UPMC Health Plan

2025 Primary Care Incentive Programs: Adult Quality Measure Guide

Premier Partners Program and Quality Partners Program

UPMC HEALTH PLAN

Please see the complete 2025 Value Set located on Provider OnLine and on the Premier Partners Program SharePoint for additional codes that are used for HEDIS® measures in this guide.

HEDIS® The Healthcare Effectiveness Data and Information Set (HEDIS®) is a registered trademark of NCQA.

CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

If you have any questions, contact your UPMC Health Plan representative or call Provider Services at ***1-866-918-1595.*** *Please remember that your incentive payment eligibility is contingent upon quarterly verification of your provider directory information.*

UPMC Health Plan does not practice medicine or exercise control over the methods or professional judgments by which providers render medical services to members. Nothing in these materials should be construed to supersede or replace the clinical judgment of a provider.

The 2025 Quality measure pages include best practice recommendations for each measure. These recommendations were compiled from various sources.

The provider of care is ultimately responsible for providing accurate and compliant information on all submission of claims and/or billing information.

We reserve the right to change and cancel these incentives without notice.

In this guide, the "Commercial" population includes employer-sponsored members, individual members on and off exchange, and small-group exchange members.

This information is current as of Dec. 15, 2024.

Table of Contents

This measure guide is intended to detail adult quality measure specifications for both the Premier Partners and Quality Partners primary care incentive programs. Measure details and specifications are outlined for each individual measure listed below. For questions about the quality measure specifications in this guide, please contact your UPMC Health Plan representative.

This guide does not include program details or measure specifications for the UPMC *for You* (Medicaid) Quality Partners Primary Care Incentive Program. The UPMC *for You* (Medicaid) Quality Partners Primary Care Incentive Program is detailed in a separate program guide.

The UPMC *for You* product line is indicated in this guide for Premier Partners purposes only and does not indicate whether a measure is or is not a part of the UPMC *for You* (Medicaid) Quality Partners Primary Care Incentive Program.

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Display Measures

Summary of Changes

Many of the quality measures included in this guide are based on the National Committee for Quality Assurance (NCQA) Healthcare Effectiveness Data and Information Set (HEDIS®) specifications. Each year in April, NCQA updates the specifications that are used for the measures in this guide. Similarly, some of the measures in this guide are based on Pharmacy Quality Alliance (PQA) specifications, which are updated each year around the same time.

When the UPMC Health Plan receives these updates from NCQA in April of 2025, this guide will be updated, as applicable. When updates are made, a summary of changes will be included on this page in the updated version of this guide for your quick reference.

The below grid is an example of how the summary of changes will be noted when the measure guide is updated.

Summary of Changes	
Measure	**Changes**
The name of the measure for which changes were made will be listed here.	The specific changes to the measure specification, for applicable measures, will be listed in detail here.

Measure Key

Measure Key		
Measure ID	This is the nationally recognized abbreviation for the measure.	
Source	This is where the measure specifications come from. Examples may include NCQA, HEDIS MY 2025, PQA 2024, and UPMC Health Plan.	
Summary of changes for 2025	These are important changes that have been implemented since the previous year. Example changes could be an age range, a new exclusion, a code to close the gap, etc.	
Description	This provides information about the measure and may describe what is required to be compliant. It may reference the measurement period and applicable ages.	
Measurement period	Period in which the member meets denominator criteria. Most measures have a measurement period of Jan. 1 – Dec. 31. Some measures have denominator criteria that indicate the need for a unique measurement period.	
Quality program, ages, product lines	Member ages listed here are based on the quality program, measure denominator, measurement period, and product line. Members in gap reports may be younger than the age listed here if the measure has a multi-year closure for the service provided. All programs are split by line of business. Quality Partners program has all ages in one program with incentives applied to all. Due to membership volume, Premier Partners program has two programs with separate evaluations by age. The Adult Premier Partners program excludes members under 22 years of age.	
	Premier Partners Program: **Ages** for the Premier Partners Program will be listed here. **Product lines** for the Premier Partners Program will be listed here. Applicable product lines are UPMC *for Life* (Medicare/SNP), Commercial, and UPMC *for You* (Medicaid).	**Quality Partners Program**: **Ages** for the Quality Partners Program will be listed here. **Product lines** for the Quality Partners Program will be listed here. Applicable product lines are UPMC *for Life* (Medicare/SNP) or Commercial. The Quality Partners Program for UPMC *for You* has a separate guide.
Denominator	This identifies the eligible population and may specify value sets within the description. If applicable, please visit Provider OnLine and/or the Premier Partners SharePoint for the HEDIS 2025 Value Set Directory.	
Denominator exclusions	This identifies specific exclusions from an otherwise eligible population and may specify value sets within the description. If applicable, please see the complete 2025 Value Set located on Provider OnLine and on the Premier Partners SharePoint.	
Method to exclude	Some measures have available methods to exclude. These may include: Claims and/or Upload to Novillus Care Gap Management Application (CGMA).	
Numerator/Service to close gap	This describes the service and its timing that is needed to close the gap. It may specify value sets within the description. If applicable, please see the complete 2025 Value Set located on Provider OnLine and on the Premier Partners SharePoint.	
Methods to close gap	This may include one or more of the following: Claims, RX Claims, Upload to Novillus Care Gap Management Application (CGMA), or N/A. A notation of N/A indicates that performing well in the measure is based on **not** doing something (i.e. not having a readmissions event or not prescribing an antibiotic).	
Codes to close gap	This section is only applicable to non-pharmacy measures. It contains codes that may close the gap; however, additional codes might be used for the measure. Please see the complete HEDIS 2025 Value Set Directory located on Provider OnLine and/or the Premier Partners SharePoint for additional codes that are used for some of these measures.	
Medications to close gap	This section is only applicable to pharmacy measures.	
Best practice recommendations	This section contains a wide array of tips and best practices that provide unique and valuable insight into closing quality gaps. These recommendations were compiled from various sources.	

Adult Immunization Status: Influenza		
Measure ID	AIS-E	
Source	NCQA, HEDIS MY 2025	
Summary of changes for 2025	Transitioned from a display measure to an incentive measure in 2025.	
Description	The percentage of members who are up to date on recommended routine influenza vaccines.	
Measurement period	Jan. 1, 2025, through Dec. 31, 2025	
Quality program, ages, product lines	**Premier Partners Program:** Ages: 22 years of age and older as of the start of the measurement period Product lines: This measure is incentivized for: • Commercial • UPMC *for You* (Medicaid) This measure is displayed for: • UPMC *for Life* (Medicare/SNP)	**Quality Partners Program:** Ages: 19 years of age and older as of the start of the measurement period Product lines: This measure is incentivized for: • Commercial This measure is displayed for: • UPMC *for Life* (Medicare/SNP)
Denominator	Members who meet the age criteria at the start of the measurement period	
Denominator exclusions	• Members who use hospice services (Hospice Encounter Value Set; Hospice Intervention Value Set) or elect to use a hospice benefit any time during the measurement period • Members who die any time during the measurement period	
Method to exclude	Claim	
Numerator/ Service to close gap	Members who received an influenza vaccine (Adult Influenza Immunization Value Set; Adult Influenza Vaccine Procedure Value Set; Influenza Virus LAIV Immunization Value Set; Influenza Virus LAIV Vaccine Procedure Value Set) on or between Jan. 1 and Dec. 31 of the measurement period	
Method to close gap	• Claim • Upload to Novillus Care Gap Management Application (CGMA)	
Codes to close gap	**Adult Influenza Immunization** • CVX: 88; 135; 140; 141; 144; 150; 153; 155; 158; 166; 168; 171; 185; 186; 197; 205 **Adult Influenza Vaccine Procedure** • CPT: 90630; 90653; 90654; 90656; 90658; 90661; 90662; 90673; 90674; 90682; 90686; 90688; 90689; 90694; 90756 **Influenza Virus LAIV Immunization** • 111; 149 **Influenza Virus LAIV Vaccine Procedure** • CPT: 90660; 90672 Please see the complete 2025 Value Set located on Provider OnLine and on the Premier Partners SharePoint for additional codes that are used for this measure.	
Best practice recommendations	• Educate patients on the importance of the annual influenza vaccine while having research, literature, and resources to give out to eliminate fears and misinformation. • Consider hosting flu clinics in the fall. • Notify patients when flu vaccines are available. • Encourage patients to notify their PCP office when they receive the flu vaccine outside of the office (e.g. at a local church, pharmacy, etc.).	

Appropriate Treatment for Upper Respiratory Infection		
Measure ID	URI	
Source	NCQA, HEDIS MY 2025	
Summary of changes for 2025	N/A	
Description	The percentage of episodes for members with a diagnosis of upper respiratory infection (URI) that did not result in an antibiotic dispensing event	
Measurement period	Jan. 1, 2025, through Dec. 28, 2025 (period of time in which the member meets denominator criteria)	
Quality program, ages, product lines	**Premier Partners Program:** Ages: 22 years of age and older as of the episode date (the date of service for the visit with a diagnosis of URI) Product lines: • Commercial • UPMC *for You* (Medicaid)	**Quality Partners Program:** Ages: 3 months and older as of the episode date (the date of service for the visit with a diagnosis of URI) Product lines: • Commercial
Denominator	Follow the steps below to identify the eligible population: **Step 1**: Identify all members who had an outpatient visit, ED visit, telephone visit, e-visit or virtual check-in (Outpatient, ED and Telehealth Value Set) during the intake period, with a diagnosis of URI (URI Value Set). **Step 2:** Determine all URI episode dates. For each member identified in step 1, determine all outpatient, telephone or ED visits, e-visits and virtual check-ins with a URI diagnosis. **Step 3:** If a member has more than one eligible episode in a 31-day period, include only the first eligible episode. For example, if a member has an eligible episode on Jan. 1, include the Jan. 1 visit and do not include eligible episodes that occur on or between Jan. 2 and Jan. 31; then, if applicable, include the next eligible episode that occurs on or after Feb. 1. Identify visits chronologically including only one per 31-day period. *Note: The denominator for this measure is based on episodes, not on members. All eligible episodes that were not excluded remain in the denominator*	
Denominator exclusions	• Members who use hospice services (Hospice Encounter Value Set; Hospice Intervention Value Set) or elect to use a hospice benefit any time during the measurement year • Members who die any time during the measurement year • Exclude visits that result in an inpatient stay (Inpatient Stay Value Set) • Remove episode dates where the member had a claim/encounter with any diagnosis for a comorbid condition (Comorbid Conditions Value Set) during the 365 days prior to or on the episode date. Do not include laboratory claims (claims with POS code 81). • Remove episode dates where a new or refill prescription for an antibiotic medication (AAB Antibiotic Medications List) was dispensed 30 days prior to the episode date or was active on the episode date. • Remove episode dates where the member had a claim/encounter with a competing diagnosis on or three days after the episode date. Either of the following meets criteria for a competing diagnosis. Do not include laboratory claims (claims with POS code 81). -Pharyngitis Value Set -Competing Diagnosis Value Set *Refer to the HEDIS 2025 Value Set Directory for a list of codes.*	
Method to exclude	Claims	
Numerator	Dispensed prescription for an antibiotic medication from the AAB Antibiotic Medications List on or 3 days after the episode date. *Refer to the HEDIS 2025 Value Set Directory for a list of codes.*	
Services to close gap	N/A *The measure is reported as an inverted rate. A higher rate indicates appropriate URI treatment (i.e., the proportion of episodes that did not result in an antibiotic dispensing event).* *The desired outcome for this measure is that members won't be prescribed antibiotics unless they have a comorbid or competing diagnosis.*	
Method to close gap	Claims	

<table>
<tr><td>Medications to close gap</td><td>
<table>
<tr><th colspan="2">AAB Antibiotic Medications List</th></tr>
<tr><td>Aminoglycosides</td><td>Amikacin; Gentamicin; Streptomycin; Tobramycin</td></tr>
<tr><td>Aminopenicillins</td><td>Amoxicillin; Ampicillin</td></tr>
<tr><td>Beta-lactamase inhibitors</td><td>Amoxicillin-clavulanate; Ampicillin-sulbactam; Piperacillin - tazobactam</td></tr>
<tr><td>First generation cephalosporins</td><td>Cefadroxil; Cefazolin; Cephalexin</td></tr>
<tr><td>Fourth generation cephalosporins</td><td>Cefepime</td></tr>
<tr><td>Lincomycin derivatives</td><td>Clindamycin; Lincomycin</td></tr>
<tr><td>Macrolides</td><td>Azithromycin; Clarithromycin; Erythromycin</td></tr>
<tr><td>Miscellaneous antibiotics</td><td>Aztreonam; Chloramphenicol; Dalfopristin-quinupristin; Daptomycin; Linezolid; Metronidazole; Vancomycin</td></tr>
<tr><td>Natural penicillins</td><td>Penicillin G benzathine-procaine; Penicillin G potassium; Penicillin G procaine; Penicillin G sodium; Penicillin V potassium; Penicillin G benzathine</td></tr>
<tr><td>Penicillinase resistant penicillins</td><td>Dicloxacillin; Nafcillin; Oxacillin</td></tr>
<tr><td>Quinolones</td><td>Ciprofloxacin; Gemifloxacin; Levofloxacin; Moxifloxican; Ofloxacin</td></tr>
<tr><td>Rifamycin derivatives</td><td>Rifampin</td></tr>
<tr><td>Second generation cephalosporin</td><td>Cefaclor; Cefotetan; Cefoxitin; Cefprozil; Cefuroximine</td></tr>
<tr><td>Sulfonamides</td><td>Sulfadiazine; Sulfamethoxazole-trimethoprim</td></tr>
<tr><td>Tetracyclines</td><td>Doxycycline; Minocycline; Tetracycline</td></tr>
<tr><td>Third generation cephalosporins</td><td>Cefdinir; Cefixime; Cefotaxime; Cefpodoxime; Ceftazidime; Ceftriaxone</td></tr>
<tr><td>Urinary anti-infectives</td><td>Fosfomycin; Nitrofurantoin; Nitrofurantoin macrocrystals-monohydrate; Trimethoprim</td></tr>
</table>

Note: The desired outcome for this measure is that members won’t be prescribed antibiotics unless they have a comorbid or competing diagnosis.
</td></tr>
<tr><td>Best practice recommendations</td><td>

Educate patients about the risks of unnecessary antibiotics.
Educate patients on proper handwashing and hygiene to prevent the spread of illness.
Educate patients that URIs, such as the common cold, are often caused by viruses that require no antibiotic treatment.
Educate on symptom relief measures such as rest and fluids and to follow up if symptoms worsen.
Submit any comorbid/competing diagnosis codes that apply on the claim/encounter.

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

<table>
<tr><th colspan="3">Asthma Medication Ratio</th></tr>
<tr><td>Measure ID</td><td colspan="2">AMR</td></tr>
<tr><td>Source</td><td colspan="2">NCQA, HEDIS MY 2025</td></tr>
<tr><td>Summary of changes for 2025</td><td colspan="2">Added albuterol-budesonide as an asthma reliever medication.</td></tr>
<tr><td>Description</td><td colspan="2">The percentage of members 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</td></tr>
<tr><td>Measurement period</td><td colspan="2">Jan. 1, 2025, through Dec. 31, 2025</td></tr>
<tr><td>Quality program, ages, product lines</td><td>Premier Partners Program:
Ages: 22-64 years old as of Dec. 31 of the measurement year

Product lines:
• Commercial
• UPMC for You (Medicaid)</td><td>Quality Partners Program:
Ages: 5-64 years old as of Dec. 31 of the measurement year

Product lines:
• Commercial</td></tr>
<tr><td>Denominator</td><td colspan="2">Follow the steps below to identify the eligible population:
Step 1: Identify members as having persistent asthma who met at least one of the following criteria during both the measurement year and the year prior to the measurement year. Criteria need not be the same across both years.
• At least one ED visit or acute inpatient encounter (ED and Acute Inpatient Value Set), with a principal diagnosis of asthma (Asthma Value Set).
• At least one acute inpatient discharge with a principal diagnosis of asthma (Asthma Value Set) on the discharge claim. To identify an acute inpatient discharge:
1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
2. Exclude nonacute inpatient stays (Nonacute Inpatient Stay Value Set).
3. Identify the discharge date for the stay.
• At least four outpatient visits, telephone visits or e-visits or virtual check-ins (Outpatient and Telehealth Value Set), on different dates of service, with any diagnosis of asthma (Asthma Value Set) and at least two asthma medication dispensing events for any controller or reliever medication. Visit type need not be the same for the four visits. Use all the medication lists in the tables below to identify asthma controller and reliever medications.
• At least four asthma medication dispensing events for any controller or reliever medication. Use all the medication lists in the tables below to identify asthma controller and reliever medications.

Step 2: A member identified as having persistent asthma because of at least four asthma medication dispensing events, where leukotriene modifiers or antibody inhibitors were the sole asthma medication dispensed in that year, must also have at least one diagnosis of asthma (Asthma Value Set) in the same year as the leukotriene modifier or antibody inhibitor (the measurement year or the year prior to the measurement year). Do not include laboratory claims (claims with POS code 81).
Asthma Reliever Medications
Description | Prescription
Beta2 adrenergic agonist—corticosteroid combination | Albuterol-budesonide
Short-acting, inhaled beta-2 agonists | Albuterol
Levalbuterol

Note: Please see “Medications to close gap” for a list of asthma controller medications.</td></tr>
<tr><td>Denominator exclusions</td><td colspan="2">• Members who had a diagnosis that requires a different treatment approach than members with asthma (Respiratory Diseases With Different Treatment Approaches Than Asthma Value Set) any time during the member’s history through Dec. 31 of the measurement year. Do not include laboratory claims (claims with POS code 81).
• Members who had no asthma controller or reliever medications (Asthma Controller and Reliever Medications List) dispensed during the measurement year
• Members who use hospice services (Hospice Encounter Value Set; Hospice Intervention Value Set) or elect to use a hospice benefit any time during the measurement year
• Members who die any time during the measurement year

Refer to the HEDIS 2025 Value Set Directory for a list of codes.</td></tr>
<tr><td>Method to exclude</td><td colspan="2">Claims</td></tr>
<tr><td>Numerator/Service to close gap</td><td colspan="2">The number of members who have a controller medications to total asthma medications ratio of ≥0.50 during the measurement year.
Refer to the HEDIS 2025 Value Set Directory for a list of codes.</td></tr>
<tr><td>Method to close gap</td><td colspan="2">RX Claim</td></tr>
</table>

<table>
<tr><td>Medications to close gap</td><td></td><td colspan="2">Asthma Controller Medications
<table><tr><th>Description</th><th>Prescriptions</th></tr><tr><td>Antibody inhibitors</td><td>Omalizumab</td></tr><tr><td>Anti-interleukin-4</td><td>Dupilumab</td></tr><tr><td>Anti-interleukin-5</td><td>Benralizumab
Mepolizumab
Reslizumab</td></tr><tr><td>Inhaled steroid combinations</td><td>Budesonide-formoterol
Fluticasone-salmeterol
Fluticasone-vilanterol
Formoterol-mometasone</td></tr><tr><td>Inhaled corticosteroids</td><td>Beclomethasone
Budesonide
Ciclesonide
Flunisolide
Fluticasone
Mometasone</td></tr><tr><td>Leukotriene modifiers</td><td>Montelukast
Zafirlukast
Zileuton</td></tr><tr><td>Methylxanthines</td><td>Theophylline</td></tr><tr><td>Long-acting beta2-adrenergic agonist (LABA)</td><td>Fluticasone furoate-umeclidinium-vilanterol
Salmeterol</td></tr><tr><td>Long-acting muscarinic antagonists (LAMA)</td><td>Tiotropium</td></tr></table></td><td></td></tr>
<tr><td>Best practice recommendations</td><td colspan="3">Update prescription at pharmacy with any dosage changes for future refills.
Educate on proper use of asthma medication and differences between controller/reliever medications.
Work with the patient and family to develop an asthma care plan.
Talk to patients about identifying and avoiding asthma triggers.
Assist patients with managing side effects of inhalers to help improve compliance.
Assess patients’ symptom control and use of rescue inhaler at every visit.
Consider single maintenance treatment (SMART) with an inhaled corticosteroid-containing inhaler if patients are likely to be non-adherent.
Encourage 90-day prescription fills and automatic refills on controller medications.</td></tr>
</table>

Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis		
Measure ID	AAB	
Source	NCQA, HEDIS MY 2025	
Summary of changes for 2025	N/A	
Description	The percentage of episodes for members with a diagnosis of acute bronchitis/ bronchiolitis that did not result in an antibiotic dispensing event	
Measurement period	Jan. 1, 2025, through Dec. 31, 2025	
Quality program, ages, product lines	**Premier Partners Program:** Ages: 22 years of age and older as of the episode Date (the date of service for the visit with a diagnosis of bronchitis/bronchiolitis) Product lines: This measure is incentivized for: • UPMC *for You* (Medicaid) This measure is displayed for: • Commercial	**Quality Partners Program:** Ages: 3 months and older as of the episode Date (the date of service for the visit with a diagnosis of bronchitis/bronchiolitis) Product lines: This measure is displayed for: • Commercial
Denominator	Follow the steps below to identify the eligible population: **Step 1**: Identify all members who had an outpatient visit, ED visit, telephone visit, e-visit or virtual check-in (Outpatient, ED and Telehealth Value Set) during the intake period, with a diagnosis of acute bronchitis/bronchiolitis (Acute Bronchitis Value Set). **Step 2:** Determine all acute bronchitis/bronchiolitis episode dates. For each member identified in step 1, determine all outpatient, telephone or ED visits, e-visits and virtual check-ins with a diagnosis of acute bronchitis/bronchiolitis. **Step 3:** If a member has more than one eligible episode in a 31-day period, include only the first eligible episode. For example, if a member has an eligible episode on Jan. 1, include the Jan. 1 visit and do not include eligible episodes that occur on or between Jan. 2 and Jan. 31; then, if applicable, include the next eligible episode that occurs on or after Feb. 1. Identify visits chronologically, including only one per 31-day period. *Note: The denominator for this measure is based on episodes, not on members. All eligible episodes that were not removed or deduplicated remain in the denominator.*	
Denominator exclusions	• Members who use hospice services (Hospice Encounter Value Set; Hospice Intervention Value Set) or elect to use a hospice benefit any time during the measurement year. • Members who die any time during the measurement year. • Exclude visits that result in an inpatient stay (Inpatient Stay Value Set). • Remove episode dates where the member had a claim/encounter with any diagnosis for a comorbid condition (Comorbid Conditions Value Set) during the 365 days prior to or on the episode date. Do not include laboratory claims (claims with POS code 81). • Remove episode dates where a new or refill prescription for an antibiotic medication (AAB Antibiotic Medications List) was dispensed 30 days prior to the episode date or was active on the episode date. • Remove episode dates where the member had a claim/encounter with a competing diagnosis on or 3 days after the episode date. Either of the following meets criteria for a competing diagnosis. Do not include laboratory claims (claims with POS code 81). -Pharyngitis Value Set. -Competing Diagnosis Value Set *Refer to the HEDIS 2025 Value Set Directory for a list of codes.*	
Method to exclude	Claims	
Numerator	Dispensed prescription for an antibiotic medication (AAB Antibiotic Medications List) on or 3 days after the episode date	
Service to close gap	N/A; The desired outcome for this measure is that members won't be prescribed antibiotics unless they have a comorbid or competing diagnosis. *The measure is reported as an inverted rate. A higher rate indicates appropriate acute bronchitis/ bronchiolitis treatment (i.e., the proportion of episodes that did not result in an antibiotic dispensing event).* *Refer to the HEDIS 2025 Value Set Directory for a list of codes.*	
Method to close gap	N/A	

