200 mcg Medications List Fentanyl 300 mcg Medications List Fentanyl 400 mcg Medications List Fentanyl 600 mcg Medications List Fentanyl 800 mcg Medications List Fentanyl 1200 mcg Medications List Fentanyl 1600 mcg Medications List	100 mcg 200 mcg 300 mcg 400 mcg 600 mcg 800 mcg 1200 mcg 1600 mcg	0.13
Fentanyl oral spray (mcg)[3]	Fentanyl 100 MCGPS Oral Medications List Fentanyl 200 MCGPS Oral Medications List Fentanyl 400 MCGPS Oral Medications List Fentanyl 600 MCGPS Oral Medications List Fentanyl 800 MCGPS Oral Medications List	100 mcg 200 mcg 400 mcg 600 mcg 800 mcg	0.18

Type of Opioid	Medication Lists	Strength	MME Conversion Factor
Fentanyl nasal spray (mcg)[4]	Fentanyl 100 MCGPS Nasal Medications List Fentanyl 300 MCGPS Nasal Medications List Fentanyl 400 MCGPS Nasal Medications List	100 mcg 300 mcg 400 mcg	0.16
Fentanyl transdermal film/ patch (mcg/hr)[5]	Fentanyl 12 MCGPH Medications List Fentanyl 25 MCGPH Medications List Fentanyl 37.5 MCGPH Medications List Fentanyl 50 MCGPH Medications List Fentanyl 62.5 MCGPH Medications List Fentanyl 75 MCGPH Medications List Fentanyl 87.5 MCGPH Medications List Fentanyl 100 MCGPH Medications List	12 mcg 25 mcg 37.5 mcg 50 mcg 62.5 mcg 75 mcg 87.5 mcg 100 mcg	7.2
Hydrocodone	Hydrocodone 10 mg Medications List Hydrocodone 15 mg Medications List Hydrocodone 20 mg Medications List Hydrocodone 30 mg Medications List Hydrocodone 40 mg Medications List Hydrocodone 50 mg Medications List Hydrocodone 60 mg Medications List Hydrocodone 80 mg Medications List Hydrocodone 100 mg Medications List Hydrocodone 120 mg Medications List	10 mg 15 mg 20 mg 30 mg 40 mg 50 mg 60 mg 80 mg 100 mg 120 mg	1
Hydrocodone	Acetaminophen Hydrocodone .5 MGPML Medications List Acetaminophen Hydrocodone .67 MGPML Medications List Acetaminophen Hydrocodone 2.5 mg Medications List Acetaminophen Hydrocodone 5 mg Medications List Acetaminophen Hydrocodone 7.5 mg Medications List Acetaminophen Hydrocodone 10 mg Medications List	.5 mg .67 mg 2.5 mg 5 mg 7.5 mg 10 mg	1
Hydrocodone	Hydrocodone Ibuprofen 2.5 mg Medications List Hydrocodone Ibuprofen 5 mg Medications List Hydrocodone Ibuprofen 7.5 mg Medications List Hydrocodone Ibuprofen 10 mg Medications List	2.5 mg 5 mg 7.5 mg 10 mg	1
Hydromorphone	Hydromorphone 1 MGPML Medications List Hydromorphone 2 mg Medications List Hydromorphone 3 mg Medications List Hydromorphone 4 mg Medications List Hydromorphone 8 mg Medications List Hydromorphone 12 mg Medications List Hydromorphone 16 mg Medications List Hydromorphone 32 mg Medications List	1 mg 2 mg 3 mg 4 mg 8 mg 12 mg 16 mg 32 mg	4

Type of Opioid	Medication Lists	Strength	MME Conversion Factor
Levorphanol	Levorphanol 2 mg Medications List Levorphanol 3 mg Medications List	2 mg 3 mg	11
Meperidine	Meperidine 10 MGPML Medications List Meperidine 50 mg Medications List Meperidine 75 mg Medications List Meperidine 100 mg Medications List Meperidine 150 mg Medications List	10 mg 50 mg 75 mg 100 mg 150 mg	0.1
Methadone[6]	Methadone 1 MGPML Medications List Methadone 2 MGPML Medications List Methadone 5 mg Medications List Methadone 10 mg Medications List Methadone 10 MGPML Medications List Methadone 40 mg Medications List	1 mg 2 mg 5 mg 10 mg 10 mg 40 mg	3
Morphine	Morphine 2 MGPML Medications List Morphine 4 MGPML Medications List Morphine 5 mg Medications List Morphine 10 mg Medications List Morphine 15 mg Medications List Morphine 20 MGPML Medications List Morphine 20 mg Medications List Morphine 30 mg Medications List Morphine 40 mg Medications List Morphine 45 mg Medications List Morphine 50 mg Medications List Morphine 60 mg Medications List Morphine 75 mg Medications List Morphine 80 mg Medications List Morphine 90 mg Medications List Morphine 100 mg Medications List Morphine 120 mg Medications List Morphine 200 mg Medications List	2 mg 4 mg 5 mg 10 mg 15 mg 20 mg 20 mg 30 mg 40 mg 45 mg 50 mg 60 mg 75 mg 80 mg 90 mg 100 mg 120 mg 200 mg	1
Morphine	Morphine Naltrexone 20 mg Medications List Morphine Naltrexone 30 mg Medications List Morphine Naltrexone 50 mg Medications List Morphine Naltrexone 60 mg Medications List Morphine Naltrexone 80 mg Medications List Morphine Naltrexone 100 mg Medications List	20 mg 30 mg 50 mg 60 mg 80 mg 100 mg	1
Opium	Belladonna Opium 30 mg Medications List Belladonna Opium 60 mg Medications List	30 mg 60 mg	1
Oxycodone	Oxycodone 1 MGPML Medications List Oxycodone 5 mg Medications List Oxycodone 7.5 mg Medications List Oxycodone 9 mg Medications List	1 mg 5 mg 7.5 mg 9 mg	1.5