<table>
<tr><td>Medications to close gap</td><td>
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<tr><th colspan="2">AAB Antibiotic Medications List</th></tr>
<tr><td>Aminoglycosides</td><td>Amikacin; Gentamicin; Streptomycin; Tobramycin</td></tr>
<tr><td>Aminopenicillins</td><td>Amoxicillin; Ampicillin</td></tr>
<tr><td>Beta-lactamase inhibitors</td><td>Amoxicillin-clavulanate; Ampicillin-sulbactam; Piperacillin - tazobactam</td></tr>
<tr><td>First generation cephalosporins</td><td>Cefadroxil; Cefazolin; Cephalexin</td></tr>
<tr><td>Fourth generation cephalosporins</td><td>Cefepime</td></tr>
<tr><td>Lincomycin derivatives</td><td>Clindamycin; Lincomycin</td></tr>
<tr><td>Macrolides</td><td>Azithromycin; Clarithromycin; Erythromycin</td></tr>
<tr><td>Miscellaneous antibiotics</td><td>Aztreonam; Chloramphenicol; Dalfopristin-quinupristin; Daptomycin; Linezolid; Metronidazole; Vancomycin</td></tr>
<tr><td>Natural penicillins</td><td>Penicillin G benzathine-procaine; Penicillin G potassium; Penicillin G procaine; Penicillin G sodium; Penicillin V potassium; Penicillin G benzathine</td></tr>
<tr><td>Penicillinase resistant penicillins</td><td>Dicloxacillin; Nafcillin; Oxacillin</td></tr>
<tr><td>Quinolones</td><td>Ciprofloxacin; Gemifloxacin; Levofloxacin; Moxifloxican; Ofloxacin</td></tr>
<tr><td>Rifamycin derivatives</td><td>Rifampin</td></tr>
<tr><td>Second generation cephalosporin</td><td>Cefaclor; Cefotetan; Cefoxitin; Cefprozil; Cefuroximine</td></tr>
<tr><td>Sulfonamides</td><td>Sulfadiazine; Sulfamethoxazole-trimethoprim</td></tr>
<tr><td>Tetracyclines</td><td>Doxycycline; Minocycline; Tetracycline</td></tr>
<tr><td>Third generation cephalosporins</td><td>Cefdinir; Cefixime; Cefotaxime; Cefpodoxime; Ceftazidime; Ceftriaxone</td></tr>
<tr><td>Urinary anti-infectives</td><td>Fosfomycin; Nitrofurantoin; Nitrofurantoin macrocrystals-monohydrate; Trimethoprim</td></tr>
</table>

Note: The desired outcome for this measure is that members won’t be prescribed antibiotics unless they have a comorbid or competing diagnosis
</td></tr>
<tr><td>Best practice recommendations</td><td>

Educate patients about the risks of unnecessary antibiotics.
Educate patients about viral and bacterial infections.
Educate patients on symptom relief measures such as rest and fluids and to follow up if symptoms worsen.
Submit any comorbid/competing diagnosis codes that apply on the claim/encounter.

</td></tr>
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<table>
<tr><th colspan="3">Breast Cancer Screening</th></tr>
<tr><td>Measure ID</td><td colspan="2">BCS-E</td></tr>
<tr><td>Source</td><td colspan="2">NCQA, HEDIS MY 2025</td></tr>
<tr><td>Summary of changes for 2025</td><td colspan="2">Added a laboratory claim exclusion to the Absence of Left Value Set and Absence of Right Breast Value Set</td></tr>
<tr><td>Description</td><td colspan="2">The percentage of members 40–74 years of age who were recommended for routine breast cancer screening and had a mammogram to screen for breast cancer</td></tr>
<tr><td>Measurement period</td><td colspan="2">Jan. 1, 2025, through Dec. 31, 2025</td></tr>
<tr><td>Quality program, ages, product lines</td><td>Premier Partners Program:
Ages: Members 40–74 years old as of Dec. 31 of the measurement year

Product lines:
• Commercial
• UPMC for You (Medicaid)
• UPMC for Life (Medicare/SNP)</td><td>Quality Partners Program:
Ages: Members 40–74 years old as of Dec. 31 of the measurement year

Product lines:
• Commercial
• UPMC for Life (Medicare/SNP)</td></tr>
<tr><td>Denominator</td><td colspan="2">Members aged 42–74 due for breast cancer screening. Members will be included if they meet either of the following criteria:
• Gender is identified as female
• Sex assigned at birth is female</td></tr>
<tr><td>Denominator exclusions</td><td colspan="2">• Members who use hospice services (Hospice Encounter Value Set; Hospice Intervention Value Set) or elect to use a hospice benefit any time during the measurement period.
• Members who die any time during the measurement period.
• Members receiving palliative care (Palliative Care Assessment Value Set; Palliative Care Encounter Value Set; Palliative Care Intervention Value Set) any time during the measurement period.
• Members who had an encounter for palliative care (ICD-10-CM code Z51.5) any time during the measurement period. Do not include laboratory claims (claims with POS 81).
• Members who had a bilateral mastectomy or both right and left unilateral mastectomies any time during the member's history through the end of the measurement period. Any of the following meet the criteria for bilateral mastectomy:
-Bilateral mastectomy (Bilateral Mastectomy Value Set)
-Unilateral mastectomy (Unilateral Mastectomy Value Set) with a bilateral modifier (CPT Modifier code 50) (same procedure)
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

<table>
<tr><th>Left Mastectomy
(Any of the following)</th><th>Right Mastectomy
(Any of the following)</th></tr>
<tr><td>Unilateral mastectomy (Unilateral Mastectomy Value Set) with a left-side modifier (CPT Modifier code LT) (same procedure)</td><td>Unilateral mastectomy (Unilateral Mastectomy Value Set) with a right-side modifier (CPT Modifier code RT) (same procedure)</td></tr>
<tr><td>Absence of the left breast (Absence of Left Breast Value Set). Do not include laboratory claims (claims with POS code 81).</td><td>Absence of the right breast (Absence of Right Breast Value Set). Do not include laboratory claims (claims with POS code 81).</td></tr>
<tr><td>Left unilateral mastectomy (Unilateral Mastectomy Left Value Set)</td><td>Right unilateral mastectomy (Unilateral Mastectomy Right Value Set)</td></tr>
</table>
• Members who had gender-affirming chest surgery (CPT code 19318) with a diagnosis of gender dysphoria (Gender Dysphoria Value Set) any time during the member's history through the end of the measurement period.</td></tr>
</table>

Denominator exclusions (continued)	• Medicare members 66 years of age and older as of Dec. 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. • Members 66 years of age and older as of Dec. 31 of the measurement year with frailty ***and*** advanced illness. Members must meet **BOTH** of the following frailty and advanced illness criteria to be excluded: 1. **Frailty**: At least two indications of frailty (Frailty Device Value Set; Frailty Diagnosis Value Set; Frailty Encounter Value Set; Frailty Symptom Value Set) with different dates of service during the measurement period. Do not include laboratory claims (claims with POS 81). 2. **Advanced Illness**: Either of the following during the measurement period or the year prior to the measurement period: ▪ Advanced illness (Advanced Illness Value Set) on at least two different dates of service. Do not include laboratory claims (claims with POS 81). ▪ Dispensed dementia medication (Dementia Medications List). *Refer to the HEDIS 2025 Value Set Directory for a list of codes.*
Methods to exclude	• Claims • Upload to Novillus Care Gap Management Application (CGMA) (upload can only be done for the mastectomy exclusion)
Numerator/Service to close gap	One or more mammograms (Mammography Value Set) any time on or between Oct. 1 two years prior to the measurement period and the end of the measurement period *Refer to the HEDIS 2025 Value Set Directory for a list of codes.*
Methods to close gap	• Claims • Upload to Novillus Care Gap Management Application (CGMA)
Codes to close gap	**Mammography** CPT: 77061; 77062; 77063; 77065; 77066; 77067 Please see the complete 2025 Value Set located on Provider OnLine and on the Premier Partners SharePoint for additional codes that are used for this measure.
Best practice recommendations	• Set provider/patient reminders to discuss breast cancer screening and mammograms annually. • Provide convenient and accessible resources to patients so testing can be performed when the patient has time (weekends, same day, or walk-in hours). • Schedule appointment for the patient while they are in the office. • Send screening invitation letters combined with reminder phone calls to patients. Reminders that are simple and provide clear, concise information are most effective. • Connect patients to community resources, such as transportation or childcare services, to remove logistical barriers to scheduling.

Cervical Cancer Screening		
Measure ID	CCS-E	
Source	NCQA, HEDIS MY 2025	
Summary of changes for 2025	The *Cervical Cancer Screening* measure is now reported using Electronic Clinical Data Systems (ECDS).	
Description	The percentage of members who were recommended for routine cervical cancer screening and were screened for cervical cancer using any of the following criteria: • Members 21-64 years of age who were recommended for routine cervical cancer screening and had cervical cytology performed within the last three years (Jan. 1, 2023, to Dec. 31, 2025) • Members 30-64 years of age who were recommended for routine cervical cancer screening and had cervical high-risk human papillomavirus (hrHPV) testing performed within the last five years (Jan. 1, 2021, to Dec. 31, 2025) • Members 30-64 years of age who were recommended for routine cervical cancer screening and had cervical cytology/high-risk human papillomavirus (hrHPV) cotesting within the last five years (Jan. 1, 2021, to Dec. 31, 2025)	
Measurement period	Jan. 1, 2025, through Dec. 31, 2025	
Quality program, ages, product lines	**Premier Partners Program:** Ages: Members 24-64 years old as of Dec. 31 of the measurement year Product lines: • Commercial • UPMC *for You* (Medicaid)	**Quality Partners Program:** Ages: Members 24-64 years old as of Dec. 31 of the measurement year Product lines: • Commercial
Denominator	Members 24-64 years old as of Dec. 31 of the measurement year. Members will be included if they meet either of the following criteria: • Gender is identified as female • Sex assigned at birth is female	
Denominator exclusions	• Members who use hospice services (Hospice Encounter Value Set; Hospice Intervention Value Set) or elect to use a hospice benefit any time during the measurement year • Members who die any time during the measurement year • Members receiving palliative care (Palliative Care Assessment Value Set; Palliative Care Encounter Value Set; Palliative Care Intervention Value Set) any time during the measurement year • Members who had an encounter for palliative care (ICD-10-CM code Z51.5) any time during the measurement year. Do not include laboratory claims (claims with POS code 81) • Hysterectomy with no residual cervix (Hysterectomy With No Residual Cervix Value Set) any time during the member's history through Dec. 31 of the measurement year • Cervical agenesis or acquired absence of cervix (Absence of Cervix Diagnosis Value Set) any time during the member's history through Dec. 31 of the measurement year. Do not include laboratory claims (claims with POS code 81) • Members with Sex Assigned at Birth (LOINC code 76689-9) of Male (LOINC code LA2-8) at any time during the patient's history *Refer to the HEDIS 2025 Value Set Directory for a list of codes.*	
Methods to exclude	• Claim • Upload to Novillus Care Gap Management Application (CGMA)	
Numerator/Service to close gap	The number of members recommended for routine cervical cancer screening who were screened for cervical cancer. Either of the following meets criteria: • Members 24–64 years of age as of Dec. 31 of the measurement year who were recommended for routine cervical cancer screening and had cervical cytology (Cervical Cytology Lab Test Value Set; Cervical Cytology Result or Finding Value Set) during the measurement year or the 2 years prior to the measurement year. • Members 30–64 years of age as of Dec. 31 of the measurement year who were recommended for routine cervical cancer screening and had cervical high-risk human papillomavirus (hrHPV) testing (High Risk HPV Lab Test Value Set) during the measurement year or the 4 years prior to the measurement year, ***and*** who were 30 years or older on the test date. ***Note:*** *Evidence of hrHPV testing within the last 5 years also captures patients who had cotesting; therefore, additional methods to identify cotesting are not necessary.*	
Methods to close gap	• Claim • Upload to Novillus Care Gap Management Application (CGMA)	

Codes to close gap	**Cervical Cytology Lab Test; Cervical Cytology Result or Finding** • HCPCS: G0147; G0148; G0141; G0124; G0123; G0143; G0145; G0144; P3000; P3001; Q0091 • CPT: 88147; 88148; 88142; 88174; 88143; 88175; 88141; 88164; 88166; 88167; 88165; 88150; 88152; 88153 **High-Risk HPV Lab Tests** • HCPCS: G0476 • CPT: 87624; 87625 Please see the complete 2025 Value Set located on Provider OnLine and on the Premier Partners SharePoint for additional codes that are used for this measure.
Best practice recommendations	• Utilize the Electronic Medical Record (EMR) to see patients who are coming due or overdue for cervical cancer screening. • Perform Pap testing in the PCP office. If this is not possible, encourage women to follow up yearly with an ob-gyn provider. • Upload medical records to Novillus CGMA that indicate a total hysterectomy was completed any time in the member's history to exclude the member from the measure.

<table>
<tr><th colspan="3">Chlamydia Screening</th></tr>
<tr><td>Measure ID</td><td colspan="2">CHL</td></tr>
<tr><td>Source</td><td colspan="2">NCQA, HEDIS MY 2025</td></tr>
<tr><td>Summary of changes for 2025</td><td colspan="2">• Updated the measure title from Chlamydia Screening in Women to Chlamydia Screening.
• Replaced references to “women” with “members recommended for routine chlamydia screening.”
• Added criteria for “members recommended for routine chlamydia screening” to the eligible population.
• Added an exclusion for members who were assigned male at birth.</td></tr>
<tr><td>Description</td><td colspan="2">The percentage of members who were recommended for routine chlamydia screening, were identified as sexually active, and had at least one test for chlamydia during the measurement year</td></tr>
<tr><td>Measurement period</td><td colspan="2">Jan. 1, 2025, through Dec. 31, 2025</td></tr>
<tr><td>Quality program, ages, product lines</td><td>Premier Partners Program:
Ages: Women 22-24 years old as of Dec. 31 of the measurement year

Product lines:
• Commercial
• UPMC for You (Medicaid)</td><td>Quality Partners Program:
Ages: Women 16-24 years old as of Dec. 31 of the measurement year

Product lines:
• Commercial</td></tr>
<tr><td>Denominator</td><td colspan="2">Identify members who were recommended for routine chlamydia screening and are sexually active. Two methods identify sexually active members: pharmacy data and claim/encounter 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 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:
• Diagnoses Indicating Sexual Activity Value Set. Do not include laboratory claims (claims with POS code 81)
• Procedures Indicating Sexual Activity Value Set
• Pregnancy Tests Value Set

Pharmacy data. At least one contraceptive medication dispensing event during the measurement year (Contraceptive Medications List).

<table>
<tr><th colspan="2">Contraceptive Medications</th></tr>
<tr><th>Description</th><th>Prescription</th></tr>
<tr><td>Contraceptives</td><td>Desogestrel-ethinyl estradiol
Dienogest-estradiol (multiphasic)
Drospirenone-ethinyl estradiol
Drospirenone-ethinyl estradiol-levomefolate (biphasic)
Ethinyl estradiol-ethynodiol
Ethinyl estradiol-etonogestrel
Ethinyl estradiol-levonorgestrel
Ethinyl estradiol-norelgestromin
Ethinyl estradiol-norethindrone
Ethinyl estradiol-norgestimate
Ethinyl estradiol-norgestrel
Etonogestrel
Levonorgestrel
Medroxyprogesterone
Norethindrone</td></tr>
<tr><td>Diaphragm</td><td>Diaphragm</td></tr>
<tr><td>Spermacide</td><td>Nonoxynol 9</td></tr>
</table>
</td></tr>
<tr><td>Denominator exclusions</td><td colspan="2">• Members who use hospice services (Hospice Encounter Value Set; Hospice Intervention Value Set) or elect to use a hospice benefit any time during the measurement year
• Members who die any time during the measurement year
• Sex assigned at birth: (LOINC code 76689-9) Male (LOINC code LA2-8) any time in the member’s history</td></tr>
</table>

Denominator exclusions (continued)	For members who met denominator criteria 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 through 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 through 6 days after the pregnancy test. *Refer to the HEDIS 2025 Value Set Directory for a list of codes.*
Method to exclude	Claims
Numerator/Service to close gap	At least one chlamydia test (Chlamydia Tests Value Set) during the measurement year *Refer to the HEDIS 2025 Value Set Directory for a list of codes.*
Methods to close gap	• Claim • Upload to Novillus Care Gap Management Application (CGMA)
Codes to close gap	**Chlamydia Tests** • CPT: 87110; 87270; 87320; 87490; 87491; 87492; 87810 • LOINC: 14463-4; 14464-2; 14465-9; 14467-5; 14474-1; 14513-6; 16600-9; 21190-4; 21191-2; 21613-5; 23838-6; 31775-0; 34710-4; 42931-6; 43304-5; 43404-3; 44806-8; 44807-6; 45068-4; 45069-2; 45072-6; 45073-4; 45075-9; 45084-1; 45089-0; 45090-8; 45093-2;45091-6; 45095-7; 4993-2; 50387-0; 53925-4; 53926-2; 57287-5; 6353-7; 6356-0; 6357-8; 80360-1; 80361-9; 80362-7; 80363-5; 80364-3; 80365-0; 80367-6; 82306-2; 87949-4; 87950-2; 88221-7; 89648-0; 91860-7; 91873-0 Please see the complete 2025 Value Set located on Provider OnLine and on the Premier Partners SharePoint for additional codes that are used for this measure.
Best practice recommendations	• Support a culture of wellness and prevention by promoting annual routine screening beginning at age 16. • Frame chlamydia testing as routine and something that is done as a standard of care. • Do a urine screen on all females during the office visit instead of sending a script to an outpatient lab. This ensures the test will be completed. • Educate patients that chlamydia is often asymptomatic and can have lasting negative effects if left untreated. • Obtain the patient's personal phone number for reporting results. • Code screening tests as "preventive" to prevent out-of-pocket costs for the patient or family.

<table>
<tr><th colspan="3">Colorectal Cancer Screening</th></tr>
<tr><td>Measure ID</td><td colspan="2">COL-E</td></tr>
<tr><td>Source</td><td colspan="2">NCQA, HEDIS MY 2025</td></tr>
<tr><td>Summary of changes for 2025</td><td colspan="2">New incentive measure for UPMC for You (Medicaid)</td></tr>
<tr><td>Description</td><td colspan="2">The percentage of members 45–75 years of age who had appropriate screening for colorectal cancer</td></tr>
<tr><td>Measurement period</td><td colspan="2">Jan. 1, 2025, through Dec. 31, 2025</td></tr>
<tr><td>Quality program, ages, product lines</td><td>Premier Partners Program:
Ages: 46-75 years as of Dec. 31 of the measurement year

Product lines:
• Commercial
• UPMC for You (Medicaid)
• UPMC for Life (Medicare/SNP)</td><td>Quality Partners Program:
Ages: 46-75 years as of Dec. 31 of the measurement year

Product lines:
• Commercial
• UPMC for Life (Medicare/SNP)</td></tr>
<tr><td>Denominator</td><td colspan="2">Members 46-75 years old as of Dec. 31 of the measurement year</td></tr>
<tr><td>Denominator exclusions</td><td colspan="2">• Members who use hospice services (Hospice Encounter Value Set; Hospice Intervention Value Set) or elect to use a hospice benefit any time during the measurement period
• Members who die any time during the measurement period
• Members receiving palliative care (Palliative Care Assessment Value Set; Palliative Care Encounter Value Set; Palliative Care Intervention Value Set) any time during the measurement period
• Members who had an encounter for palliative care (ICD-10-CM code Z51.5) any time during the measurement year. Do not include laboratory claims (claims with POS 81).
• Members who had colorectal cancer (Colorectal Cancer Value Set) any time during the member's history through Dec. 31 of the measurement year. Do not include laboratory claims (claims with POS 81).
• Members who had a total colectomy (Total Colectomy Value Set) any time during the member's history through Dec. 31 of the measurement period
• Medicare members 66 years of age and older by the end of the measurement period who meet either of the following:
-Enrolled in an Institutional SNP (I-SNP) any time during the measurement period.
-Living long-term in an institution any time during the measurement period, as identified by the LTI flag in the monthly membership detail data file.
• Members 66 years of age and older by the end of the measurement period, with frailty and advanced illness. Members must meet BOTH frailty and advanced illness criteria to be excluded:
1. Frailty. At least two indications of frailty (Frailty Device Value Set; Frailty Diagnosis Value Set; Frailty Encounter Value Set; Frailty Symptom Value Set) with different dates of service during the measurement period. Do not include laboratory claims (claims with POS 81).
2. Advanced Illness. Either of the following during the measurement period or the year prior to the measurement period:
▪ Advanced illness (Advanced Illness Value Set) on at least two different dates of service. Do not include laboratory claims (claims with POS 81).
▪ Dispensed dementia medication (Dementia Medications List).

Refer to the HEDIS 2025 Value Set Directory for a list of codes.</td></tr>
<tr><td>Methods to exclude</td><td colspan="2">• Claim
• Upload to Novillus Care Gap Management Application (CGMA)</td></tr>
<tr><td>Numerator/Service to close gap</td><td colspan="2">Members with one or more screenings for colorectal cancer. Any of the following meet criteria:
• Fecal occult blood test (FOBT Lab Test Value Set; FOBT Test Result or Finding Value Set) during the measurement period.
• Stool DNA (sDNA) with FIT test (sDNA FIT Lab Test Value Set) during the measurement period or the 2 years prior to the measurement period.
• Flexible sigmoidoscopy (Flexible Sigmoidoscopy Value Set) during the measurement period or the 4 years prior to the measurement period.
• CT colonography (CT Colonography Value Set) during the measurement period or the 4 years prior to the measurement period. Note that CT colonography may not be a covered service, but will close the quality gap in care.
• Colonoscopy (Colonoscopy Value Set) during the measurement period or the 9 years prior to the measurement period
Refer to the HEDIS 2025 Value Set Directory for a list of codes.</td></tr>
</table>

Methods to close gap	• Claim • Upload to Novillus Care Gap Management Application (CGMA)
Codes to close gap	**Colonoscopy** • HCPCS: G0105; G0121 • CPT: 44388; 44389; 44390; 44391; 44392; 44394; 44401; 44402; 44403; 44404; 44405; 44406; 44407; 44408; 45378; 45379; 45380; 45381; 45382; 45384; 45385; 45386; 45388; 45389; 45390; 45391; 45392; 45393; 45398 **sDNA FIT Lab Test** • LOINC: 77353-1; 77354-9 • CPT: 81528 **FOBT Lab Test** • HCPCS: G0328 • CPT: 82270; 82274 **Flexible Sigmoidoscopy** • HCPCS: G0104 • CPT: 45330; 45331; 45332; 45333; 45334; 45335; 45337; 45338; 45340; 45341; 45342; 45346; 45347; 45349; 45350 Please see the complete 2025 Value Set located on Provider OnLine and on the Premier Partners SharePoint for additional codes that are used for this measure.
Best practice recommendations	• Offer multiple screening options to patients. This can be an effective strategy for improving patients' willingness to complete the screening. • Routinely generate a list to identify overdue patients. • Use electronic health record (EHR) reminders and alerts. • Schedule the patient's colonoscopy while they are in the office. • For patients who decline a colonoscopy, offer less invasive testing. • Get InSure® Fit™ Kits from Quest at no cost to the provider office to distribute to patients while they are in the office. • When distributing FIT kits, provide a deadline for the patient to return the kit. • Ensure staff can review FIT kit instructions with the patient prior to them leaving the office. • Follow up with a call to patients given an InSure Fit Kit if the kit has not been returned within a certain amount of time. • Offer solutions to patient-reported barriers or knowledge gaps. • Use dedicated staff (e.g., RNs or MAs) to engage patients, provide detailed information about screening, and help schedule visits, as needed. • Any visit type should be used as an opportunity to promote colorectal screenings. If the patient declines, demonstrate concern and re-engage the patient at future visits.

<table>
<tr><th colspan="3">Concurrent Use of Opioids and Benzodiazepines</th></tr>
<tr><td>Measure ID</td><td colspan="2">COB</td></tr>
<tr><td>Source</td><td colspan="2">PQA 2024</td></tr>
<tr><td>Summary of changes for 2025</td><td colspan="2">N/A</td></tr>
<tr><td>Description</td><td colspan="2">The percentage of individuals who did not have concurrent use of prescription opioids and benzodiazepines.</td></tr>
<tr><td>Measurement period</td><td colspan="2">Jan. 1, 2025, through Dec. 2, 2025 (Period of time in which the member meets denominator criteria)</td></tr>
<tr><td>Quality program, ages, product lines</td><td>Premier Partners Program:
Ages: 22 years of age and older

Product lines:
• UPMC for Life (Medicare/SNP)</td><td>Quality Partners Program:
Ages: 18 years of age and older

Product lines:
• UPMC for Life (Medicare/SNP)</td></tr>
<tr><td>Denominator</td><td colspan="2">Individuals with ≥2 prescription claims for opioid medications on different dates of service and with ≥15 cumulative days' supply during the measurement year
Use the steps below to determine the eligible population:

Step 1: Identify individuals who meet the age criteria as of the first day of the measurement year.

Step 2: Identify individuals with an IPSD that is ≥30 days from the last day of the measurement year (Jan. 1 through Dec. 2). The IPSD is the index prescription start date, i.e., the earliest date of service for an opioid during the measurement year.

Step 3: Identify individuals with ≥2 prescription claims for opioids on different dates of service, and with ≥15 cumulative days' supply during the measurement year. Exclude days' supply that occur after the end of the measurement year.

Note:
• The prescription claims can be for the same or different opioids.
• For multiple opioid claims with the same date of service, calculate the number of days covered by an opioid using the prescription claims with the longest days' supply.
• For multiple opioid claims with different dates of service, sum the days' supply for all the prescription claims, regardless of overlapping days' supply.</td></tr>
<tr><td>Denominator exclusions</td><td colspan="2">Exclude individuals with any of the following during the measurement year:
• Hospice
• Cancer diagnosis
• Sickle cell disease
• Palliative care</td></tr>
<tr><td>Method to exclude</td><td colspan="2">Claims</td></tr>
<tr><td>Numerator/Service to close gap</td><td colspan="2">The number of individuals from the denominator who did not have the following:
• ≥2 prescription claims for any benzodiazepines with different dates of service during the measurement period; AND
• Concurrent use of opioids and benzodiazepines for ≥30 cumulative days.

Service to close the gap: N/A; The desired outcome for this measure is that members will not have concurrent use of opioids and benzodiazepines for ≥30 cumulative days.

A higher rate indicates better performance for this measure.</td></tr>
<tr><td>Method to close gap</td><td colspan="2">N/A: The desired outcome for this measure is that members will not have concurrent use of opioids and benzodiazepines for ≥30 cumulative days.</td></tr>
<tr><td>Medications to close gap</td><td colspan="2">
<table>
<tr><th colspan="3">Opioid Medications [a, b]</th></tr>
<tr><td>benzhydrocodone
buprenorphine
butorphanol
codeine
dihydrocodeine
fentanyl</td><td>hydrocodone
hydromorphone
levorphanol
meperidine
methadone
morphine</td><td>opium
oxycodone
oxymorphone
pentazocine
tapentadol
tramadol</td></tr>
<tr><td colspan="3">[a] Includes combination products and prescription opioid cough medications.
[b] Excludes the following: injectable formulations; sublingual sufentanil (used in a supervised setting); and single-agent and combination buprenorphine products used to treat opioid use disorder (i.e., buprenorphine sublingual tablets, Probuphine® Implant kit subcutaneous implant, and all buprenorphine/naloxone combination products).</td></tr>
</table>
</td></tr>
</table>

<table>
<tr><td>Medications to close gap (continued)</td><td>
<table>
<tr><th colspan="3">Benzodiazepine Medications [c, d]</th></tr>
<tr><td>alprazolam
chlordiazepoxide
clobazam
clonazepam
clorazepate</td><td>diazepam
estazolam
flurazepam
lorazepam
midazolam</td><td>oxazepam
quazepam
temazepam
triazolam</td></tr>
<tr><td colspan="3">[c] Includes combination products.
[d] Excludes injectable formulations.</td></tr>
</table>
</td></tr>
<tr><td>Best practice recommendations</td><td>

Consider an alternative to a benzodiazepine if a patient already is taking an opioid or vice versa.
Assess whether tapering the patient off either the benzodiazepine or opioid is clinically appropriate. If the decision is made to taper, individualize the taper plan for each patient and focus on safe and effective treatment and support for the patient's treatment goals.
Prioritize patients taking multiple benzodiazepines or patients taking benzodiazepines in combination with prescribed opioids, other sedatives, and/or amphetamines. Attempt gradual tapering with eventual discontinuation (if possible) for patients on long-standing treatment.
Limit dose and duration if new therapy is needed.

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

Controlling High Blood Pressure		
Measure ID	CBP	
Source	NCQA, HEDIS MY 2025	
Summary of changes for 2025	N/A	
Description	The percentage of members who had a diagnosis of hypertension (HTN) and whose blood pressure (BP) was adequately controlled (<140/90 mm Hg) during the measurement year	
Measurement period	Jan. 1, 2025, through Dec. 31, 2025	
Quality program, ages, product lines	**Premier Partners Program:** Ages: 22-85 years as of Dec. 31 of the measurement year Product lines: • Commercial • UPMC *for You* (Medicaid) • UPMC *for Life* (Medicare/SNP)	**Quality Partners Program:** Ages: 18-85 years as of Dec. 31 of the measurement year Product lines: • Commercial • UPMC *for Life* (Medicare/SNP)
Denominator	Identify members who had at least two outpatient visits, telephone visits, e-visits or virtual check-ins (Outpatient and Telehealth Without UBREV Value Set) on different dates of service with a diagnosis of hypertension (Essential Hypertension Value Set) on or between Jan. 1 of the year prior to the measurement year and Jun. 30 of the measurement year.	
Denominator exclusions	• Members who use hospice services (Hospice Encounter Value Set; Hospice Intervention Value Set) or elect to use a hospice benefit any time during the measurement year • Members who die any time during the measurement year. • Members receiving palliative care (Palliative Care Assessment Value Set; Palliative Care Encounter Value Set; Palliative Care Intervention Value Set) any time during the measurement year. • Members who had an encounter for palliative care (ICD-10-CM code Z51.5) anytime during the measurement year. Do not include laboratory claims (claims with POS code 81). • Members with a diagnosis that indicates end-stage renal disease (ESRD) (ESRD Diagnosis Value Set; History of Kidney Transplant Value Set), any time during the member's history on or prior to Dec. 31 of the measurement year. Do not include laboratory claims (claims with POS code 81). • Members with a procedure that indicates ESRD: dialysis (Dialysis Procedure Value Set), nephrectomy (Total Nephrectomy Value Set; Partial Nephrectomy Value Set) or kidney transplant (Kidney Transplant Value Set) any time during the member's history on or prior to Dec. 31 of the measurement year. • Members with a diagnosis of pregnancy (Pregnancy Value Set) any time during the measurement year. Do not include laboratory claims (claims with POS code 81). • Medicare members 66 years of age and older as of Dec. 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. • Members 66–80 years of age as of Dec. 31 of the measurement year (all product lines) with frailty ***and*** advanced illness. Members must meet **BOTH** frailty and advanced illness criteria to be excluded: 1. **Frailty-** At least two indications of frailty (Frailty Device Value Set; Frailty Diagnosis Value Set; Frailty Encounter Value Set; Frailty Symptom Value Set) with different dates of service during the measurement year. Do not include laboratory claims (claims with POS code 81). 2. **Advanced Illness-** Either of the following during the measurement year or the year prior to the measurement year: -Advanced illness (Advanced Illness Value Set) on at least two different dates of service. Do not include laboratory claims (claims with POS code 81). -Dispensed dementia medication (Dementia Medications List). • Members 81 years of age and older as of Dec. 31 of the measurement year (all product lines) with at least two indications of frailty (Frailty Device Value Set; Frailty Diagnosis Value Set; Frailty Encounter Value Set; Frailty Symptom Value Set) with different dates of service during the measurement year. Do not include laboratory claims (claims with POS code 81). • Members who had a nonacute inpatient admission during the measurement year *Refer to the HEDIS 2025 Value Set Directory for a list of codes.*	
Method to exclude	Claims	

Numerator/Service to close gap	Identify the most recent BP reading (Systolic Blood Pressure Value Set; Diastolic Blood Pressure Value Set) taken during the measurement year. -Do not include CPT Category II codes (Systolic and Diastolic Result Value Set) with a modifier (CPT CAT II Modifier Value Set). -Do not include BPs taken in an acute inpatient setting (Acute Inpatient Value Set; Acute Inpatient POS Value Set) or during an ED visit (ED Value Set; POS code 23). The BP reading must occur *on or after* the date of the second diagnosis of hypertension (identified using the event/diagnosis criteria). The member is numerator compliant if the BP is <140/90 mm Hg. The member is not compliant if the BP is ≥140/90 mm Hg, if there is no BP reading during the measurement year or if the reading is incomplete (e.g., the systolic or diastolic level is missing). If there are multiple BPs on the same date of service, use the lowest systolic and lowest diastolic BP on that date as the representative BP. *Refer to the HEDIS 2025 Value Set Directory for a list of codes.*
Methods to close gap	• Claims • Upload to Novillus Care Gap Management Application (CGMA)
Codes to close gap	A systolic and diastolic value must be reported. • 3074F: Systolic blood pressure <130 mm Hg • 3075F: Systolic blood pressure 130–139 mm Hg • 3077F: Systolic blood pressure ≥140 mm Hg (will not close the gap) • 3078F: Diastolic blood pressure <80 mm Hg • 3079F: Diastolic blood pressure 80–89 mm Hg • 3080F: Diastolic blood pressure ≥90 mm Hg (will not close the gap) This measure requires that the last blood pressure of the measurement year is reported, regardless of the result. Codes that represent blood pressures equal to or greater than 140/90 might need to be reported if the last blood pressure of the measurement year is ≥140/90 and are therefore listed here to support the measure requirement for the last blood pressure reading. Please see the complete 2025 Value Set located on Provider OnLine and on the Premier Partners SharePoint for additional codes that are used for this measure.
Best practice recommendations	• Educate members on diet, exercise, stress management, and lifestyle factors—such as smoking and alcohol consumption—that can affect blood pressure. • Refer members to care management for lifestyle or chronic disease management (as needed). • Encourage members to take their blood pressure medications as prescribed, even when their blood pressure is under control. • If the patient's blood pressure is elevated when they arrive, recheck the blood pressure after the patient has had a chance to sit for a while and be sure to document the new value in the medical record.

Incentive Measures

Depression Screening		
Measure ID	DS is the measure ID for internal use at UPMC Health Plan.	
Source	UPMC Health Plan	
Summary of changes for 2025	No changes to this measure	
Description	Rate: The percentage of members who had a depression screening during the measurement year Incentive: The number of unique members for whom the provider submitted a depression screening result code (G8431, G8510, G8511, G8940) during the measurement year	
Measurement period	Jan. 1, 2025, through Dec. 31, 2025	
Quality program, ages, product lines	**Premier Partners Program:** Note this measure does not roll into the overall line of business score for the Premier Partners Program. Ages: 22 years and older Product lines: • Commercial • UPMC *for You* (Medicaid) • UPMC *for Life* (Medicare/SNP)	**Quality Partners Program:** Note this measure does not roll into the overall line of business score for the Quality Partners Program. Ages: 18 years and older Product lines: • Commercial • UPMC *for Life* (Medicare/SNP)
Denominator	Average monthly membership across all product lines during the measurement year	
Denominator exclusions	• Members who die any time during the measurement year • All Premier Partners Program participants are ineligible for the Quality Partners Program incentive for this measure.	
Method to exclude	N/A	
Numerator/Service to close gap	One eligible code per member, per date of service is counted. To determine total numerator, follow these two steps: **Step 1:** Identify all dates of service per member where any screening was performed • If an eligible code was submitted, count it in the numerator • If an eligible code was not submitted, submit claim through EMR or through the claims tab in Provider OnLine. Note: claims or manual uploads will not be accepted through the Partners Program Gaps in Care link/Novillus Care Gap Management Application/CGMA). **Step 2:** Count all occurrences in step 1 Individuals should be screened using nationally recognized standardized instruments, such as a two-question screening followed by a nine-question screening if the initial results are positive during routine intake for identified member groups.	
Methods to close gap	Claims	
Codes to close gap	**Rate:** • HCPCS: G8431, G8510, G8511, G8940, G0444 • CPT Code: 96127 Incentive: The number of unique members for whom the provider submitted a depression screening result code (G8431, G8510, G8511, G8940) during the measurement year	
Best practice recommendations	• Utilize the Electronic Medical Record (EMR) to see patients who have had a G0444 or 96127 code billed but no eligible result code. Submit a zero dollar claim with the HCPCS result code via Provider OnLine. • Appropriate interventions for positive screens may include “watchful waiting,” medications, brief therapies, or referral to specialty care. • Order Prescription for Wellness for members who would benefit from working with a health coach.	

Eye Exam for Patients with Diabetes		
Measure ID	EED	
Source	NCQA, HEDIS MY 2025	
Summary of changes for 2025	• Moved bilateral eye enucleation from the numerator to required exclusions. • Added new criteria for identifying numerator events.	
Description	The percentage of members with diabetes (types 1 and 2) who had a retinal eye exam	
Measurement period	Jan. 1, 2025, through Dec. 31, 2025	
Quality program, ages, product lines	**Premier Partners Program:** Ages: 22-75 years old as of Dec. 31 of the measurement year Product lines: • Commercial • UPMC *for Life* (Medicare/SNP) • UPMC *for You* (Medicaid)	**Quality Partners Program:** Ages: 18-75 years old as of Dec. 31 of the measurement year Product lines: • Commercial • UPMC *for Life* (Medicare/SNP)
Denominator	There are two ways to identify members with diabetes: by claim/encounter data and by pharmacy data. The organization must use both methods to identify the eligible population, but a member only needs to be identified by one method to be included in the measure. Members may be identified as having diabetes during the measurement year or the year prior to the measurement year. ***Claim/encounter data*.** Members who had at least two diagnoses of diabetes (Diabetes Value Set) on different dates of service during the measurement year or the year prior to the measurement year. Do not include laboratory claims (claims with POS code 81). ***Pharmacy data***. Members who were dispensed insulin or hypoglycemics/ antihyperglycemics during the measurement year or the year prior to the measurement year (Diabetes Medications List) ***and*** have at least one diagnosis of diabetes (Diabetes Value Set) during the measurement year or the year prior to the measurement year. Do not include laboratory claims (claims with POS code 81).	
Denominator exclusions	• Bilateral eye enucleation any time during the member's history through Dec. 31 of the measurement year: -Unilateral eye enucleation (Unilateral Eye Enucleation Value Set) with a bilateral modifier (CPT Modifier code 50). -Two unilateral eye enucleations (Unilateral Eye Enucleation Value Set) with service dates 14 days or more apart. For example, if the service date for the first unilateral eye enucleation was February 1 of the measurement year, the service date for the second unilateral eye enucleation must be on or after Feb. 15. -Left unilateral eye enucleation (ICD-10-PCS code 08T1XZZ) and right unilateral eye enucleation (ICD-10-PCS code 08T0XZZ) on the same or different dates of service. -A unilateral eye enucleation (Unilateral Eye Enucleation Value Set) and a left unilateral eye enucleation (ICD-10-PCS code 08T1XZZ) with service dates 14 days or more apart. -A unilateral eye enucleation (Unilateral Eye Enucleation Value Set) and a right unilateral eye enucleation (ICD-10-PCS code 08T0XZZ) with service dates 14 days or more apart. • Members who use hospice services (Hospice Encounter Value Set; Hospice Intervention Value Set) or elect to use a hospice benefit any time during the measurement year • Members who die any time during the measurement year. • Members receiving palliative care (Palliative Care Assessment Value Set; Palliative Care Encounter Value Set; Palliative Care Intervention Value Set) any time during the measurement year. • Members who had an encounter for palliative care (ICD-10-CM code Z51.5) any time during the measurement year. Do not include laboratory claims (claims with POS code 81). • Medicare members 66 years of age and older as of Dec. 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. • Members 66 years of age and older as of Dec. 31 of the measurement year (all product lines) with frailty ***and*** advanced illness. Members must meet **BOTH** frailty and advanced illness criteria to be excluded: 1. **Frailty-** At least two indications of frailty (Frailty Device Value Set; Frailty Diagnosis Value Set; Frailty Encounter Value Set; Frailty Symptom Value Set) with different dates of service during the measurement year. Do not include laboratory claims (claims with POS code 81).	

<table>
<tr><td>Denominator exclusions (continued)</td><td>2. Advanced Illness- Either of the following during the measurement year or the year prior to the measurement year:
-Advanced illness (Advanced Illness Value Set) on at least two different dates of service. Do not include laboratory claims (claims with POS code 81).
-Dispensed dementia medication (Dementia Medications List).

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.

Refer to the HEDIS 2025 Value Set Directory for a list of codes.</td></tr>
<tr><td>Method to exclude</td><td>Claims</td></tr>
<tr><td>Numerator/Service to close gap</td><td>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.
Any of the following meet criteria:
Any code in the Retinal Eye Exams Value Set billed by an eye care professional (optometrist or ophthalmologist) during the measurement year.
Any code in the Retinal Eye Exams Value Set billed by an eye care professional (optometrist or ophthalmologist) during the year prior to the measurement year, with a diagnosis of diabetes without complications (Diabetes Mellitus Without Complications Value Set).
Any code in the Eye Exam With Evidence of Retinopathy Value Set, Eye Exam Without Evidence of Retinopathy Value Set billed by any provider type during the measurement year. Do not include codes with a modifier (CPT CAT II Modifier Value Set).
Retinal imaging with interpretation and reporting by a qualified reading center (Retinal Imaging Value Set) billed by any provider type during the measurement year.
Automated eye exam (CPT code 92229) billed by any provider type during the measurement year.
Any code in the Eye Exam Without Evidence of Retinopathy Value Set billed by any provider type during the year prior to the measurement year. Do not include codes with a modifier (CPT CAT II Modifier Value Set).
Diabetic retinal screening negative in prior year (CPT-CAT-II code 3072F) billed by any provider type during the measurement year. Do not include codes with a modifier (CPT CAT II Modifier Value Set).
Any combination that indicates findings from a retinal exam for diabetic retinopathy performed in both the left and right eye by any provider:
<table>
<tr><th>Left Eye</th><th>Right Eye</th></tr>
<tr><td>Any level of retinopathy (LOINC code 71490-7 with Diabetic Retinopathy Severity Level Value Set) during the measurement year.</td><td>Any level of retinopathy (LOINC code 71491-5 with Diabetic Retinopathy Severity Level Value Set) during the measurement year.</td></tr>
<tr><td>No retinopathy (LOINC code 71490-7 with LOINC code LA18643-9) in the year prior to the measurement year.</td><td>No retinopathy (LOINC code 71491-5 with LOINC code LA18643-9) in the year prior to the measurement year.</td></tr>
</table>
Refer to the HEDIS 2025 Value Set Directory for a list of codes.</td></tr>
<tr><td>Methods to close gap</td><td>Claim
Upload to Novillus Care Gap Management Application (CGMA)</td></tr>
<tr><td>Codes to close gap</td><td>Eye Exam with Evidence of Retinopathy
CPT/CPT II: 2022F; 2024F; 2026F
Eye Exam Without Evidence of Retinopathy
CPT/CPT II: 2023F;2025F; 2033F
Retinal Imaging Value Set
CPT: 92227; 92228</td></tr>
</table>

Codes to close gap (continued)	**Automated Eye Exam** • CPT: 92229 **Diabetic Retinal Screening Negative in Prior Year** • CPT/CPT II: 3072F (This code can be used to indicate a diabetic retinal screening was negative in the year before the measurement year, which can be used to close the gap for the current measurement year.) Please see the complete 2025 Value Set located on Provider OnLine and on the Premier Partners SharePoint for additional codes that are used for this measure.
Best practice recommendations	• Educate patients on preventive retinal eye exam screenings they can receive through their medical benefit coverage. • Provide on-site retinal screenings. Be certain that photographs are interpreted by an eye care professional. Claims must be submitted by an eye care professional. • Develop collaborative relationships with local eye care providers to minimize access barriers and allow for point-of-service scheduling. • Provide patient reminders to accommodate patients' communication preferences (email, phone calls, text messages, etc.). • If a patient had a negative exam in the year prior, upload the report or submit the applicable CPT II code for gap closure.