Type of Opioid	Medication Lists	Strength	MME Conversion Factor
	Oxycodone 10 mg Medications List	10 mg	
	Oxycodone 13.5 mg Medications List	13.5 mg	
	Oxycodone 15 mg Medications List	15 mg	
	Oxycodone 18 mg Medications List	18 mg	
	Oxycodone 20 mg Medications List	20 mg	
	Oxycodone 20 MGPML Medications List	20 mg	
	Oxycodone 27 mg Medications List	27 mg	
	Oxycodone 30 mg Medications List	30 mg	
	Oxycodone 36 mg Medications List	36 mg	
	Oxycodone 40 mg Medications List	40 mg	
	Oxycodone 60 mg Medications List	60 mg	
	Oxycodone 80 mg Medications List	80 mg	
Oxycodone	Acetaminophen Oxycodone 1 MGPML Medications List	1 mg	1.5
	Acetaminophen Oxycodone 2 MGPML Medications List	2 mg	
	Acetaminophen Oxycodone 2.5 mg Medications List	2.5 mg	
	Acetaminophen Oxycodone 5 mg Medications List	5 mg	
	Acetaminophen Oxycodone 7.5 mg Medications List	7.5 mg	
	Acetaminophen Oxycodone 10 mg Medications List	10 mg	
Oxycodone	Aspirin Oxycodone 4.84 mg Medications List	4.84 mg	1.5
Oxycodone	Ibuprofen Oxycodone 5 mg Medications List	5 mg	1.5
Oxymorphone	Oxymorphone 5 mg Medications List	5 mg	3
	Oxymorphone 7.5 mg Medications List	7.5 mg	
	Oxymorphone 10 mg Medications List	10 mg	
	Oxymorphone 15 mg Medications List	15 mg	
	Oxymorphone 20 mg Medications List	20 mg	
	Oxymorphone 30 mg Medications List	30 mg	
	Oxymorphone 40 mg Medications List	40 mg	
Pentazocine	Naloxone Pentazocine 50 mg Medications List	50 mg	0.37
Tapentadol	Tapentadol 50 mg Medications List	50 mg	0.4
	Tapentadol 75 mg Medications List	75 mg	
	Tapentadol 100 mg Medications List	100 mg	
	Tapentadol 150 mg Medications List	150 mg	
	Tapentadol 200 mg Medications List	200 mg	
	Tapentadol 250 mg Medications List	250 mg	
Tramadol	Tramadol 5 MGPML Medications List	5 mg	0.1
	Tramadol 50 mg Medications List	50 mg	
	Tramadol 100 mg Medications List	100 mg	
	Tramadol 150 mg Medications List	150 mg	
	Tramadol 200 mg Medications List	200 mg	
	Tramadol 300 mg Medications List	300 mg	
Tramadol	Acetaminophen Tramadol 37.5 mg Medications List	37.5 mg	0.1

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

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

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

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

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

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

Note

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

Data Elements for Reporting

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

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

Metric	Data Element	Reporting Instructions
OpioidUseHighDosage	Benefit	Metadata
	EligiblePopulation	Report once
	ExclusionAdminRequired	Report once
	NumeratorByAdmin	Report once
	Rate	(Percent)

Rules for Allowable Adjustments of HEDIS

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

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

Rules for Allowable Adjustments of Use of Opioids at High Dosage

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

Data Update Freeze

CMIT will undergo system updates requiring a data update freeze starting July 14, 2023 at 11:59 PM. Data is current as of that date and will undergo any pending updates after the system updates are complete. Please reach out to MMSsupport@battelle.org with any specific questions.