<table>
<tr><th colspan="3">Follow-Up After Emergency Department Visit for People with Multiple High-Risk Chronic Conditions</th></tr>
<tr><td>Measure ID</td><td colspan="2">FMC</td></tr>
<tr><td>Source</td><td colspan="2">NCQA, HEDIS MY 2025</td></tr>
<tr><td>Summary of changes for 2025</td><td colspan="2">Added a laboratory claim exclusion to a value set for which laboratory claims should not be used</td></tr>
<tr><td>Description</td><td colspan="2">The percentage of emergency department (ED) visits for members who have multiple high-risk chronic conditions who had a follow-up service within 7 days of the ED visit</td></tr>
<tr><td>Measurement period</td><td colspan="2">Jan. 1, 2025, through Dec. 24, 2025 (Period of time in which the member meets denominator criteria)</td></tr>
<tr><td>Quality program, ages, product lines</td><td>Premier Partners Program:
Ages: 22 years and older as of Dec. 31 of the measurement year

Product lines:
• UPMC for Life (Medicare/SNP)</td><td>Quality Partners Program:
Ages: 18 years and older as of Dec. 31 of the measurement year

Product lines:
• UPMC for Life (Medicare/SNP)</td></tr>
<tr><td>Denominator</td><td colspan="2">Step 1: An ED visit (ED Value Set) on or between Jan. 1 and Dec. 24 of the measurement year where the member met age criteria 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 ED visits between Jan. 1 and Dec. 24 of the measurement year.

Step 2: Identify ED visits where the member had a chronic condition prior to the ED visit. The following are eligible chronic condition diagnoses. Each bullet indicates an eligible chronic condition (for example, COPD and asthma are considered the same chronic condition):
• COPD, asthma or unspecified bronchitis (COPD Diagnosis Value Set; Asthma Diagnosis Value Set; ICD-10-CM code J40).
• Alzheimer’s disease and related disorders (Dementia Value Set; Frontotemporal Dementia Value Set).
• Chronic kidney disease (Chronic Kidney Disease Value Set).
• Depression (Major Depression Value Set; Dysthymic Disorder Value Set).
• Heart failure (Chronic Heart Failure Value Set; Heart Failure Diagnosis Value Set).
• Acute myocardial infarction (MI Value Set; Old Myocardial Infarction Value Set).
• Atrial fibrillation (Atrial Fibrillation Value Set).
• Stroke and transient ischemic attack (Stroke Value Set).
-Remove any visit with a principal diagnosis of encounter for other specified aftercare (ICD-10-CM code Z51.89).
-Remove any visit with any diagnosis of concussion with loss of consciousness or fracture of vault of skull, initial encounter (Other Stroke Exclusions Value Set).

Using the eligible chronic condition diagnoses above, identify members who had any of the following during the measurement year or the year prior to the measurement year, but prior to the ED visit (count services that occur over both years):
• At least two outpatient visits, ED visits, telephone visits, e-visits, virtual check-ins or nonacute inpatient encounters (Outpatient, ED, Telehealth and 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 eligible chronic condition. Visit type need not be the same for the two visits, but the visits must be for the same eligible chronic condition. 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 eligible chronic condition.
• At least one acute inpatient discharge with an eligible chronic condition on the discharge claim. To identify an acute 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.

For each ED visit, identify the total number of chronic conditions the member had prior to the ED visit.

Step 3: Identify ED visits where the member had two or more different chronic conditions prior to the ED visit, that meet the criteria included in step 2. These are eligible ED visits.</td></tr>
</table>

Denominator (continued)	**Step 4:** If a member has more than one ED visit in an 8-day period, include only the first eligible ED visit. For example, if a member has an eligible ED visit on Jan. 1, include the Jan. 1 visit and do not include ED visits that occur on or between Jan. 2 and Jan. 8. Then, if applicable, include the next eligible ED visit that occurs on or after Jan. 9. Identify visits chronologically, including only one visit per 8-day period.
Denominator exclusions	• Members who use hospice services (Hospice Encounter Value Set; Hospice Intervention Value Set) or elect to use a hospice benefit any time during the measurement year • Members who die any time during the measurement year • 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 7 days after the ED visit, regardless of the principal diagnosis for admission. *Refer to the HEDIS 2025 Value Set Directory for a list of codes.*
Method to exclude	Claims
Numerator/Service to close gap	A follow-up service within 7 days after the ED visit (8 total days). Include visits that occur on the date of the ED visit. The following meet criteria for follow-up: • An outpatient visit, telephone visit, e-visit or virtual check-in (Outpatient and Telehealth Value Set). • Transitional care management services (Transitional Care Management Services Value Set). • Case management visits (Case Management Encounter Value Set). • Complex Care Management Services (Complex Care Management Services Value Set). • An outpatient or telehealth behavioral health visit (Visit Setting Unspecified Value Set ***with*** Outpatient POS Value Set). • An outpatient or telehealth behavioral health visit (BH Outpatient Value Set). • An intensive outpatient encounter or partial hospitalization (Visit Setting Unspecified Value Set ***with*** POS code 52). • An intensive outpatient encounter or partial hospitalization (Partial Hospitalization or Intensive Outpatient Value Set). • A community mental health center visit (Visit Setting Unspecified Value Set ***with*** POS code 53). • Electroconvulsive therapy (Electroconvulsive Therapy Value Set) ***with*** (Outpatient POS Value Set; POS code 24; POS code 52; POS code 53). • A telehealth visit (Visit Setting Unspecified Value Set ***with*** Telehealth POS Value Set). • A substance use disorder service (Substance Use Disorder Services Value Set). • Substance use disorder counseling and surveillance (Substance Abuse Counseling and Surveillance Value Set). Do not include laboratory claims (claims with POS code 81). *Refer to the HEDIS 2025 Value Set Directory for a list of codes.*
Methods to close gap	• Claims • Upload to Novillus Care Gap Management Application (CGMA)
Codes to close gap	**Outpatient and Telehealth** • CPT: 99483; 99345; 99342; 99344; 99341; 99350; 99348; 99349; 99347; 99385; 99386; 99387; 99384; 99382; 99381; 99383; 99245; 99243; 99244; 99242; 99205; 99203; 99204; 99202; 99211; 99215; 99213; 99214; 99212; 99422; 99423; 99421; 99395; 99396; 99397; 99394; 99392; 99391; 99393; 99401; 99402; 99403; 99404; 99411; 99412; 98971; 98972; 98970; 99458; 99457; 98981; 98980; 98967; 98968; 98966; 99442; 99443; 99441; 99429; 99456; 99455 • HCPCS: G0071; G0402; G0438; G0439; G0463; G2010; G2012; G2250; G2251; G2252; T1015 **Transitional Care Management Services** • CPT: 99495; 99496 **BH Outpatient** • HCPCS: G0176; H0040; H0039; H0004; H0002; T1015; H0037; H0036; H2015; H2016; H2010; H2000; H2011; G0463; H0034; H0031; H2013; H2017; H2018; G0512; G0155; H2014; G0409; H2019; H2020; G0177 • CPT: 99483; 98961; 98962; 98960; 99345; 99342; 99344; 99341; 99350; 99348; 99349; 99347; 99510; 99385; 99386; 99387; 99384; 99382; 99381; 99383; 99494; 99492; 99245; 99243; 99244; 99242; 99205; 99203; 99204; 99202; 99211; 99215; 99213; 99214; 99212; 99395; 99396; 99397; 99394; 99392; 99391; 99393; 99078; 99401; 99402; 99403; 99404; 99411; 99412; 99493 **Case Management Encounter** • HCPCS: T1016; T1017; T2022; T2023 • CPT: 99366

Codes to close gap (continued)	**Complex Care Management Services** • HCPCS: G0506 • CPT: 99439; 99487; 99489; 99490; 99491 **Substance Use Disorder Services** • HCPCS: G0396; G0397; G0443; H0001; H0005; H0007; H0015; H0016; H0022; H0047; H0050; H2035; H2036; T1006; T1012 • CPT: 99408; 99409 **Substance Abuse Counseling and Surveillance** • ICD-10CM: Z71.41; Z71.51 **Partial Hospitalization or Intensive Outpatient** • HCPCS: G0410; G0411; H0035; H2001; H2012; S0201; S9480; S9484; S9485 **Visit Setting Unspecified*** • CPT: 90847; 90853; 99238; 99239; 90875; 90876; 99223; 99222; 99221; 99255; 99253; 99254; 99252; 90849; 90791; 90792; 90845; 90840; 90839; 90832; 90833; 90834; 90836; 90837; 90838; 99233; 99232; 99231 ***When a code from the Visit Setting Unspecified Value Set is used; providers must also use a POS code from the following list:** • Outpatient POS: 13; 33; 50; 14; 12; 49; 05; 15; 19; 11; 22; 18; 09; 71; 72; 03; 16; 07; 20; 17 • Telehealth POS: 02; 10 • POS: 52, 53 Please see the complete 2025 Value Set located on Provider OnLine and on the Premier Partners SharePoint for additional codes that are used for this measure.
Best practice recommendations	• Develop a process to identify patients who are in the ED. • Educate patients to notify the PCP office when they are discharged from the ED. • Observation visits are included in the *Follow-Up After Emergency Department Visit for People with Multiple High-Risk Chronic Conditions* measure. Attempt to see all discharged patients within 7 days of hospital discharge to ensure numerator compliance, and to reduce readmissions.

Glycemic Status Assessment for Patients With Diabetes		
Measure ID	GSD	
Source	NCQA, HEDIS MY 2025	
Summary of changes for 2025	N/A	
Description	The percentage of members with diabetes (types 1 and 2) whose *most recent* glycemic status (hemoglobin A1c [HbA1c] or glucose management indicator [GMI]) was controlled during the measurement year. See Numerator/Service to close gap section for values that meet control criteria, by line of business. *Note: If the member did not have a glycemic status reported during the measurement year or the Health Plan did not receive the result, the member does not meet criteria for numerator compliance.*	
Measurement period	Jan. 1, 2025, through Dec. 31, 2025	
Quality program, ages, product lines	**Premier Partners Program:** Ages: 22-75 years old as of Dec. 31 of the measurement year Product lines: • Commercial • UPMC *for Life* (Medicare/SNP) • UPMC *for You* (Medicaid)	**Quality Partners Program:** Ages: 18-75 years old as of Dec. 31 of the measurement year Product lines: • Commercial • UPMC *for Life* (Medicare/SNP)
Denominator	There are two ways to identify members with diabetes: by claim/encounter data and by pharmacy data. The organization must use both methods to identify the eligible population, but a member only needs to be identified by one method to be included in the measure. Members may be identified as having diabetes during the measurement year or the year prior to the measurement year. ***Claim/encounter data*.** Members who had at least two diagnoses of diabetes (Diabetes Value Set) on different dates of service during the measurement year or the year prior to the measurement year. Do not include laboratory claims (claims with POS code 81). ***Pharmacy data***. Members who were dispensed insulin or hypoglycemics/ antihyperglycemics during the measurement year or the year prior to the measurement year (Diabetes Medications List) ***and*** have at least one diagnosis of diabetes (Diabetes Value Set) during the measurement year or the year prior to the measurement year. Do not include laboratory claims (claims with POS code 81).	
Denominator exclusions	• Members who use hospice services (Hospice Encounter Value Set; Hospice Intervention Value Set) or elect to use a hospice benefit any time during the measurement year • Members who die any time during the measurement year. • Members receiving palliative care (Palliative Care Assessment Value Set; Palliative Care Encounter Value Set; Palliative Care Intervention Value Set) any time during the measurement year. • Members who had an encounter for palliative care (ICD-10-CM code Z51.5) any time during the measurement year. Do not include laboratory claims (claims with POS code 81). • Medicare members 66 years of age and older as of Dec. 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. • Members 66 years of age and older as of Dec. 31 of the measurement year (all product lines) with frailty ***and*** advanced illness. Members must meet **BOTH** frailty and advanced illness criteria to be excluded: 1. **Frailty-** At least two indications of frailty (Frailty Device Value Set; Frailty Diagnosis Value Set; Frailty Encounter Value Set; Frailty Symptom Value Set) with different dates of service during the measurement year. Do not include laboratory claims (claims with POS code 81). 2. **Advanced Illness-** Either of the following during the measurement year or the year prior to the measurement year: -Advanced illness (Advanced Illness Value Set) on at least two different dates of service. Do not include laboratory claims (claims with POS code 81). -Dispensed dementia medication (Dementia Medications List). *Refer to the HEDIS 2025 Value Set Directory for a list of codes.*	
Method to exclude	Claims	

Numerator/Service to close gap	A glycemic status during the measurement year and the most recent result is controlled. If the member did not have a glycemic status reported during the measurement year or the Health Plan did not receive the result, the member does not meet criteria for numerator compliance. If there are multiple glycemic status assessments on the same date of service, use the lowest result. Use the following criteria to determine if the result is controlled: **For Premier Partners Program:** • Commercial and Medicaid members are numerator compliant if the *most recent* glycemic status was < 8.0%. • Medicare members are numerator compliant if the most recent glycemic status was ≤ 9.0% **For Quality Partners Program:** • Commercial members are numerator compliant if the *most recent* glycemic status was < 8.0%. • Medicare members are numerator compliant if the most recent glycemic status was ≤ 9.0% *Refer to the HEDIS 2025 Value Set Directory for a list of codes.*
Methods to close gap	• Claim • Upload to Novillus Care Gap Management Application (CGMA)
Codes to close gap	The following codes can be used to identify the most recent **HbA1c:** CPT/CPT II: • 3044F: HbA1c <7.0 • 3046F: HbA1c >9.0 • 3051F: HbA1c ≥7 and <8 • 3052F: HbA1c ≥8 and ≤9 Glucose management indicator (GMI) values must be submitted via Novillus CGMA. GMI values must include documentation of the continuous glucose monitoring data date range used to derive the value. The terminal date in the range should be used to assign assessment date. This measure requires that the last glycemic status assessment of the measurement year is reported. Codes that represent uncontrolled values might need to be reported if they represent the last value of the measurement year and are therefore listed here to support the measure requirement for the last HbA1c value. Please see the complete 2025 Value Set located on Provider OnLine and on the Premier Partners SharePoint for additional codes that are used for this measure.
Best practice recommendations	• Develop a process for submitting CPT II codes or uploading results for facilities where there is no lab feed. • Order Prescription for Wellness for members whose glycemic status is not controlled or who need assistance with developing self-management skills. • Identify members who would benefit from working with a certified diabetes educator to manage their condition.

Kidney Health Evaluation for Patients With Diabetes		
Measure ID	KED	
Source	NCQA, HEDIS MY 2025	
Summary of changes for 2025	N/A	
Description	The percentage of members 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	
Measurement period	Jan. 1, 2025, through Dec. 31, 2025	
Quality program, ages, product lines	**Premier Partners Program:** Ages: 22-85 years old as of Dec. 31 of the measurement year Product lines: • Commercial • UPMC *for Life* (Medicare/SNP) • UPMC *for You* (Medicaid)	**Quality Partners Program:** Ages: 18-85 years old as of Dec. 31 of the measurement year Product lines: • Commercial • UPMC *for Life* (Medicare/SNP)
Denominator	There are two ways to identify members with diabetes: by claim/encounter data and by pharmacy data. The organization must use both methods to identify the eligible population, but a member only needs to be identified by one method to be included in the measure. Members may be identified as having diabetes during the measurement year or the year prior to the measurement year. ***Claim/encounter data*.** Members who had at least two diagnoses of diabetes (Diabetes Value Set) on different dates of service during the measurement year or the year prior to the measurement year. Do not include laboratory claims (claims with POS code 81). ***Pharmacy data***. Members who were dispensed insulin or hypoglycemics/ antihyperglycemics during the measurement year or the year prior to the measurement year (Diabetes Medications List) ***and*** have at least one diagnosis of diabetes (Diabetes Value Set) during the measurement year or the year prior to the measurement year. Do not include laboratory claims (claims with POS code 81).	
Denominator exclusions	• Members who use hospice services (Hospice Encounter Value Set; Hospice Intervention Value Set) or elect to use a hospice benefit any time during the measurement year • Members who die any time during the measurement year • Members receiving palliative care (Palliative Care Assessment Value Set; Palliative Care Encounter Value Set; Palliative Care Intervention Value Set) any time during the measurement year • Members who had an encounter for palliative care (ICD-10-CM code Z51.5) any time during the measurement year. Do not include laboratory claims (claims with POS code 81) • Members who had dialysis (Dialysis Procedure Value Set) any time during the member's history on or prior to Dec. 31 of the measurement year • Members with a diagnosis of ESRD (ESRD Diagnosis Value Set) any time during the member's history on or prior to Dec. 31 of the measurement year. Do not include laboratory claims (claims with POS code 81). • Medicare members 66 years of age and older as of Dec. 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. • Members 66-80 years of age as of Dec. 31 of the measurement year (all product lines) with frailty **and** advanced illness. Members must meet **both** frailty and advanced illness criteria to be excluded: 1. **Frailty-** At least two indications of frailty (Frailty Device Value Set; Frailty Diagnosis Value Set; Frailty Encounter Value Set; Frailty Symptom Value Set) with different dates of service during the measurement year. Do not include laboratory claims (claims with POS code 81). 2. **Advanced Illness-** Either of the following during the measurement year or the year prior to the measurement year: -Advanced illness (Advanced Illness Value Set) on at least two different dates of service. Do not include laboratory claims (claims with POS code 81) -Dispensed dementia medication (Dementia Medications List)	

Denominator exclusions (continued)	• Members 81 years of age and older as of Dec. 31 of the measurement year (all product lines) with at least two indications of frailty (Frailty Device Value Set; Frailty Diagnosis Value Set; Frailty Encounter Value Set; Frailty Symptom Value Set) with different dates of service during the measurement year. Do not include laboratory claims (claims with POS code 81).
Method to exclude	Claims
Numerator/Service to close gap	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 Dec. 1 of the measurement year, then the urine creatinine test must have a service date on or between Nov. 27 and Dec. 5 of the measurement year. **-**A uACR (Urine Albumin Creatinine Ratio Lab Test Value Set). *Refer to the HEDIS 2025 Value Set Directory for a list of codes.*
Methods to close gap	• Claim • Upload to Novillus Care Gap Management Application (CGMA)
Codes to close gap	**Estimated Glomerular Filtration Lab Tests** • CPT: 80047; 80048; 80050; 80053; 80069; 82565 • LOINC: 102097-3; 50044-7; 50210-4; 50384-7; 62238-1; 69405-9; 70969-1; 77147-7; 94677-2; 98979-8; 98980-6 **Urine Albumin Creatinine Ratio Lab Tests** • LOINC: 13705-9; 14958-3; 14959-1; 30000-4; 44292-1; 59159-4; 76401-9; 77253-3; 77254-1; 89998-9; 9318-7 Quantitative Urine Albumin and Urine Creatinine Lab tests (If not submitting a code from the Urine Albumin Creatinine Ratio Lab Tests Value Set, one code from each Value Set below must be submitted to close the gap): **Quantitative Urine Albumin Lab Test** • CPT: 82043 • LOINC: 100158-5; 14957-5; 1754-1; 21059-1; 30003-8; 43605-5; 53530-2; 53531-0; 57369-1; 89999-7 **Urine Creatinine Lab Test** • CPT: 82570 • LOINC: 20624-3; 2161-8; 35674-1; 39982-4; 57344-4; 57346-9; 58951-5 Please see the complete 2025 Value Set located on Provider OnLine and on the Premier Partners SharePoint for additional codes that are used for this measure.
Best practice recommendations	• Provide on-site urine specimen collection and processing. If not available, contract with a service for specimen collection. • Provide patient education around diabetes and self-management.

<table>
<tr><th colspan="3">Medication Adherence for Cholesterol (Statins)</th></tr>
<tr><td>Measure ID</td><td colspan="2">CMA</td></tr>
<tr><td>Source</td><td colspan="2">PQA 2024</td></tr>
<tr><td>Summary of changes for 2025</td><td colspan="2">N/A</td></tr>
<tr><td>Description</td><td colspan="2">The percentage of individuals who met the Proportion of Days Covered (PDC) threshold of 80% for statins during the measurement year.</td></tr>
<tr><td>Measurement period</td><td colspan="2">Jan. 1, 2025, through Dec. 31, 2025</td></tr>
<tr><td>Quality program, ages, product lines</td><td>Premier Partners Program:
Ages: 22 years of age and older

Product lines:
• UPMC for Life (Medicare/SNP)</td><td>Quality Partners Program:
Ages: 18 years of age and older

Product lines:
• UPMC for Life (Medicare/SNP)</td></tr>
<tr><td>Denominator</td><td colspan="2">Individuals with ≥2 prescription claims for any statin (See Statin Medications and Combinations table below) on different dates of service in the treatment period.
Use the steps below to determine the eligible population.
Step 1: Identify individuals who meet the age criteria as of the first day of the measurement year
Step 2: Identify individuals with ≥2 prescription claims on different dates of service for any statin during the measurement year. The prescription claims can be for the same or different medications.
Step 3: Determine each individual’s treatment period. The treatment period is the time period (in days) from the IPSD to the end of the measurement year, death or last day of enrollment, whichever occurs first. The IPSD is the Index Prescription Start Date, i.e., the earliest date of service for a target medication during the measurement year.
Step 4: Identify individuals with a treatment period that is ≥91 days during the measurement year.</td></tr>
<tr><td>Denominator exclusions</td><td colspan="2">• Hospice care at any time during the measurement year.
• An ESRD diagnosis at any time during the measurement year.</td></tr>
<tr><td>Method to exclude</td><td colspan="2">Claims</td></tr>
<tr><td>Numerator/Service to close gap</td><td colspan="2">The number of individuals who met the proportion of days covered (PDC) threshold of 80% during the measurement year

Proportion of days covered refers to the proportion of days in the treatment period “covered” by prescription claims for the same medication or another in its therapeutic category.</td></tr>
<tr><td>Method to close gap</td><td colspan="2">RX Claim</td></tr>
<tr><td>Medications to close gap</td><td colspan="2"><table><tr><th colspan="3">Statin Medications and Combinations[a]</th></tr><tr><td>Atorvastatin (+/- amlodipine, ezetimibe)
Fluvastatin
Lovastatin (+/- niacin)</td><td>Pitavastatin
Pravastatin</td><td>Rosuvastatin (+/- ezetimibe)
Simvastatin (+/- ezetimibe, niacin)</td></tr><tr><td colspan="3">[a]Active ingredients are limited to oral formulations only</td></tr></table></td></tr>
<tr><td>Best practice recommendations</td><td colspan="2">• Urge patients to use UPMC ID cards to fill statin prescriptions. Formulary (covered) statins are available at no cost share when filled at a preferred pharmacy during the initial phase of coverage.
• Encourage 100-day prescription fills for UPMC for Life (Medicare/SNP) members.
• If the medication dose or instructions change, make sure the pharmacy receives an updated prescription and all refills of the old prescription are canceled.
• Encourage patients to use UPMC Health Plan-preferred pharmacies, as these pharmacies are held to quality standards and are more likely to ensure the medication fill is run through the UPMC ID card.
• Encourage patients to ask for automatic refills for their medications as well as a pill box to keep them on track for taking medication as prescribed. This will decrease the chance of missing a dose or running out of medication.
• If providing samples, do so before sending a prescription to the pharmacy to see if the patient can tolerate the medication before filling a prescription.</td></tr>
</table>

<table>
<tr><th colspan="3">Medication Adherence for Diabetes</th></tr>
<tr><td>Measure ID</td><td colspan="2">DMA</td></tr>
<tr><td>Source</td><td colspan="2">PQA 2024</td></tr>
<tr><td>Summary of changes for 2025</td><td colspan="2">N/A</td></tr>
<tr><td>Description</td><td colspan="2">The percentage of individuals who met the Proportion of Days Covered (PDC) threshold of 80% for diabetes medications during the measurement year.</td></tr>
<tr><td>Measurement period</td><td colspan="2">Jan. 1, 2025, through Dec. 31, 2025</td></tr>
<tr><td>Ages</td><td>Premier Partners Program:
Ages: 22 years of age and older

Product lines:
• UPMC for Life (Medicare/SNP)</td><td>Quality Partners Program:
Ages: 18 years of age and older

Product lines:
• UPMC for Life (Medicare/SNP)</td></tr>
<tr><td>Denominator</td><td colspan="2">Individuals with ≥2 prescription claims for any of the diabetes medications in the Diabetes Medication Table below on different dates of service in the treatment period.

Use the steps below to determine the eligible population.
Step 1: Identify individuals who meet the age criteria as of the first day of the measurement year
Step 2: Identify individuals with ≥2 prescription claims on different dates of service for any diabetes medication (See Diabetes Medication Table below) during the measurement year. The prescription claims can be for the same or different medications.
Step 3: Determine each individual's treatment period. The treatment period is the time period (in days) from the IPSD to the end of the measurement year, death or last day of enrollment, whichever occurs first. The IPSD is the Index Prescription Start Date, i.e., the earliest date of service for a target medication during the measurement year.
Step 4: Identify individuals with a treatment period that is ≥91 days during the measurement year.</td></tr>
<tr><td>Denominator exclusions</td><td colspan="2">Members are excluded from the denominator if any of the following occurs during the measurement period:
• Hospice care at any time during the measurement year.
• An ESRD diagnosis at any time during the measurement year.
• One or more prescription claims for insulin during the treatment period.</td></tr>
<tr><td>Method to exclude</td><td colspan="2">Claims</td></tr>
<tr><td>Numerator/ Service to close gap</td><td colspan="2">The number of individuals who met the proportion of days covered (PDC) threshold of 80% during the measurement year

Proportion of days covered refers to the proportion of days in the treatment period "covered" by prescription claims for the same medication or another on the Diabetes Medication Table.</td></tr>
<tr><td>Method to close gap</td><td colspan="2">Rx claims</td></tr>
<tr><td>Medications to close gap</td><td colspan="2">
<table>
<tr><th colspan="2">Diabetes Medication Table</th></tr>
<tr><th colspan="2">Biguanide Medications and Combinations [a, b]</th></tr>
<tr><td colspan="2">metformin (+/- alogliptin, canagliflozin, dapagliflozin, empagliflozin, ertugliflozin, glipizide, glyburide, linagliptin, pioglitazone, repaglinide, rosiglitazone, saxagliptin, sitagliptin)</td></tr>
<tr><td colspan="2">[a] Active ingredients are limited to oral formulations only.
[b] Excludes nutritional supplement/dietary management combination products.</td></tr>
<tr><th colspan="2">Sulfonylurea Medications and Combinations[a]</th></tr>
<tr><td>chlorpropamide[b]
glimepiride (+/- pioglitazone, rosiglitazone[b])
glipizide (+/- metformin)</td><td>glyburide (+/- metformin)
tolazamide
tolbutamide[b]</td></tr>
<tr><td colspan="2">[a] Active ingredients are limited to oral formulations only.
[b] There are no active NDCs for chlorpropamide, glimepiride/rosiglitazone, or tolbutamide.</td></tr>
<tr><th colspan="2">Thiazolidinedione Medications and Combinations[a]</th></tr>
<tr><td>pioglitazone (+/- alogliptin, glimepiride, metformin)</td><td>rosiglitazone (+/- glimperide[b], metformin)</td></tr>
<tr><td colspan="2">[a] Active ingredients are limited to oral formulations only.
[b] There are no active NDCs for rosiglitazone/glimepiride.</td></tr>
<tr><th colspan="2">DPP-4 Medications and Combinations[a]</th></tr>
<tr><td>alogliptin (+/- metformin, pioglitazone)
linagliptin (+/- empagliflozin, metformin)</td><td>saxagliptin (+/- metformin, dapagliflozin)
sitagliptin (+/- metformin, ertugliflozin)</td></tr>
<tr><td colspan="2">[a] Active ingredients are limited to oral formulations only.</td></tr>
</table>
</td></tr>
</table>

<table>
<tr><td>Medications to close gap (continued)</td><td>
<table>
<tr><th colspan="2">GIP/GLP-1 Receptor Agonists Medications[a]</th></tr>
<tr><td>albiglutide[b]
dulaglutide
exenatide
liraglutide</td><td>lixisenatide
semaglutide
tirzepatide</td></tr>
<tr><td colspan="2">[a] Excludes products indicated only for weight loss;
[b] No active NDCs for albiglutide</td></tr>
<tr><th colspan="2">Meglitinide Medications and Combinations[a]</th></tr>
<tr><td>nateglinide</td><td>repaglinide (+/- metformin)</td></tr>
<tr><td colspan="2">[a] Active ingredients are limited to oral formulations only.</td></tr>
<tr><th colspan="2">SGLT2 Inhibitor Medications and Combinations[a]</th></tr>
<tr><td>bexagliflozin
canagliflozin (+/- metformin)
dapagliflozin (+/- metformin, saxagliptin)</td><td>empagliflozin (+/- metformin, linagliptin)
ertugliflozin (+/- sitagliptin, metformin)</td></tr>
<tr><td colspan="2">[a] Active ingredients are limited to oral formulations only.</td></tr>
</table>
</td></tr>
<tr><td>Best practice recommendations</td><td>

Urge patients to use UPMC ID cards to fill prescriptions. Many formulary (covered) generic and brand medications for diabetes are available at no cost share when filled at a preferred pharmacy during the initial phase of coverage.
Encourage 100-day prescription fills for UPMC for Life (Medicare/SNP) members.
If the medication dose or instructions change, make sure the pharmacy receives an updated prescription and all refills of the old prescription are canceled.
Encourage patients to use UPMC Health Plan-preferred pharmacies, as these pharmacies are held to quality standards and are more likely to ensure the medication fill is run through UPMC ID card.
Encourage patients to ask for automatic refills for their medications as well as a pill box to keep them on track for taking medication as prescribed. This will decrease the chance of missing a dose or running out of medication.
If providing samples, do so before sending a prescription to the pharmacy to see if the patient can tolerate the medication before filling a prescription.

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

<table>
<tr><th colspan="3">Medication Adherence for Hypertension (RAS Antagonist)</th></tr>
<tr><td>Measure ID</td><td colspan="2">HMA</td></tr>
<tr><td>Source</td><td colspan="2">PQA 2024</td></tr>
<tr><td>Summary of changes for 2025</td><td colspan="2">N/A</td></tr>
<tr><td>Description</td><td colspan="2">The percentage of individuals who met the Proportion of Days Covered (PDC) threshold of 80% for RAS antagonists during the measurement year.</td></tr>
<tr><td>Measurement period</td><td colspan="2">Jan. 1, 2025, through Dec. 31, 2025</td></tr>
<tr><td>Quality program, ages, product lines</td><td>Premier Partners Program:
Ages: 22 years of age and older

Product lines:
• UPMC for Life (Medicare/SNP)</td><td>Quality Partners Program:
Ages: 18 years of age and older

Product lines:
• UPMC for Life (Medicare/SNP)</td></tr>
<tr><td>Denominator</td><td colspan="2">Individuals with ≥2 prescription claims for any RAS antagonist medications included in the Renin Angiotensin System (RAS) Antagonists Table below, on different dates of service in the treatment period.
Use the steps below to determine the eligible population.

Step 1: Identify individuals who meet the age criteria as of the first day of the measurement year
Step 2: Identify individuals with ≥2 prescription claims on different dates of service for any RAS antagonist medication (See Renin Angiotensin System (RAS) Antagonists Table below) during the measurement year. The prescription claims can be for the same or different medications.
Step 3: Determine each individual's treatment period. The treatment period is the time period (in days) from the IPSD to the end of the measurement year, death or last day of enrollment, whichever occurs first. The IPSD is the Index Prescription Start Date, i.e., the earliest date of service for a target medication during the measurement year.
Step 4: Identify individuals with a treatment period that is ≥91 days during the measurement year.</td></tr>
<tr><td>Denominator exclusions</td><td colspan="2">Members are excluded from the denominator if any of the following occur during the measurement period:
• Hospice care at any time during the measurement year.
• An ESRD diagnosis at any time during the measurement year.
• A prescription claim for sacubitril/valsartan during the treatment period.</td></tr>
<tr><td>Method to exclude</td><td colspan="2">Claims</td></tr>
<tr><td>Numerator/Service to close gap</td><td colspan="2">The number of individuals who met the proportion of days covered (PDC) threshold of 80% during the measurement year
Proportion of days covered refers to the proportion of days in the treatment period "covered" by prescription claims for the same medication or another on the Renin Angiotensin System (RAS) Antagonists Medication Table.</td></tr>
<tr><td>Method to close gap</td><td colspan="2">Rx claims</td></tr>
<tr><td>Medications to close gap</td><td colspan="2">
<table>
<tr><th colspan="2">Renin Angiotensin System (RAS) Antagonists [a, b]</th></tr>
<tr><th colspan="2">Direct Renin Inhibitor Medications and Combinations</th></tr>
<tr><td>aliskiren (+/- hydrochlorothiazide)</td><td></td></tr>
<tr><th colspan="2">ARB Medications and Combinations</th></tr>
<tr><td>azilsartan (+/- chlorthalidone)
candesartan (+/- hydrochlorothiazide)
eprosartan (+/- hydrochlorothiazide)
irbesartan (+/- hydrochlorothiazide)
losartan (+/- hydrochlorothiazide)</td><td>olmesartan (+/- amlodipine, hydrochlorothiazide)
telmisartan (+/- amlodipine, hydrochlorothiazide)
valsartan (+/- amlodipine, hydrochlorothiazide, nebivolol[c])</td></tr>
<tr><th colspan="2">ACE Inhibitor Medications and Combinations</th></tr>
<tr><td>benazepril (+/- amlodipine, hydrochlorothiazide)
captopril (+/- hydrochlorothiazide)
enalapril (+/- hydrochlorothiazide)
fosinopril (+/- hydrochlorothiazide)
lisinopril (+/- hydrochlorothiazide)</td><td>moexipril (+/- hydrochlorothiazide)
perindopril (+/- amlodipine)
quinapril (+/- hydrochlorothiazide)
ramipril
trandolapril (+/- verapamil)</td></tr>
<tr><td colspan="2">[a] Active ingredients are limited to oral formulations only.
[b] Excludes nutritional supplement/dietary management combination products.
[c] There are no active NDCs for valsartan/nebivolol.</td></tr>
</table>
</td></tr>
<tr><td>Best practice recommendations</td><td colspan="2">• Urge patients to use UPMC ID cards to fill prescriptions. Many formulary (covered) generic and brand medications for diabetes are available at no cost share when filled at a preferred pharmacy during the initial phase of coverage.
• Encourage 100-day prescription fills for UPMC for Life (Medicare/SNP) members.
• If the medication dose or instructions change, make sure the pharmacy receives an updated prescription and all refills of the old prescription are canceled.</td></tr>
</table>

Best practice recommendations (continued)	• Encourage patients to use UPMC Health Plan-preferred pharmacies, as these pharmacies are held to quality standards and are more likely to ensure the medication fill is run through the UPMC ID card. • Encourage patients to ask for automatic refills for their medications as well as a pill box to keep them on track for taking medication as prescribed. This will decrease the chance of missing a dose or running out of medication. • If providing samples, do so before sending a prescription to the pharmacy to see if the patient can tolerate the medication before filling a prescription.

Medication Reconciliation Post-Discharge		
Measure ID	TRC	
Source	NCQA, HEDIS MY 2025	
Summary of changes for 2025	N/A	
Description	The percentage of discharges for members who had documentation of medication reconciliation on the date of discharge through 30 days after discharge (31 total days)	
Measurement period	Jan. 1, 2025, through Dec. 1, 2025 (Period of time in which the member meets denominator criteria)	
Quality program, ages, product lines	**Premier Partners Program:** Ages: 22 years of age and older as of Dec. 31 of the measurement year Product lines: • UPMC *for Life* (Medicare/SNP)	**Quality Partners Program:** Ages: 18 years of age and older as of Dec. 31 of the measurement year Product lines: • UPMC *for Life* (Medicare/SNP)
Denominator	An acute or nonacute inpatient discharge on or between Jan. 1 and Dec. 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 Jan. 1 and Dec. 1 of the measurement year. 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. 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). 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.	
Denominator exclusions	• Members who use hospice services (Hospice Encounter Value Set; Hospice Intervention Value Set) or elect to use a hospice benefit any time during the measurement year • Members who die any time during the measurement year • Exclude both the initial and the readmission/direct transfer discharge if the last discharge occurs after Dec. 1 of the measurement year *Refer to the HEDIS 2025 Value Set Directory for a list of codes.*	
Method to exclude	Claims	
Numerator/Service to close gap	Medication reconciliation conducted by a prescribing practitioner, clinical pharmacist, physician assistant or registered nurse on the date of discharge through 30 days after discharge (31 total days). Either of the following meet criteria: • Medication Reconciliation Encounter Value Set • Medication Reconciliation Intervention Value Set. Do not include codes with a modifier (CPT CAT II Modifier Value Set) *Refer to the HEDIS 2025 Value Set Directory for a list of codes.*	

Methods to close gap	• Claim • Upload to Novillus Care Gap Management Application (CGMA)
Codes to close gap	**Medication Reconciliation Encounter; Medication Reconciliation Intervention** • CPT: 99483; 99495; 99496 • CPT II: 1111F Please see the complete 2025 Value Set located on Provider OnLine and on the Premier Partners SharePoint for additional codes that are used for this measure.
Best practice recommendations	• Develop a process to complete medication reconciliation and/or transitional care management services on all hospital discharge patients. • Consider completing telephonic or face-to-face medication reconciliation within a week of hospital discharge to make sure the patient is taking new medications as prescribed and has stopped taking medications that were discontinued, to answer medication-related questions, and to compare the hospital discharge summary to the outpatient record. • When seeing the patient face-to-face, ask the patient to bring all the medications they are taking to review bottles and ensure accuracy. • Ask specific questions about medications (especially new medications): -Are there are any financial concerns with getting prescriptions filled? -Is the patient taking the medication as prescribed? -Does the patient understand what the medications are for and why it is important to take them? • Update the patient's medication list in the health record to avoid future discrepancies.

Patient Engagement After Inpatient Discharge		
Measure ID	TRC	
Source	NCQA, HEDIS MY 2025	
Summary of changes for 2025	• New display measure for Commercial for both programs • New display measure for UPMC *for You* (Medicaid) for Premier Partners Program	
Description	The percentage of discharges for members who had documentation of patient engagement (e.g., office visits, visits to the home, telehealth) provided within 30 days after discharge	
Measurement period	Jan. 1, 2025, through Dec. 1, 2025 (Period of time in which the member meets denominator criteria)	
Quality program, ages, product lines	**Premier Partners Program:** Ages: 22 years of age and older as of Dec. 31 of the measurement year Product lines: This measure is incentivized for: • UPMC *for Life* (Medicare/SNP) This measure is displayed for: • Commercial • UPMC *for You* (Medicaid)	**Quality Partners Program:** Ages: 18 years of age and older as of Dec. 31 of the measurement year Product lines: This measure is incentivized for: • UPMC *for Life* (Medicare/SNP) This measure is displayed for: • Commercial
Denominator	An acute or nonacute inpatient discharge on or between Jan. 1 and Dec. 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 Jan. 1 and Dec. 1 of the measurement year. 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. 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). 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.	
Denominator exclusions	• Members who use hospice services (Hospice Encounter Value Set; Hospice Intervention Value Set) or elect to use a hospice benefit any time during the measurement year • Members who die any time during the measurement year • Exclude both the initial and the readmission/direct transfer discharge if the last discharge occurs after Dec. 1 of the measurement year *Refer to the HEDIS 2025 Value Set Directory for a list of codes.*	
Method to exclude	Claims	

Numerator/Service to close gap	Patient engagement provided within 30 days after discharge. Do not include patient engagement that occurs on the date of discharge. The following meet criteria for patient engagement: • An outpatient visit, telephone visit, e-visit or virtual check-in (Outpatient and Telehealth Value Set) • Transitional care management services (Transitional Care Management Services Value Set) *Refer to the HEDIS 2025 Value Set Directory for a list of codes.*
Methods to close gap	• Claim • Upload to Novillus Care Gap Management Application (CGMA)
Codes to close gap	**Outpatient and Telehealth** • CPT: 99483; 99345; 99342; 99344; 99341; 99350; 99348; 99349; 99347; 99385; 99386; 99387; 99384; 99382; 99381; 99383; 99245; 99243; 99244; 99242; 99205; 99203; 99204; 99202; 99211; 99215; 99213; 99214; 99212; 99422; 99423; 99421; 99395; 99396; 99397; 99394; 99392; 99391; 99393; 99401; 99402; 99403; 99404; 99411; 99412; 98971; 98972; 98970; 99458; 99457; 98981; 98980; 98967; 98968; 98966; 99442; 99443; 99441; 99429; 99456; 99455 • HCPCS: G0071; G0402; G0438; G0439; G0463; G2010; G2012; G2250; G2251; G2252; T1015 **Transitional Care Management Services** • CPT: 99495; 99496 Please see the complete 2025 Value Set located on Provider OnLine and on the Premier Partners SharePoint for additional codes that are used for this measure.
Best practice recommendations	• Utilize Admission, Discharge, Transfer (ADT) reports to identify patients who will require follow-up appointments. • Conduct telephonic outreach to patients who haven't scheduled a follow-up appointment within two weeks of discharge. • If transportation is a barrier, consider follow-up via a telephone, e-visit, or virtual check-in. • During the appointment, allow time to answer the patient's questions about their condition, treatment, medications, etc.

<table>
<tr><th colspan="3">Pharmacotherapy Management of COPD: Bronchodilator</th></tr>
<tr><td>Measure ID</td><td colspan="2">PCE</td></tr>
<tr><td>Source</td><td colspan="2">NCQA, HEDIS MY 2025</td></tr>
<tr><td>Summary of changes for 2025</td><td colspan="2">N/A</td></tr>
<tr><td>Description</td><td colspan="2">The percentage of COPD exacerbations for members 40 years of age and older who had an acute inpatient discharge or ED visit on or between Jan. 1 and Nov. 30 of the measurement year and who were dispensed a bronchodilator (or there was evidence of an active prescription) within 30 days of the event
Note: The eligible population for this measure is based on acute inpatient discharges and ED visits, not on members. It is possible for the denominator to include multiple events for the same individual.</td></tr>
<tr><td>Measurement period</td><td colspan="2">Jan. 1, 2025, through Nov. 30, 2025 (Period of time in which the member meets denominator criteria)</td></tr>
<tr><td>Quality program, ages, product lines</td><td>Premier Partners Program:
Ages: 40 years of age and older as of Jan. 1 of the measurement year

Product lines:
• Commercial
• UPMC for You (Medicaid)</td><td>Quality Partners Program:
Ages: 40 years of age and older as of Jan. 1 of the measurement year

Product lines:
• This is a Display measure for Commercial</td></tr>
<tr><td>Denominator</td><td colspan="2">A COPD exacerbation as indicated by an acute inpatient discharge or ED encounter with a principal diagnosis of COPD.
Follow the steps below to identify the eligible population.
Step 1: Identify all members who had either of the following during the intake period:
• An ED visit (ED Value Set) with a principal diagnosis of COPD, emphysema or chronic bronchitis (Chronic Obstructive Pulmonary Diseases Value Set).
• An acute inpatient discharge with a principal diagnosis of COPD, emphysema or chronic bronchitis (Chronic Obstructive Pulmonary Diseases Value Set) on the discharge claim. 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.

Step 2: Identify all COPD episodes. For each member identified in step 1, identify all acute inpatient discharges and ED visits. An acute inpatient discharge and ED visit on the same date are counted as one COPD episode. Multiple ED visits on the same date are counted as one COPD episode. Do not include ED visits that result in an inpatient stay (Inpatient Stay Value Set)

Step 3: Test for direct transfers. For episodes with a direct transfer to an acute or nonacute setting for any diagnosis, the episode date is the discharge date from the last admission.

A direct transfer is when the discharge date from the first inpatient setting precedes the admission date to a second inpatient setting by one calendar day or less. For example:
• An inpatient discharge on June 1, followed by an admission to another inpatient setting on June 1, is a direct transfer.
• An inpatient discharge on Jun. 1, followed by an admission to an inpatient setting on Jun. 2, is a direct transfer.
• An inpatient discharge on Jun. 1, followed by an admission to another inpatient setting on Jun. 3, is not a direct transfer; these are two distinct inpatient stays.