Use of Pharmacotherapy for Opioid Use Disorder (OUD-AD)

CMIT Measure ID: 750 | **CMIT ID:** 00750-02-C-MACS | **Measure Type:** Process

Date of Information: 01/17/2023 | **Revision:** 3 | **Program:** Medicaid: Adult Core Set

View Description +

Properties

Date of Information	01/17/2023
Abbreviated Measure Title	Not Available
Description	Percentage of Medicaid beneficiaries ages 18 to 64 with an opioid use disorder (OUD) who filled a prescription for or were administered or dispensed an FDA-approved medication for the disorder during the measurement year. Five rates are reported: A total (overall) rate capturing any medications used in medication assisted treatment of opioid dependence and addiction (Rate 1) Four separate rates representing the following types of FDA-approved drug products: Buprenorphine (Rate 2) Oral naltrexone (Rate 3) Long-acting, injectable naltrexone (Rate 4) Methadone (Rate 5)
Numerator	For each beneficiary in the denominator population, follow the steps below to identify beneficiaries for the total numerator and the numerator for each rate.; Numerator 1 (Total): Beneficiaries with evidence of at least one prescription filled, or who were administered or dispensed an FDA-approved medication for OUD during the measurement year through use of pharmacy claims (relevant NDC code) or through relevant HCPCS coding of medical service. Numerator 2 (Buprenorphine): Beneficiaries with evidence of at least one prescription for buprenorphine at any point during the measurement year. Numerator 3 (Oral Naltrexone): Beneficiaries with evidence of at least one prescription for oral naltrexone at any point during the measurement year. Numerator 4 (Long-Acting, Injectable Naltrexone): Beneficiaries with evidence of at least one prescription for long-acting,

	injectable naltrexone at any point during the measurement year. Numerator 5 (Methadone): Identify beneficiaries with evidence of at least one dose of methadone at any point during the measurement year.
Denominator	Beneficiaries age 18 to 64 years with an opioid use disorder. Age is calculated as of January 1 of the measurement year.
Denominator Exclusions	None
Rationale	Not available
Evidence	Not available
Denominator Exceptions	None
Numerator Exceptions	None
Risk Adjusted	No
Program Name Abbreviation	MACS
Program Status	Active

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

SUMMARY OF CHANGES TO HEDIS MY 2023

- Added instructions to report rates stratified by race and ethnicity for each product line.
- Added a required exclusion for members who died during the measurement year.
- Added new data elements tables for race and ethnicity stratification reporting.
- Revised the "Other" criteria in the Nonclinical Components table under *Rules for Allowable Adjustments of HEDIS.*
- Revised the "Required exclusions" criteria in the Clinical Components table under *Rules for Allowable Adjustments of HEDIS.*

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:*
  - White.
  - Black or African American.
  - American Indian or Alaska Native.
  - Asian.
  - Native Hawaiian or Other Pacific Islander.
  - 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 in hospice or using hospice services any time during the measurement year. Refer to *General Guideline 15: Members in Hospice.* • Members who died any time during the measurement year. Refer to *General Guideline 16: Deceased Members.*

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

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

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

Product lines	Commercial, Medicaid (report each product line separately).
Ages	Children who turn 30 months old during the measurement year. Calculate the 30-month birthday as the second birthday plus 180 days.
Continuous enrollment	15 months plus 1 day–30 months of age. Calculate the 15-month birthday plus 1 day as the first birthday plus 91 days.
Allowable gap	No more than one gap in enrollment of up to 45 days during the continuous enrollment period. To determine continuous enrollment for a Medicaid member

	for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage (e.g., a member whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).
Anchor date	The date when the child turns 30 months old.
Benefit	Medical.
Event/diagnosis	None.
Required exclusions	Exclude members who meet either of the following criteria: • Members in hospice or using hospice services any time during the measurement year. Refer to *General Guideline 15: Members in Hospice.* • Members who died any time during the measurement year. Refer to *General Guideline 16: Deceased Members.*

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

Denominator	The Rate 2 eligible population.
Numerator	Two or more well-child visits (Well-Care Value Set) on different dates of service between the child's 15-month birthday plus 1 day and the 30-month birthday. The well-child visit must occur with a PCP, but the PCP does not have to be the practitioner assigned to the child.

Note

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

Data Elements for Reporting

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

Table W30-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	White	Direct	EligiblePopulation	For each Metric and Stratification
Age15To30Months	BlackOrAfricanAmerican	Indirect	Numerator	For each Metric and Stratification
	AmericanIndianOrAlaskaNative	Total	Rate	(Percent)
	Asian			
	NativeHawaiianOrOtherPacificIslander			
	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*	Total	Rate	(Percent)
	Unknown**			

*AskedButNoAnswer is only reported for Source='Direct.'
**Unknown is only reported for Source='Indirect.'

Rules for Allowable Adjustments of HEDIS

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

Rules for Allowable Adjustments of 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.