Use the following method to identify admissions to and discharges from inpatient settings.
1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
2. Identify the admission and discharge dates for the stay.</td></tr>
<tr><td>Denominator exclusions</td><td colspan="2">• Members who use hospice services (Hospice Encounter Value Set; Hospice Intervention Value Set) or elect to use a hospice benefit any time during the measurement year
• Members who die any time during the measurement year

Refer to the HEDIS 2025 Value Set Directory for a list of codes.</td></tr>
<tr><td>Method to exclude</td><td colspan="2">Claims</td></tr>
<tr><td>Numerator/Service to close gap</td><td colspan="2">Dispensed prescription for a bronchodilator (Bronchodilator Medications List) on or 30 days after the episode date. Count bronchodilators that are active on the relevant date.</td></tr>
<tr><td>Method to close gap</td><td colspan="2">RX Claims</td></tr>
</table>

<table>
<tr><td>Medications to close gap</td><td>
<table>
<tr><th colspan="2">Bronchodilator Medications</th></tr>
<tr><th>Description</th><th>Prescription</th></tr>
<tr><td>Anticholinergic agents</td><td>Aclidinium bromide
Ipratropium
Tiotropium
Umeclidinium</td></tr>
<tr><td>Beta 2-agonists</td><td>Albuterol
Arformoterol
Formoterol
Indacaterol
Levalbuterol
Metaproterenol
Olodaterol
Salmeterol</td></tr>
<tr><td>Bronchodilator combinations</td><td>Albuterol-ipratropium
Budesonide-formoterol
Fluticasone-salmeterol
Fluticasone-vilanterol
Fluticasone furoate-umeclidinium-vilanterol
Formoterol-aclidinium
Formoterol-glycopyrrolate
Formoterol-mometasone
Glycopyrrolate-indacaterol
Olodaterol-tiotropium
Umeclidinium-vilanterol</td></tr>
</table>
Refer to the HEDIS 2025 Value Set Directory for a list of codes.
</td></tr>
<tr><td>Best practice recommendations</td><td>Follow up with patients who have COPD within five days of inpatient hospital or ED discharge to confirm medications were filled post-discharge.</td></tr>
</table>

Plan All-Cause Readmissions		
Measure ID	PCR	
Source	NCQA, HEDIS MY 2025	
Summary of changes for 2025	N/A	
Description	For members who meet the age criteria, 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	
Measurement period	Jan. 1, 2025, through Dec. 1, 2025 (Period of time in which the member meets denominator criteria)	
Quality program, ages, product lines	**Premier Partners Program:** Ages: 22 years of age and older as of the index discharge date. Product lines: • UPMC *for Life* (Medicare/SNP) • Commercial • UPMC *for You* (Medicaid)	**Quality Partners Program:** Ages: 18 years of age and older as of the index discharge date. Product lines: • UPMC *for Life* (Medicare/SNP) • Commercial
Denominator	An acute inpatient or observation stay discharge on or between Jan. 1 and Dec. 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 members who had one or more discharges on or between Jan. 1 and Dec. 1 of the measurement year. Follow the steps below to identify acute inpatient and observation stays. **Step 1:** Identify all acute inpatient and observation stay discharges on or between Jan. 1 and Dec. 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.	
Denominator exclusions	• Members who use hospice services (Hospice Encounter Value Set; Hospice Intervention Value Set) or elect to use a hospice benefit any time during the measurement year • Exclude the hospital stay if the direct transfer's discharge date occurs after Dec. 1 of the measurement year • Exclude hospital stays where the Index Admission Date is the same as the Index Discharge Date • 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.*	
Method to exclude	Claims	
Numerator	At least one acute readmission for any diagnosis within 30 days of the Index Discharge Date. *Refer to the HEDIS 2025 Value Set Directory for a list of codes.*	
Service to close gap	N/A: *The goal of this measure is to prevent the patient from being readmitted.*	

Method to close gap	N/A
Codes to close gap	N/A
Best practice recommendations	• Utilize Admission, Discharge, Transfer (ADT) reports to identify patients who were recently discharged from the hospital and may need follow-up care to prevent readmissions. • Develop a process to ensure that all patients are seen by a provider after hospital discharge to avoid readmissions. • Ensure common causes of readmission are addressed at follow-up visits, i.e., medication reconciliation, symptom management, etc. • Educate patients on when to call the PCP office versus when to go to an ED.

<table>
<tr><th colspan="3">Polypharmacy: Use of Multiple Anticholinergic Medications in Older Adults</th></tr>
<tr><td>Measure ID</td><td colspan="2">POLY-ACH</td></tr>
<tr><td>Source</td><td colspan="2">PQA 2024</td></tr>
<tr><td>Summary of changes for 2025</td><td colspan="2">This measure transitioned from a display measure to an incentive measure in 2025.</td></tr>
<tr><td>Description</td><td colspan="2">The percentage of individuals ≥65 years of age who do not have concurrent use of ≥2 unique anticholinergic medications.

A higher rate indicates better performance.</td></tr>
<tr><td>Measurement period</td><td colspan="2">Jan. 1, 2025, through Dec. 2, 2025 (Period of time in which the member meets denominator criteria)</td></tr>
<tr><td>Quality program, ages, product lines</td><td>Premier Partners Program:
Ages: ≥65 years of age as of the first day of the measurement period.

Product lines:
• UPMC for Life (Medicare/SNP)</td><td>Quality Partners Program:
Ages: ≥65 years of age as of the first day of the measurement period.

Product lines:
• UPMC for Life (Medicare/SNP)</td></tr>
<tr><td>Denominator</td><td colspan="2">Individuals with ≥2 prescription claims for the same anticholinergic medication on different dates of service during the measurement year

Use the steps below to determine the eligible population.

Step 1: Identify individuals ≥65 years of age as of the first day of the measurement year.

Step 2: Identify individuals with ≥2 prescription claims for the same target medication (Medication Table; POLY-ACH-A: Anticholinergic Medications) on different dates of service during the measurement year.

Step 3: Identify individuals whose earliest date of service for any target medication, with ≥2 prescription claims on different dates of service, is ≥30 days from the last day of the measurement year (January 1 through December 2).</td></tr>
<tr><td>Denominator exclusions</td><td colspan="2">Any individuals in hospice care at any time during the measurement year</td></tr>
<tr><td>Method to exclude</td><td colspan="2">Claims</td></tr>
<tr><td>Numerator/Service to close gap</td><td colspan="2">The number of individuals from the denominator who did not have concurrent use for ≥30 cumulative days of ≥2 unique anticholinergic medications, each with ≥2 prescription claims on different dates of service during the measurement year

Concurrent use is identified using the dates of service and days' supply of an individual's prescription claims. The days of concurrent use is the count of days during the measurement year with overlapping days' supply for ≥2 unique anticholinergic medications.

Service to close the gap: N/A; The desired outcome for this measure is that members will not have concurrent use for ≥30 cumulative days of ≥2 unique anticholinergic medications, each with ≥2 prescription claims on different dates of service during the measurement year.</td></tr>
<tr><td>Method to close gap</td><td colspan="2">N/A; The desired outcome for this measure is that members will not have concurrent use for ≥30 cumulative days of ≥2 unique anticholinergic medications, each with ≥2 prescription claims on different dates of service during the measurement year.</td></tr>
<tr><td>Medications to close gap</td><td colspan="2">
<table>
<tr><th colspan="3">POLY-ACH-A: Anticholinergic Medications [a, b]</th></tr>
<tr><th colspan="3">Antihistamine Medications</th></tr>
<tr><td>brompheniramine
chlorpheniramine
cyproheptadine</td><td>dimenhydrinate [c]
diphenhydramine (oral)
doxylamine</td><td>hydroxyzine
meclizine
triprolidine</td></tr>
<tr><th colspan="3">Antiparkinsonian Agent Medications</th></tr>
<tr><td>benztropine</td><td>trihexyphenidyl</td><td></td></tr>
<tr><th colspan="3">Skeletal Muscle Relaxant Medications</th></tr>
<tr><td>cyclobenzaprine</td><td>orphenadrine</td><td></td></tr>
<tr><th colspan="3">Antidepressant Medications</th></tr>
<tr><td>amitriptyline
amoxapine
clomipramine
desipramine</td><td>doxepin (>6 mg/day)[c]
imipramine
nortriptyline</td><td>paroxetine</td></tr>
</table>
</td></tr>
</table>

<table>
<tr><td>Medications to close gap (continued)</td><td>
<table>
<tr><th colspan="3">Antipsychotic Medications</th></tr>
<tr><td>chlorpromazine
clozapine</td><td>olanzapine
perphenazine</td><td></td></tr>
<tr><th colspan="3">POLY-ACH-A: Anticholinergic Medications [a, b] (Continued)</th></tr>
<tr><th colspan="3">Antimuscarinic (urinary incontinence) Medications</th></tr>
<tr><td>darifenacin
fesoterodine
flavoxate</td><td>oxybutynin
solifenacin</td><td>tolterodine
trospium</td></tr>
<tr><th colspan="3">Antispasmodic Medications</th></tr>
<tr><td>atropine (excludes ophthalmic)
clidinium-chlordiazepoxide[d]</td><td>dicyclomine
homatropine (excludes ophthalmic)
hyoscyamine</td><td>scopolamine (excludes ophthalmic)</td></tr>
<tr><th colspan="3">Antiemetic Medications</th></tr>
<tr><td>prochlorperazine</td><td>promethazine</td><td></td></tr>
<tr><td colspan="3">a Includes combination products that contain a target medication listed and the following routes of administration: buccal, nasal, oral, transdermal, rectal, and sublingual. Injectable and inhalation routes of administration are not included (not able to accurately estimate days' supply needed for measure logic). For combination products that contain more than one target medication, each target medication (active ingredient) should be considered independently.
b Source: Medications in this table are from Table 7. Drugs with Strong Anticholinergic Properties of the American Geriatrics Society 2023 Updated Beers Criteria for Potentially Inappropriate Medication Use in Older Adults.
c There are no active NDCs for dimenhydrinate.
d During the individual's measurement year, calculate a daily dose for each fill of doxepin with the following formula: (quantity dispensed x dose)/days' supply. For both denominator and numerator calculation, only include prescription claims for doxepin where the daily dose is >6 mg/day.
e Chlordiazepoxide is not a target medication as a single drug.</td></tr>
<tr><td colspan="3">Note: The desired outcome for this measure is that members won't have concurrent use for ≥30 cumulative days of ≥2 unique anticholinergic medications, each with ≥2 prescription claims on different dates of service during the measurement year.</td></tr>
</table>
</td></tr>
<tr><td>Best practice recommendations</td><td>

Avoid the use of anticholinergic medications in older adults (when applicable) based on the clinical scenario.
Consider using alternative agents and limit the use of multiple anticholinergic medications whenever possible.
Evaluate for periodic deprescribing attempts to assess ongoing need and/or the lowest effective dose if combination therapy cannot be avoided.

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

Statin Therapy for Patients with Cardiovascular Disease		
Measure ID	SPC	
Source	NCQA, HEDIS MY 2025	
Summary of changes for 2025	Added a required exclusion for muscular reactions to statins.	
Description	The percentage of members who meet the age criteria during the measurement year who were identified as having clinical atherosclerotic cardiovascular disease (ASCVD) and who were dispensed at least one high-intensity or moderate-intensity statin medication during the measurement year	
Measurement period	Jan. 1, 2025, through Dec. 31, 2025	
Quality program, ages, product lines	**Premier Partners Program:** Ages: • Males 22-75 years old as of Dec. 31 of the measurement year • Females 40-75 years old as of Dec. 31 of the measurement year Product lines: • Commercial • UPMC *for You* (Medicaid) • UPMC *for Life* (Medicare/SNP)	**Quality Partners Program:** Ages: • Males 21-75 years old as of Dec. 31 of the measurement year • Females 40-75 years old as of Dec. 31 of the measurement year Product lines: • Commercial • UPMC *for Life* (Medicare/SNP)
Denominator	Members are identified for the eligible population in two ways: by event or by diagnosis. The organization must use *both* methods to identify the eligible population, but a member only needs to be identified by one method to be included in the measure. ***Event:*** Any of the following during the year prior to the measurement year meet criteria: • *MI.* Discharged from an inpatient setting with an MI (MI Value Set; Old Myocardial Infarction Value Set) on the discharge claim. To identify discharges: 1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set). 2. Identify the discharge date for the stay. • *CABG.* Members who had CABG (CABG Value Set) in any setting. • *PCI.* Members who had PCI (PCI Value Set) in any setting. • *Other revascularization*. Members who had any other revascularization procedures (Other Revascularization Value Set) in any setting. ***Diagnosis:*** Identify members who had at least one encounter with a diagnosis of IVD during both the measurement year and the year prior to the measurement year. The following encounters meet criteria: • An outpatient visit, telephone visit, e-visit, virtual check-in or acute inpatient encounter (Outpatient, Telehealth and Acute Inpatient Value Set) with an IVD diagnosis (IVD Value Set). • At least one acute inpatient discharge with an IVD diagnosis (IVD Value Set) on the discharge claim. To identify an acute inpatient discharge: 1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set). 2. Exclude nonacute inpatient stays (Nonacute Inpatient Stay Value Set). 3. Identify the discharge date for the stay.	
Denominator exclusions	• Members who use hospice services (Hospice Encounter Value Set; Hospice Intervention Value Set) or elect to use a hospice benefit any time during the measurement year • Members who die any time during the measurement year • Members receiving palliative care (Palliative Care Assessment Value Set; Palliative Care Encounter Value Set; Palliative Care Intervention Value Set) any time during the measurement year • Members who had an encounter for palliative care (ICD-10-CM code Z51.5) anytime during the measurement year. Do not include laboratory claims (claims with POS code 81) • Members with a diagnosis of pregnancy (Pregnancy Value Set) during the measurement year or the year prior to the measurement year. Do not include laboratory claims (claims with POS code 81). • In vitro fertilization (IVF Value Set) in the measurement year or the year prior to the measurement year • Dispensed at least one prescription for clomiphene (Estrogen Agonists Medications List) during the measurement year or the year prior to the measurement year • ESRD (ESRD Diagnosis Value Set) during the measurement year or the year prior to the measurement year. Do not include laboratory claims (claims with POS code 81). • Dialysis (Dialysis Procedure Value Set) during the measurement year or the year prior to the measurement year • Cirrhosis (Cirrhosis Value Set) during the measurement year or the year prior to the measurement year. Do not include laboratory claims (claims with POS code 81).	

<table>
<tr><td>Denominator exclusions (continued)</td><td>

Myalgia, myositis, myopathy or rhabdomyolysis (Muscular Pain and Disease Value Set) during the measurement year. Do not include laboratory claims (claims with POS code 81).
Myalgia or rhabdomyolysis caused by a statin (Muscular Reactions to Statins Value Set) any time during the member's history through Dec. 31 of the measurement year.
Medicare members 66 years of age and older as of Dec. 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.
Members 66 years of age and older as of Dec. 31 of the measurement year (all product lines) with frailty and advanced illness. Members must meet both frailty and advanced illness criteria to be excluded:

Frailty. At least two indications of frailty (Frailty Device Value Set; Frailty Diagnosis Value Set; Frailty Encounter Value Set; Frailty Symptom Value Set) with different dates of service during the measurement year. Do not include laboratory claims (claims with POS code 81).
Advanced Illness. Either of the following during the measurement year or the year prior to the measurement year:
-Advanced illness (Advanced Illness Value Set) on at least two different dates of service. Do not include laboratory claims (claims with POS code 81).
-Dispensed dementia medication (Dementia Medications List)

Refer to the HEDIS 2025 Value Set Directory for a list of codes.
</td></tr>
<tr><td>Method to exclude</td><td>Claims</td></tr>
<tr><td>Numerator/Service to close gap</td><td>The number of members who had at least one dispensing event for a high-intensity or moderate-intensity statin medication (High and Moderate Intensity Statin Medications List) during the measurement year

Refer to the HEDIS 2025 Value Set Directory for a list of codes.</td></tr>
<tr><td>Method to close gap</td><td>RX Claim</td></tr>
<tr><td>Medications to close gap</td><td>
<table>
<tr><th colspan="2">High- and moderate- intensity statins</th></tr>
<tr><th>Description</th><th>Prescription</th></tr>
<tr><td>High-intensity statin therapy</td><td>Atorvastatin 40-80 mg
Amlodipine-atorvastatin 40-80 mg
Rosuvastatin 20-40 mg
Simvastatin 80 mg
Ezetimibe-simvastatin 80 mg</td></tr>
<tr><td>Moderate-intensity statin therapy</td><td>Atorvastatin 10-20 mg
Amlodipine-atorvastatin 10-20 mg
Rosuvastatin 5-10 mg
Simvastatin 20-40 mg
Ezetimibe-simvastatin 20-40 mg
Pravastatin 40-80 mg
Lovastatin 40 mg
Fluvastatin 40-80 mg
Pitavastatin 1-4 mg</td></tr>
</table>
</td></tr>
<tr><td>Best practice recommendations</td><td>

Develop a process for all individuals with atherosclerotic cardiovascular disease (ASCVD) to be prescribed a moderate or high-intensity statin for secondary prevention, even if lipid levels are at or below goal.
During the period that the patient is prescribed a statin, ask if the patient is taking the medication, assess barriers to compliance, and encourage them to get refills as appropriate.
Educate providers on documentation of exclusions for this measure and ensure applicable exclusions are used at least once within each measurement year. Refer to HEDIS Value Sets for exclusion codes.
Utilize Health Plan reports to identify members who are already on a low dose stating and may need to be transitioned to a moderate or high dose statin.
Urge patients to use UPMC ID cards to fill prescriptions. Formulary (covered) statins may be available at no cost-share for patients, depending on their benefit set up.
If side effects have occurred with prior statin therapy, assess whether patients would be candidates for a rechallenge. Rechallenge strategies can include re-initiation of the same statin medication at the same or a lower dose, trialing a different statin, or utilizing alternative dosing of longer half-life statins (e.g., rosuvastatin, atorvastatin).

Rosuvastatin can be dosed every other day or once or twice weekly, and atorvastatin can be dosed every other day. Even dosed less frequently, data show these medications still

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

Best practice recommendations (continued)		provide lipid lowering and cardiovascular benefit. If choosing to prescribe less frequently, be sure to send the prescription to the pharmacy with the correct directions and quantity prescribed so as not to affect medication adherence calculations. ▪ Ex: rosuvastatin 5mg once weekly, quantity of 4 tablets for a 28-day supply ▪ Ex: atorvastatin 10mg every other day, quantity of 15 tablets for a 30-day supply.

Statin Therapy for Patients with Diabetes		
Measure ID	SPD	
Source	NCQA, HEDIS MY 2025	
Summary of changes for 2025	Added a required exclusion for muscular reactions to statins.	
Description	The percentage of members 40-75 years of age during the measurement year with diabetes who do not have clinical atherosclerotic cardiovascular disease (ASCVD) who were dispensed at least one statin medication of any intensity during the measurement year	
Measurement period	Jan. 1, 2025, through Dec. 31, 2025	
Quality program, ages, product lines	**Premier Partners Program:** Ages: 40-75 years old as of Dec. 31 of the measurement year Product lines: • Commercial • UPMC *for You* (Medicaid)	**Quality Partners Program:** Ages: 40-75 years old as of Dec. 31 of the measurement year Product lines: • Commercial
Denominator	There are two ways to identify members with diabetes: by claim/encounter data and by pharmacy data. The organization must use both methods to identify the eligible population, but a member only needs to be identified by one method to be included in the measure. Members may be identified as having diabetes during the measurement year or the year prior to the measurement year. ***Claim/encounter data****:* Members who had at least two diagnoses of diabetes (Diabetes Value Set) on different dates of service during the measurement year or the year prior to the measurement year. Do not include laboratory claims (claims with POS code 81). ***Pharmacy data****:* Members who were dispensed insulin or hypoglycemics/antihyperglycemics during the measurement year or the year prior to the measurement year (Diabetes Medications List) and have at least one diagnosis of diabetes (Diabetes Value Set) during the measurement year or the year prior to the measurement year. Do not include laboratory claims (claims with POS code 81).	
Denominator exclusions	• Members with at least one of the following during the year prior to the measurement year: -*MI.* Discharged from an inpatient setting with an MI (MI Value Set; Old Myocardial Infarction Value Set) on the discharge claim. To identify discharges: 1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set). 2. Identify the discharge date for the stay. -*CABG.* Members who had CABG (CABG Value Set) in any setting. -*PCI.* Members who had PCI (PCI Value Set) in any setting. -*Other revascularization.* Members who had any other revascularization procedure (Other Revascularization Value Set) in any setting. • Members who had at least one encounter with a diagnosis of IVD during both the measurement year and the year prior to the measurement year. The following encounters meet criteria: -An outpatient visit, telephone visit, e-visit, virtual check-in or acute inpatient encounter (Outpatient, Telehealth and Acute Inpatient Value Set) with an IVD diagnosis (IVD Value Set). -At least one acute inpatient discharge with an IVD diagnosis (IVD Value Set) on the discharge claim. To identify an acute inpatient discharge: 1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set). 2. Exclude nonacute inpatient stays (Nonacute Inpatient Stay Value Set). 3. Identify the discharge date for the stay. • Members with a diagnosis of pregnancy (Pregnancy Value Set) during the measurement year or year prior to the measurement year. Do not include laboratory claims (claims with POS code 81). • In vitro fertilization (IVF Value Set) in the measurement year or year prior to the measurement year. • Dispensed at least one prescription for clomiphene (Estrogen Agonists Medications List) during the measurement year or the year prior to the measurement year. • ESRD (ESRD Diagnosis Value Set) during the measurement year or the year prior to the measurement year. Do not include laboratory claims (claims with POS code 81). • Dialysis (Dialysis Procedure Value Set) during the measurement year or the year prior to the measurement year. • Cirrhosis (Cirrhosis Value Set) during the measurement year or the year prior to the measurement year. Do not include laboratory claims (claims with POS code 81). • Myalgia, myositis, myopathy or rhabdomyolysis (Muscular Pain and Disease Value Set) during the measurement year. Do not include laboratory claims (claims with POS code 81). • Myalgia or rhabdomyolysis caused by a statin (Muscular Reactions to Statins Value Set) any time during the member's history through Dec. 31 of the measurement year.	

<table>
<tr><td>Denominator exclusions (continued)</td><td>

Members who use hospice services (Hospice Encounter Value Set; Hospice Intervention Value Set) or elect to use a hospice benefit any time during the measurement year.
Members who die any time during the measurement year.
Members receiving palliative care (Palliative Care Assessment Value Set; Palliative Care Encounter Value Set; Palliative Care Intervention Value Set) any time during the measurement year.
Members who had an encounter for palliative care (ICD-10-CM code Z51.5) any time during the measurement year. Do not include laboratory claims (claims with POS code 81).
Members 66 years of age and older as of December 31 of the measurement year (all product lines) with frailty and advanced illness. Members must meet both frailty and advanced illness criteria to be excluded:

Frailty. At least two indications of frailty (Frailty Device Value Set; Frailty Diagnosis Value Set; Frailty Encounter Value Set; Frailty Symptom Value Set) with different dates of service during the measurement year. Do not include laboratory claims (claims with POS code 81).
Advanced Illness. Either of the following during the measurement year or the year prior to the measurement year:
-Advanced illness (Advanced Illness Value Set) on at least two different dates of service. Do not include laboratory claims (claims with POS code 81).
-Dispensed dementia medication (Dementia Medications List).

Refer to the HEDIS 2025 Value Set Directory for a list of codes.
</td></tr>
<tr><td>Method to exclude</td><td>Claims</td></tr>
<tr><td>Numerator/Service to close gap</td><td>The number of members who had at least one dispensing event for a high-intensity, moderate intensity, or low-intensity statin medication (High, Moderate and Low Intensity Statin Medications List) during the measurement year.

Refer to the HEDIS 2025 Value Set Directory for a list of codes.</td></tr>
<tr><td>Method to close gap</td><td>RX Claim</td></tr>
<tr><td>Medications to close gap</td><td>
<table>
<tr><th colspan="2">High, Moderate, and Low-Intensity Statin Medications</th></tr>
<tr><th>Description</th><th>Prescription</th></tr>
<tr><td>High-intensity statin therapy</td><td>Atorvastatin 40-80 mg
Amlodipine-atorvastatin 40-80 mg
Rosuvastatin 20-40 mg
Simvastatin 80 mg
Ezetimibe-simvastatin 80 mg</td></tr>
<tr><td>Moderate-intensity statin therapy</td><td>Atorvastatin 10-20 mg
Amlodipine-atorvastatin 10-20 mg
Rosuvastatin 5-10 mg
Simvastatin 20-40 mg
Ezetimibe-simvastatin 20-40 mg
Pravastatin 40-80 mg
Lovastatin 40 mg
Fluvastatin 40-80 mg
Pitavastatin 1-4 mg</td></tr>
<tr><td>Low-intensity statin therapy</td><td>Ezetimibe-simvastatin 10 mg
Fluvastatin 20 mg
Lovastatin 10-20 mg
Pravastatin 10–20 mg
Simvastatin 5-10 mg</td></tr>
</table>
</td></tr>
<tr><td>Best practice recommendations</td><td>

Develop a process for all individuals with diabetes between ages 40 and 75 to be prescribed a statin medication, even if lipid levels are at or below goal, per the ADA and AHA best practice recommendations.
During the period of time that the patient is prescribed a statin, ask if the patient is taking the medication and encourage them to get refills as appropriate.
Educate providers on documentation of exclusions for this measure and ensure applicable exclusions are used at least once within each measurement year. Refer to HEDIS Value Sets for exclusion codes.
Urge patients to use UPMC ID cards to fill prescriptions. Formulary (covered) statins may be available at no cost-share for patients, depending on their benefit plan.
If side effects have occurred with prior statin therapy, assess whether patients would be candidates for a rechallenge. Rechallenge strategies can include re-initiation of same statin medication at the same or a lower dose, trialing a different statin, or utilizing alternative dosing of longer half-life statins (e.g., rosuvastatin, atorvastatin).

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

Best practice recommendations (continued)	○ Rosuvastatin can be dosed every other day or once or twice weekly, and atorvastatin can be dosed every other day. Even dosed less frequently, data show these medications still provide lipid lowering and cardiovascular benefit. If choosing to prescribe less frequently, be sure to send the prescription to the pharmacy with the correct directions and quantity prescribed so as not to affect medication adherence calculations. ▪ Ex: rosuvastatin 5mg once weekly, quantity of 4 tablets for a 28-day supply ▪ Ex: atorvastatin 10mg every other day, quantity of 15 tablets for a 30-day supply

<table>
<tr><th colspan="4">Statin Use in Persons with Diabetes</th></tr>
<tr><td>Measure ID</td><td colspan="3">SUPD</td></tr>
<tr><td>Source</td><td colspan="3">PQA 2024</td></tr>
<tr><td>Summary of changes for 2025</td><td colspan="3">N/A</td></tr>
<tr><td>Description</td><td colspan="3">The percentage of members 40-75 years old who were dispensed at least two diabetes medication fills and received a statin medication fill during the measurement period</td></tr>
<tr><td>Measurement period</td><td colspan="3">Jan. 1, 2025, through Dec. 31, 2025</td></tr>
<tr><td>Quality program, ages, product lines</td><td colspan="2">Premier Partners Program:
Ages: 40-75 years old as of the first day of the measurement year

Product lines:
• UPMC for Life (Medicare/SNP)</td><td>Quality Partners Program:
Ages: 40-75 years old as of the first day of the measurement year

Product lines:
• UPMC for Life (Medicare/SNP)</td></tr>
<tr><td>Denominator</td><td colspan="3">Members who were dispensed two or more prescription fills for a diabetes medication during the measurement year (See Diabetes Medications table below).
<table>
<tr><th colspan="3">Diabetes Medications [a, b, c, d]</th></tr>
<tr><td colspan="3">Biguanide Medications and Combinations</td></tr>
<tr><td colspan="3">metformin (+/- alogliptin, canagliflozin, dapagliflozin, empagliflozin, ertugliflozin, glipizide, glyburide, linagliptin, pioglitzone, repaglinide, rosiglitazone, saxagliptin, sitagliptin)</td></tr>
<tr><td colspan="3">Sulfonylurea Medications and Combinations</td></tr>
<tr><td>chlorpropamide[e]
glipizide (+/- metformin)</td><td>glimepiride (+/- pioglitazone, rosiglitazone)[e]
glyburide (+/- metformin)</td><td>tolazamide
tolbutamide[e]</td></tr>
<tr><td colspan="3">Meglitinide Medications and Combinations</td></tr>
<tr><td>nateglinide</td><td>repaglinide (+/- metformin)</td><td></td></tr>
<tr><td colspan="3">Alpha-Glucosidase Inhibitors</td></tr>
<tr><td>acarbose</td><td>miglitol</td><td></td></tr>
<tr><td colspan="3">Thiazolidinedione Medications and Combinations</td></tr>
<tr><td>pioglitazone (+/- alogliptin, glimiperide, metformin)</td><td>rosiglitazone (+/- glimepiride[e], metformin)</td><td></td></tr>
<tr><td colspan="3">GIP/GLP-1 Receptor Agonist Medications and Combinations</td></tr>
<tr><td>albiglutide[e]
dulaglutide</td><td>exenatide
liraglutide (+/- insulin degludec)</td><td>lixisenatide (+/- insulin glargine)
semaglutide
tirzepatide</td></tr>
<tr><td colspan="3">Amylin Analogs</td></tr>
<tr><td>pramlintide</td><td></td><td></td></tr>
<tr><td colspan="3">DPP-4 Inhibitor Medications and Combinations</td></tr>
<tr><td>alogliptin (+/- metformin, pioglitazone)
linagliptin (+/- empagliflozin, metformin)</td><td>saxagliptin (+/- dapagliflozin, metformin)</td><td>sitagliptin (+/- metformin, ertugliflozin)</td></tr>
<tr><td colspan="3">Insulin Medications and Combinations</td></tr>
<tr><td>insulin aspart (+/- insulin aspart protamine, niacinamide)
insulin degludec (+/- liraglutide)
insulin detemir</td><td>insulin glargine (+/- lixisenatide)
insulin glulisine</td><td>insulin isophane (+/- regular insulin)
insulin lispro (+/- insulin lispro protamine)
insulin regular (including inhalation powder)</td></tr>
<tr><td colspan="3">SGLT2 Inhibitor Medications and Combinations</td></tr>
<tr><td>bexagliflozin
canagliflozin (+/- metformin)
dapagliflozin (+ metformin, saxagliptin)[f]</td><td>empagliflozin (+ linagliptin, metformin)[f]</td><td>ertugliflozin (+/- sitagliptin, metformin)</td></tr>
</table>
a Active ingredients are limited to oral, inhalation and injectable formulations only.
b Excludes nutritional supplement/dietary management combination products, and specific products FDA indicated for weight loss.
c Combination products including dapagliflozin or empagliflozin (and another diabetes medication from the table) are included.
d For biologic reference products contained in the Medication Table, biosimilars associated with the reference product, regardless of interchangeable status, are also included in the associated value sets, unless otherwise noted.
e There are no active NDCs for albiglutide, chlorpropamide, glimepiride/rosiglitazone, or tolbutamide.
f Dapagliflozin and empagliflozin single ingredient products are not included due to FDA-approved non-diabetes indications.
Members are only included in the measure calculation if the first fill of their diabetes medication occurs at least 90 days before the end of the measurement year.</td></tr>
</table>

<table>
<tr><td>Denominator exclusions</td><td>Members are excluded from the denominator if any of the following occurs during the measurement period:
Hospice
ESRD
Rhabdomyolysis or Myopathy
Pregnancy, Lactation, or Fertility
Cirrhosis
Pre-Diabetes
Polycystic Ovary Syndrome (PCOS)</td></tr>
<tr><td>Method to exclude</td><td>Claims</td></tr>
<tr><td>Numerator/Service to close gap</td><td>Ensure members in the denominator receive a statin medication fill during the measurement year.</td></tr>
<tr><td>Method to close gap</td><td>RX Claim</td></tr>
<tr><td>Medications to close gap</td><td>Statin Medications[a]<table><tr><th>Statin Medications</th></tr><tr><td>Atorvastatin
Fluvastatin
Lovastatin
Pitavastatin
Pravastatin
Rosuvastatin
Simvastatin</td></tr><tr><th>Statin Combination Products</th></tr><tr><td>Atorvastatin and amlodipine
Atorvastatin and ezetimibe
Ezetimibe and simvastatin
Niacin and lovastatin
Niacin and simvastatin
Rosuvastatin and ezetimibe</td></tr><tr><td>[a] The active ingredients are limited to oral formulations only.</td></tr></table></td></tr>
<tr><td>Best practice recommendations</td><td>Develop a process for all individuals ages 40-75 with diabetes to be prescribed a statin medication, even if lipid levels are at or below goal, per the ADA and AHA best practice recommendations.
During the period of time the patient is prescribed a statin, inquire if your patient is taking their medication and encourage them to refill prescriptions as appropriate.
Educate providers on documentation of exclusions for this measure and ensure applicable exclusions are used at least once within each measurement year.
Urge patients to use UPMC ID cards to fill prescriptions. Formulary (covered) statins may be available at no cost-share for patients, depending on their benefit set up.
If side effects have occurred with prior statin therapy, assess whether patients would be candidates for a rechallenge. Rechallenge strategies can include re-initiation of the same statin medication at the same or a lower dose, trialing a different statin, or utilizing alternative dosing of longer half-life statins (e.g., rosuvastatin, atorvastatin).
Rosuvastatin can be dosed every other day or once or twice weekly, and atorvastatin can be dosed every other day. Even dosed less frequently, data show these medications still provide lipid lowering and cardiovascular benefit. If choosing to prescribe less frequently, be sure to send the prescription to the pharmacy with the correct directions and quantity prescribed so as not to affect medication adherence calculations.
Ex: rosuvastatin 5mg once weekly, quantity of 4 tablets for a 28-day supply
Ex: atorvastatin 10mg every other day, quantity of 15 tablets for a 30-day supply</td></tr>
</table>

7-Day Follow Up for Inpatient Discharge		
Measure ID	N/A	
Source	NCQA, HEDIS MY 2025 TRC specs; UPMC Health Plan	
Summary of changes for 2025	Observation stays were removed from the denominator for this measure.	
Description	The percentage of inpatient discharges for members 22 years of age and older who had documentation of patient engagement (e.g., office visits, visits to the home, telehealth) provided within 7 days after discharge	
Measurement period	Jan. 1, 2025, through Dec. 24, 2025 (Period of time in which the member meets denominator criteria)	
Quality program, ages, product lines	**Premier Partners Program:** Ages: 22 years and older as of Dec. 31 of the measurement year Product lines: • UPMC for Life (Medicare/SNP)	**Quality Partners Program:** N/A: this measure is not included in the Quality Partners Program.
Denominator	An acute or nonacute inpatient discharge on or between Jan. 1 and Dec. 24 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 inpatient discharges, not on members. If members have more than one discharge, include all discharges on or between Jan. 1 and Dec. 24 of the measurement year. 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 7 days after discharge (8 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 8-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). 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.	
Denominator exclusions	• Members who use hospice services (Hospice Encounter Value Set; Hospice Intervention Value Set) or elect to use a hospice benefit any time during the measurement year • Members who die any time during the measurement year • Exclude both the initial and the readmission/direct transfer discharge if the last discharge occurs after Dec. 24 of the measurement year *Refer to the HEDIS 2025 Value Set Directory for a list of codes.*	
Method to exclude	Claims	
Numerator/Service to close gap	Patient engagement provided within 7 days after inpatient discharge. Do not include patient engagement that occurs on the date of discharge. The following meet criteria for patient engagement: • An outpatient visit, telephone visit, e-visit or virtual check-in (Outpatient and Telehealth Value Set) • Transitional care management services (Transitional Care Management Services Value Set) *Refer to the HEDIS 2025 Value Set Directory for a list of codes.*	
Method to close gap	Claim	

The NCQA HEDIS measure specification has been adjusted pursuant to NCQA's Rules for Allowable Adjustments of HEDIS. The adjusted measure specification may be used only for internal quality improvement purposes.

Codes to close gap	**Outpatient and Telehealth** • CPT: 99483; 99345; 99342; 99344; 99341; 99350; 99348; 99349; 99347; 99385; 99386; 99387; 99384; 99382; 99381; 99383; 99245; 99243; 99244; 99242; 99205; 99203; 99204; 99202; 99211; 99215; 99213; 99214; 99212; 99422; 99423; 99421; 99395; 99396; 99397; 99394; 99392; 99391; 99393; 99401; 99402; 99403; 99404; 99411; 99412; 98971; 98972; 98970; 99458; 99457; 98981; 98980; 98967; 98968; 98966; 99442; 99443; 99441; 99429; 99456; 99455 • HCPCS: G0071; G0402; G0438; G0439; G0463; G2010; G2012; G2250; G2251; G2252; T1015 **Transitional Care Management Services** • CPT: 99495; 99496 Please see the complete 2025 Value Set located on Provider OnLine and on the Premier Partners SharePoint for additional codes that are used for this measure.
Best practice recommendations	• Utilize Admission, Discharge, Transfer (ADT) reports to identify patients who will require follow-up appointments. • Conduct telephonic outreach to patients who haven't scheduled a follow-up appointment within two weeks of discharge. • If transportation is a barrier, consider follow-up via a telephone, e-visit, or virtual check-in. • During the appointment, allow time to answer the patient's questions about their condition, treatment, medications, etc.

The NCQA HEDIS measure specification has been adjusted pursuant to NCQA's Rules for Allowable Adjustments of HEDIS. The adjusted measure specification may be used only for internal quality improvement purposes.

Acute Hospital Utilization		
Measure ID	AHU	
Source	NCQA, HEDIS MY 2025	
Summary of changes for 2025	New display measure in 2025	
Description	For members who meet the age criteria, the risk-adjusted ratio of observed-to-expected acute inpatient and observation stay discharges during the measurement year.	
Measurement period	Jan. 1, 2025, through Dec. 31, 2025	
Quality program, ages, product lines	**Premier Partners Program:** Ages: Members 22 years of age and older Product lines: • Commercial	**Quality Partners Program:** Ages: Members 18 years of age and older Product lines: • Commercial
Denominator	Members who meet the age criteria	
Denominator exclusions	• Members who use hospice services (Hospice Encounter Value Set; Hospice Intervention Value Set) or elect to use a hospice benefit any time during the measurement year. Exclude inpatient and observation discharges with any of the following on the discharge claim: • A principal diagnosis of mental health or chemical dependency (Mental and Behavioral Disorders Value Set). • A principal diagnosis of live-born infant (Deliveries Infant Record Value Set). • A maternity-related principal diagnosis (Maternity Diagnosis Value Set). • A maternity-related stay (Maternity 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). • Inpatient and observation stays with a discharge for death. *Refer to the HEDIS 2025 Value Set Directory for a list of codes.*	
Method to exclude	Claim	
Numerator/ Service to close gap	An acute inpatient or observation stay discharge. Note: The goal of this measure is to avoid acute hospital utilization Use the following steps to identify and categorize acute inpatient and observation stay discharges for the observed events: **Step 1:** Identify all acute inpatient and observation discharges during the measurement year. To identify acute inpatient and observation 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. **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. **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.	

Numerator/ Service to close gap (continued)	Calculation of risk-adjusted outcomes (counts of discharges) uses predetermined risk weights generated by two separate regression models. Weights from each model are combined to predict how many discharges each member might have during the measurement year, given age, gender and presence or absence of a comorbid condition.
Method to close gap	N/A; The goal of this measure is to avoid acute hospital utilization
Codes to close gap	N/A
Best practice recommendations	• Ensure patients are seen for regular, preventive care to avoid the need for unplanned hospital utilization. • Educate patients about what they should do in the event of an acute health issue, i.e. when to call the PCP office versus when it is appropriate to seek emergency medical care.

Adult Immunization Status: Pneumococcal		
Measure ID	AIS-E	
Source	NCQA, HEDIS MY 2025	
Summary of changes for 2025	New display measure in 2025	
Description	The percentage of members 65 years of age and older who are up to date on recommended routine pneumococcal vaccine.	
Measurement period	Jan. 1, 2025, through Dec. 31, 2025	
Quality program, ages, product lines	**Premier Partners Program:** Ages: 65 years of age and older as of the start of the measurement period Product lines: • Commercial • UPMC *for You* (Medicaid)	**Quality Partners Program:** Ages: 65 years of age and older as of the start of the measurement period Product lines: • Commercial
Denominator	Members 65 years of age and older as of the start of the measurement period	
Denominator exclusions	• Members who use hospice services (Hospice Encounter Value Set; Hospice Intervention Value Set) or elect to use a hospice benefit any time during the measurement period • Members who die any time during the measurement period	
Method to exclude	Claims	
Numerator/Service to close gap	Members who received at least one dose of an adult pneumococcal vaccine (Adult Pneumococcal Immunization Value Set; Adult Pneumococcal Vaccine Procedure Value Set) on or after their 19th birthday, before or during the measurement period	
Method to close gap	Claims	
Codes to close gap	**Adult Pneumococcal Immunization** • CVX: 215; 216; 133; 152; 33; 109 **Adult Pneumococcal Vaccine Procedure** • CPT: 90670; 90671; 90677; 90732 • HCPCS: G0009 Please see the complete 2025 Value Set located on Provider OnLine and on the Premier Partners SharePoint for additional codes that are used for this measure.	
Best practice recommendations	Educate patients on the importance of routine vaccines while having research, literature, and resources to give out to eliminate fears and misinformation.	

Blood Pressure Control for Patients with Diabetes		
Measure ID	BPD	
Source	NCQA, HEDIS MY 2025	
Summary of changes for 2025	N/A	
Description	The percentage of members with diabetes (types 1 and 2) whose blood pressure (BP) was adequately controlled (<140/90 mm Hg) during the measurement year	
Measurement period	Jan. 1, 2025, through Dec. 31, 2025	
Quality program, ages, product lines	**Premier Partners Program:** Ages: 22-75 years of age as of Dec. 31 of the measurement year Product lines: • Commercial • UPMC *for You* (Medicaid)	**Quality Partners Program:** Ages: 18-75 years of age as of Dec. 31 of the measurement year Product lines: • Commercial
Denominator	There are two ways to identify members with diabetes: by claim/encounter data and by pharmacy data. The organization must use both methods to identify the eligible population, but a member only needs to be identified by one method to be included in the measure. Members may be identified as having diabetes during the measurement year or the year prior to the measurement year. ***Claim/encounter data*.** Members who had at least two diagnoses of diabetes (Diabetes Value Set) on different dates of service during the measurement year or the year prior to the measurement year. Do not include laboratory claims (claims with POS code 81). ***Pharmacy data***. Members who were dispensed insulin or hypoglycemics/ antihyperglycemics during the measurement year or the year prior to the measurement year (Diabetes Medications List) ***and*** have at least one diagnosis of diabetes (Diabetes Value Set) during the measurement year or the year prior to the measurement year. Do not include laboratory claims (claims with POS code 81).	
Denominator exclusions	• Members who use hospice services (Hospice Encounter Value Set; Hospice Intervention Value Set) or elect to use a hospice benefit any time during the measurement year • Members who die any time during the measurement year • Members receiving palliative care (Palliative Care Assessment Value Set; Palliative Care Encounter Value Set; Palliative Care Intervention Value Set;) any time during the measurement year • Members who had an encounter for palliative care (ICD-10-CM code Z51.5) any time during the measurement year. Do not include laboratory claims (claims with POS code 81) • Members 66 years of age and older as of Dec. 31 of the measurement year (all product lines) with frailty and advanced illness. Members must meet both frailty and advanced illness criteria to be excluded: 1. **Frailty**: At least two indications of frailty (Frailty Device Value Set; Frailty Diagnosis Value Set; Frailty Encounter Value Set; Frailty Symptom Value Set) with different dates of service during the measurement year. Do not include laboratory claims (claims with POS code 81) 2. **Advanced Illness:** Either of the following during the measurement year or the year prior to the measurement year: -Advanced illness (Advanced Illness Value Set) on at least two different dates of service. Do not include laboratory claims (claims with POS code 81) -Dispensed dementia medication (Dementia Medications List) *Refer to the HEDIS 2025 Value Set Directory for a list of codes.*	
Method to exclude	Claims	
Numerator/Service to close gap	Identify the most recent BP reading (Systolic Blood Pressure Value Set; Diastolic Blood Pressure Value Set) taken during the measurement year. -Do not include CPT Category II codes (Systolic and Diastolic Result Value Set) with a modifier (CPT CAT II Modifier Value Set). -Do not include BPs taken in an acute inpatient setting (Acute Inpatient Value Set; Acute Inpatient POS Value Set) or during an ED visit (ED Value Set; POS code 23). The 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. *Refer to the HEDIS 2025 Value Set Directory for a list of codes.*	

Method to close gap	Claims
Codes to close gap	A systolic and diastolic value must be reported. • 3074F: Systolic blood pressure <130 mm Hg • 3075F: Systolic blood pressure 130–139 mm Hg • 3077F: Systolic blood pressure ≥140 mm Hg (will not close the gap) • 3078F: Diastolic blood pressure <80 mm Hg • 3079F: Diastolic blood pressure 80–89 mm Hg • 3080F: Diastolic blood pressure ≥90 mm Hg (will not close the gap) This measure requires that the last blood pressure of the measurement year is reported, regardless of the result. Codes that represent blood pressures equal to or greater than 140/90 might need to be reported if the last blood pressure of the measurement year is ≥140/90 and are therefore listed here to support the measure requirement for the last blood pressure reading. Please see the complete 2025 Value Set located on Provider OnLine and on the Premier Partners SharePoint for additional codes that are used for this measure.
Best practice recommendations	• Educate members on diet, exercise, stress management, and lifestyle factors–such as smoking and alcohol consumption–that can affect blood pressure. • Refer members to care management for lifestyle or chronic disease management (as needed). • Encourage members to take their blood pressure medications as prescribed, even when their blood pressure is under control. • If the patient's blood pressure is elevated when they arrive, recheck the blood pressure after the patient has had a chance to sit for a while, and be sure to document the new value in the medical record.

<table>
<tr><th colspan="3">Depression Screening and Follow-Up: Follow-Up on Positive Screen</th></tr>
<tr><td>Measure ID</td><td colspan="2">DSF-E</td></tr>
<tr><td>Source</td><td colspan="2">NCQA, HEDIS MY 2025, UPMC Health Plan</td></tr>
<tr><td>Summary of changes for 2025</td><td colspan="2">New display measure in 2025 primary care incentive programs</td></tr>
<tr><td>Description</td><td colspan="2">The percentage of members who were screened for clinical depression using a standardized instrument and, if screened positive, received follow-up care within 30 days of the positive screen finding.</td></tr>
<tr><td>Measurement period</td><td colspan="2">Jan. 1, 2025, through Dec. 1, 2025</td></tr>
<tr><td>Quality program, ages, product lines</td><td>Premier Partners Program:
Ages: 22 years of age and older

Product lines:
• Commercial
• UPMC for You (Medicaid)
• UPMC for Life (Medicare/SNP)</td><td>Quality Partners Program:
Ages: 18 years of age and older

Product lines:
• Commercial
• UPMC for Life (Medicare/SNP)</td></tr>
<tr><td>Denominator</td><td colspan="2">Members who meet age criteria and who had a positive depression screen finding based on the submission of the G8431, G8511, or G8940 codes between Jan. 1 and Dec. 1 of the measurement period.

Examples of standardized screening instruments with thresholds for positive findings include:
<table>
<tr><th>Instruments for Adults (18+ years)</th><th>Positive Finding</th></tr>
<tr><td>Patient Health Questionnaire (PHQ-9)®</td><td>Total score ≥10</td></tr>
<tr><td>Patient Health Questionnaire-2 (PHQ-2)®[1]</td><td>Total score ≥3</td></tr>
<tr><td>Beck Depression Inventory-Fast Screen (BDI-FS)®[1,2]</td><td>Total score ≥8</td></tr>
<tr><td>Beck Depression Inventory (BDI-II)</td><td>Total score ≥20</td></tr>
<tr><td>Center for Epidemiologic Studies Depression Scale—Revised (CESD-R)</td><td>Total score ≥17</td></tr>
<tr><td>Duke Anxiety—Depression Scale (DUKE-AD)®[2]</td><td>Total score ≥30</td></tr>
<tr><td>Geriatric Depression Scale Short Form (GDS)[1]</td><td>Total score ≥5</td></tr>
<tr><td>Geriatric Depression Scale Long Form (GDS)</td><td>Total score ≥10</td></tr>
<tr><td>Edinburg Post-Natal Depression Scale (EPDS)</td><td>Total score ≥10</td></tr>
<tr><td>My Mood Monitor (M3)®</td><td>Total score ≥5</td></tr>
<tr><td>PROMIS Depression</td><td>Total score (T Score) ≥60</td></tr>
<tr><td>Clinically Useful Depression Outcome Scale (CUDOS)</td><td>Total score ≥31</td></tr>
</table></td></tr>
<tr><td>Denominator exclusions</td><td colspan="2">• Members with a history of bipolar disorder (Bipolar Disorder Value Set; Other Bipolar Disorder Value Set) any time during the member's history through the end of the year prior to the measurement period. Do not include laboratory claims (claims with POS code 81).
• Members with depression (Depression Value Set) that starts during the year prior to the measurement period. Do not include laboratory claims (claims with POS code 81).
• Members who use hospice services (Hospice Encounter Value Set; Hospice Intervention Value Set) or elect to use a hospice benefit any time during the measurement period.
• Members who die any time during the measurement period.
Refer to the HEDIS 2025 Value Set Directory for a list of codes.</td></tr>
<tr><td>Method to exclude</td><td colspan="2">Claims</td></tr>
</table>

The NCQA HEDIS measure specification has been adjusted pursuant to NCQA's Rules for Allowable Adjustments of HEDIS. The adjusted measure specification may be used only for internal quality improvement purposes.

Numerator/Service to close gap	Members who received follow-up care on or up to 30 days after the date of the first positive screen (31 days total). Any of the following on or up to 30 days after the first positive screen: • An outpatient, telephone, e-visit or virtual check-in follow-up visit (Follow Up Visit Value Set) **with** a diagnosis of depression or other behavioral health condition (Depression or Other Behavioral Health Condition Value Set). • A depression case management encounter (Depression Case Management Encounter Value Set) that documents assessment for symptoms of depression (Symptoms of Depression Value Set) or a diagnosis of depression or other behavioral health condition (Depression or Other Behavioral Health Condition Value Set). • A behavioral health encounter, including assessment, therapy, collaborative care or medication management (Behavioral Health Encounter Value Set). • A diagnosis of encounter for exercise counseling (ICD-10-CM code Z71.82). Do not include laboratory claims (claims with POS code 81). • A dispensed antidepressant medication (Antidepressant Medications List).
Method to close gap	Claims
Codes to close gap	**Follow Up Visit Value Set** (must be used with a diagnosis of depression or other behavioral health condition) • CPT: 99483; 98961; 98962; 98960; 99345; 99342; 99344; 99341; 99350; 99348; 99349; 99347; 99385; 99386; 99387; 99384; 99382; 99381; 99383; 99245; 99243; 99244; 99242; 99205; 99203; 99204; 99202; 99211; 99215; 99213; 99214; 99212; 99422; 99423; 99421; 99395; 99396; 99397; 99394; 99392; 99391; 99393; 99078; 99401; 99402; 99403; 99404; 99411; 99412; 98971; 98972; 98970; 99458; 99457; 98981; 98980; 98967; 98968; 98966; 99442; 99443; 99441 • HCPCS: G2252; G2012; G2251; T1015; G0463; G0071; G2250; G2010 **Depression Case Management Encounter Value Set** • CPT: 99494; 99492; 99366; 99493 • HCPCS: T1016; T2022; G0512; T1017; T2023 **Behavioral Health Encounter Value Set** • CPT: 99484; 90870; 90847; 90846; 90853; 90880; 90875; 90876; 99492; 90887; 90849; 90865; 90791; 90792; 90845; 90839; 90832; 90833; 90834; 90836; 90837; 90838; 99493; 90867; 90868; 90869 **A diagnosis of encounter for exercise counseling** • ICD-10-CM code: Z71.82 Please see the complete 2025 Value Set located on Provider OnLine and on the Premier Partners SharePoint for additional codes that are used for this measure.
Best practice recommendations	N/A- First year measure

The NCQA HEDIS measure specification has been adjusted pursuant to NCQA's Rules for Allowable Adjustments of HEDIS. The adjusted measure specification may be used only for internal quality improvement purposes.

<table>
<tr><th colspan="3">Initial Opioid Prescribing For Long Duration</th></tr>
<tr><td>Measure ID</td><td colspan="2">IOP-LD</td></tr>
<tr><td>Source</td><td colspan="2">PQA 2024</td></tr>
<tr><td>Summary of changes for 2025</td><td colspan="2">New display measure in 2025 for UPMC for Life (Medicare/SNP) product line</td></tr>
<tr><td>Description</td><td colspan="2">The percentage of members who meet age criteria, who do not have ≥1 initial opioid prescriptions for >7 cumulative days' supply.

A higher rate indicates better performance.</td></tr>
<tr><td>Measurement period</td><td colspan="2">Jan. 1, 2025, through Dec. 31, 2025</td></tr>
<tr><td>Quality program, ages, product lines</td><td>Premier Partners Program:
Ages: 22 years of age and older

Product lines:
• UPMC for Life (Medicare/SNP)</td><td>Quality Partners Program:
Ages: 18 years of age and older

Product lines:
• UPMC for Life (Medicare/SNP)</td></tr>
<tr><td>Denominator</td><td colspan="2">Use the steps below to determine the eligible population.
Step 1: Identify individuals who meet age criteria as of the first day of the measurement year.

Step 2: Identify individuals with ≥1 prescription claims for an opioid (See Opioids Medication Table below) during the measurement year.

Step 3: Identify individuals with a negative medication history for any opioid medication during the lookback period. The lookback period is a period of 90 days prior to each opioid prescription claim.

For example, an individual has opioid prescription claims on August 1, September 15 and December 20. For each of these dates of service, use the lookback period of 90 days to determine if the individual had no prescription claims for opioids. For example, for August 1, determine whether the individual had no prescription claims for opioids from May 3 – July 31. Repeat for the September 15 and December 20 opioid prescription claims.

Note:
• The prescription claims can be for the same or different opioids.
• For multiple opioid claims with the same date of service, calculate the number of days covered by an opioid using the prescription claims with the longest days' supply.
• For multiple opioid claims with different dates of service, sum the days' supply for all the prescription claims regardless of overlapping days' supply.
• Count the unique individuals (i.e., if an individual has multiple lookback periods, count the individual only once in the denominator).
<table>
<tr><th colspan="3">Opioids Medications [a, b]</th></tr>
<tr><td>benzyhydrocodone
butorphanol
codeine
dihydrocodeine
fentanyl
hydrocodone</td><td>hydromorphone
levorphanol
meperidine
methadone
morphine
opium</td><td>oxycodone
oxymorphone
pentazocine
tapentadol
tramadol</td></tr>
<tr><td colspan="3">[a] Includes combination products.
[b] Excludes the following: injectable formulations; opioid cough and cold products; sublingual sufentanil (used in a supervised setting); and all buprenorphine products (as a partial opioid agonist is not expected to be associated with overdose risk in the same dose-dependent manner as doses for full agonist opioids).</td></tr>
</table></td></tr>
<tr><td>Denominator exclusions</td><td colspan="2">Exclude individuals who met at least one of the following during the measurement year or the 90 days prior to the IPSD*:
• Hospice
• Cancer diagnosis
• Sickle cell disease
• Palliative care

*The IPSD is the Index Prescription Start Date, or the earliest date of service for an opioid medication during the measurement year.</td></tr>
<tr><td>Method to exclude</td><td colspan="2">Claims</td></tr>
<tr><td>Numerator/Service to close gap</td><td colspan="2">The number of individuals from the denominator who do not have >7 cumulative days' supply for all opioid prescription claims within any opioid initiation period.</td></tr>
</table>

Numerator/Service to close gap (continued)	Use the steps below to identify individuals from the denominator with >7 cumulative days' supply for all opioid prescription claims within any opioid initiation period. *The goal is <u>not</u> to have >7 cumulative days' supply for all opioid prescription claims within any opioid initiation period.* **Step 1:** For each individual in the denominator population, identify all initial opioid prescriptions and corresponding opioid initiation periods. **Step 2:** For each individual, starting with each initial opioid prescription, sum the days' supply of all opioid prescription claims within each opioid initiation period (i.e., date of service for the initial opioid prescription + 2 days). For example, if the date of service for an initial opioid prescription is on March 15, identify any opioid prescriptions claims from March 15 through March 17. Note: • The prescription claims can be for the same or different opioids. • For multiple opioid claims with the same date of service, calculate the number of days covered by an opioid using the prescription claim with the longest days' supply. • For multiple opioid claims with different dates of service, sum the days' supply for all the prescription claims regardless of overlapping days' supply. • If the opioid initiation period extends beyond the end of the measurement year, the opioid initiation period is truncated to the last day of the measurement year. **Step 3:** Count the unique individuals with >7 cumulative days' supply for all opioid prescription claims during any opioid initiation period in the measurement year.
Method to close gap	N/A
Medications to close gap	N/A: *The goal is <u>not</u> to have >7 cumulative days' supply for all opioid prescription claims within any opioid initiation period.*
Best practice recommendations	• Limit use of opioid medications in (when applicable) based on the clinical scenario. • Consider prescribing nonopioid analgesics and nonpharmacologic therapies as first-line options. • Prescribe the lowest effective dose for no longer than the expected duration of pain severe enough to require opioids. • Use short-acting opioid medications for acute, post-operative pain management since long-acting opioid medications generally should be avoided in this setting. • Avoid prescribing opioid medications in combination with other sedative medications, such as benzodiazepines. • Evaluate the patient for risk factors for OUD or other harm. • Establish and measure goals for pain control and increased functionality with the patient.

Osteoporosis Management in Women Who Had a Fracture		
Measure ID	OMW	
Source	NCQA, HEDIS MY 2025	
Summary of changes for 2025	N/A	
Description	The percentage of women 67–85 years of age who suffered a fracture and who had either a bone mineral density (BMD) test or prescription for a drug to treat osteoporosis in the 180 days (six months) after the fracture	
Measurement period	Jul. 1, 2024, through Jun. 30, 2025 (Period of time in which the member meets denominator criteria)	
Quality program, ages, product lines	**Premier Partners Program:** Ages: 67-85 years of age as of Dec. 31 of the measurement year Product lines: UPMC *for Life* (Medicare/SNP)	**Quality Partners Program:** Ages: 67-85 years of age as of Dec. 31 of the measurement year Product lines: UPMC *for Life* (Medicare/SNP)
Denominator	**Step 1:** Identify all members who had either of the following during the intake period. • An outpatient visit or ED visit (Outpatient and ED Value Set) for a fracture (Fractures Value Set) -Do not include visits that result in an inpatient stay (Inpatient Stay Value Set) • An acute or nonacute inpatient discharge with a fracture (Fractures Value Set) on the discharge claim. 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. **Step 2:** Test for negative diagnosis history. Remove episodes where the member had a fracture (Fractures Value Set) during the 60-day period prior to the episode date. Do not include laboratory claims (claims with POS code 81). **Step 3**: Select the Index Episode Start Date (IESD), or the earliest episode date during the intake period that meets all denominator criteria. The measure examines the earliest eligible episode per member that meets the criteria above.	
Denominator exclusions	• Members who use hospice services (Hospice Encounter Value Set; Hospice Intervention Value Set) or elect to use a hospice benefit any time during the measurement year • Members who die any time during the measurement year • Members who received palliative care (Palliative Care Assessment Value Set; Palliative Care Encounter Value Set; Palliative Care Intervention Value Set) any time during the intake period through the end of the measurement year. • Members who had an encounter for palliative care (ICD-10-CM code Z51.5) any time during the intake period through the end of the measurement year. Do not include laboratory claims (claims with POS code 81). • Members 67 years of age and older as of Dec. 31 of the measurement year who meet either of the following: -Enrolled in an Institutional SNP (I-SNP) any time during the intake period through the end of the measurement year. -Living long-term in an institution any time during the intake period through the end of the measurement year as identified by the LTI flag in the monthly membership detail data file. • Members 67–80 years of age as of Dec. 31 of the measurement year (all product lines) with frailty **and** advanced illness. Members must meet **both** frailty and advanced illness criteria to be excluded: 1. **Frailty.** At least two indications of frailty (Frailty Device Value Set; Frailty Diagnosis Value Set; Frailty Encounter Value Set; Frailty Symptom Value Set) with different dates of service during the intake period through the end of the measurement year. Do not include laboratory claims (claims with POS code 81). 2. **Advanced Illness.** Either of the following during the measurement year or the year prior to the measurement year: -Advanced illness (Advanced Illness Value Set) on at least two different dates of service. Do not include laboratory claims (claims with POS code 81). -Dispensed dementia medication (Dementia Medications List). • Members 81 years of age and older as of Dec. 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 intake period through the end of the measurement year. Do not include laboratory claims (claims with POS code 81).	

<table>
<tr><td>Denominator exclusions (continued)</td><td>Remove episode dates where any of the following are met:
Members who had a BMD test (Bone Mineral Density Tests Value Set) during the 730 days prior to the episode date.
Members who had a claim/encounter for osteoporosis therapy (Osteoporosis Medication Therapy Value Set) during the 365 days prior to the episode date.
Members who received a dispensed prescription or had an active prescription to treat osteoporosis (Osteoporosis Medications List) during the 365 days prior to the episode date.
Refer to the HEDIS 2025 Value Set Directory for a list of codes.</td></tr>
<tr><td>Methods to exclude</td><td>Claims
Upload to Novillus Care Gap Management Application (CGMA)</td></tr>
<tr><td>Numerator/Service to close gap</td><td>Appropriate testing or treatment for osteoporosis after the fracture defined by any of the following criteria:
A BMD test (Bone Mineral Density Tests Value Set), in any setting, on the IESD or in the 180-day period after the IESD
If the IESD was an inpatient stay, a BMD test (Bone Mineral Density Tests Value Set) during the inpatient stay
Osteoporosis therapy (Osteoporosis Medication Therapy Value Set) on the IESD or in the 180-day period after the IESD
If the IESD was an inpatient stay, long-acting osteoporosis therapy (Long-Acting Osteoporosis Medications Value Set) during the inpatient stay
A dispensed prescription to treat osteoporosis (Osteoporosis Medications List) on the IESD or in the 180-day period after the IESD
The IESD is the index episode start date, i.e., the earliest episode date during the measurement period that meets denominator criteria.

Refer to the HEDIS 2025 Value Set Directory for a list of codes.</td></tr>
<tr><td>Methods to close gap</td><td>Claims
Upload to Novillus Care Gap Management Application (CGMA)</td></tr>
<tr><td>Codes/Medications to close gap</td><td>Bone Mineral Density Tests
ICD-10: BP48ZZ1; BP49ZZ1; BP4GZZ1; BP4HZZ1; BP4LZZ1; BP4MZZ1; BP4NZZ1; BP4PZZ1; BQ00ZZ1; BQ01ZZ1; BQ03ZZ1; BQ04ZZ1; BR00ZZ1; BR07ZZ1; BR09ZZ1; BR0GZZ1
CPT: 76977; 77078; 77080; 77081; 77085; 77086
Osteoporosis Medication Therapy
HCPCS: J0897; J1740; J3110; J3111; J3489
Long-Acting Osteoporosis Medications
HCPCS: J0897; J1740; J3489
<table>
<tr><th colspan="2">Osteoporosis Medications</th></tr>
<tr><th>Description</th><th>Prescription</th></tr>
<tr><td>Bisphosphonates</td><td>Alendronate
Alendronate-cholecalciferol
Ibandronate
Risedronate
Zoledronic acid</td></tr>
<tr><td>Other agents</td><td>Abaloparatide
Denosumab
Raloxifene
Romosozumab
Teriparatide</td></tr>
</table>
Please see the complete 2025 Value Set located on Provider OnLine and on the Premier Partners SharePoint for additional codes that are used for this measure.</td></tr>
<tr><td>Best practice recommendations</td><td>Encourage lifestyle changes that may reduce the risk of breaking a bone, i.e., smoking cessation, limiting alcohol, and fall prevention.
Develop a process to ensure women with fractures are treated with a bone mineral density (BMD) test or prescription for a drug to treat osteoporosis within six months of the fracture.</td></tr>
</table>

<table>
<tr><th colspan="3">Polypharmacy: Use of Multiple CNS-Active Medications in Older Adults</th></tr>
<tr><td>Measure ID</td><td colspan="2">POLY-CNS</td></tr>
<tr><td>Source</td><td colspan="2">PQA 2024</td></tr>
<tr><td>Summary of changes for 2025</td><td colspan="2">N/A</td></tr>
<tr><td>Description</td><td colspan="2">The percentage of individuals ≥65 years of age who do not have concurrent use of ≥3 unique central-nervous system (CNS)-active medications

A higher rates indicates better performance.</td></tr>
<tr><td>Measurement period</td><td colspan="2">Jan. 1, 2025, through Dec. 2, 2025 (Period of time in which the member meets denominator criteria)</td></tr>
<tr><td>Quality program, ages, product lines</td><td>Premier Partners Program:
Ages: ≥65 years of age as of the first day of the measurement year

Product lines:
UPMC for Life (Medicare/SNP)</td><td>Quality Partners Program:
Ages: ≥65 years of age as of the first day of the measurement year

Product lines:
UPMC for Life (Medicare/SNP)</td></tr>
<tr><td>Denominator</td><td colspan="2">Use the steps below to identify the eligible population in the denominator.

Step 1: Identify individuals ≥65 years of age as of the first day of the measurement year.

Step 2: Identify individuals with ≥2 prescription claims for the same target medication, (Medication Table; POLY-CNS-A: CNS-Active Medications) on different dates of service during the measurement year.

Step 3: Identify individuals whose earliest date of service for any target medication (Medication Table; POLY-CNS-A: CNS-Active Medications) with ≥2 prescription claims on different dates of service, is ≥30 days from the last day of the measurement year (January 1 through December 2).</td></tr>
<tr><td>Denominator exclusions</td><td colspan="2">Exclude individuals with any of the following during the measurement year:
Hospice
Seizure Disorder</td></tr>
<tr><td>Method to exclude</td><td colspan="2">Claims</td></tr>
<tr><td>Numerator/Service to close gap</td><td colspan="2">The number of individuals from the denominator who did not have concurrent use for ≥30 cumulative days of ≥3 unique CNS-active medications, each with ≥2 prescription claims on different dates of service during the measurement year.

Service to close the gap: N/A; The desired outcome for this measure is that members will not have concurrent use for ≥30 cumulative days of ≥3 unique CNS-active medications, each with ≥2 prescription claims on different dates of service during the measurement year.</td></tr>
<tr><td>Method to close gap</td><td colspan="2">N/A; The desired outcome for this measure is that members will not have concurrent use for ≥30 cumulative days of ≥3 unique CNS-active medications, each with ≥2 prescription claims on different dates of service during the measurement year.</td></tr>
<tr><td>Medications to close gap</td><td colspan="2">
<table>
<tr><th colspan="3">POLY-CNS-A: CNS-Active Medications[a]</th></tr>
<tr><th colspan="3">Antiepileptic Medications</th></tr>
<tr><td>brivaracetam
cannabidiol
carbamazepine
divalproex sodium
eslicarbazepine
ethosuximide
ethotoin[b]
felbamate
fenfluramine</td><td>gabapentin
lacosamide
lamotrigine
levetiracetam
methsuximide
oxcarbazepine
perampanel
phenobarbital
phenytoin</td><td>pregabalin
primidone
rufinamide
stiripentol
tiagabine
topiramate
valproic acid[b]
vigabatrin
zonisamide</td></tr>
<tr><th colspan="3">Antipsychotic Medications</th></tr>
<tr><td>aripiprazole
asenapine
brexpiprazole
cariprazine
chlorpromazine
clozapine
fluphenazine
haloperidol</td><td>iloperidone
loxapine
lumateperone
lurasidone
molindone
olanzapine
paliperidone
perphenazine</td><td>pimavanserin
pimozide
quetiapine
risperidone
thioridazine
thiothixene
trifluoperazine
ziprasidone</td></tr>
</table>
</td></tr>
</table>

Medications to close gap (continued)

POLY-CNS-A: CNS-Active Medications[a] (continued)

Benzodiazepines and Nonbenzodiazepine Sedative/Hypnotic Medications

alprazolam	estazolam	quazepam
chlordiazepoxide	eszopiclone	temazepam
clobazam	flurazepam	triazolam
clonazepam	lorazepam	zaleplon
clorazepate	midazolam	zolpidem
diazepam	oxazepam	

Opioid Medications[c]

benzhydrocodone	hydrocodone	opium
buprenorphine[d]	hydromorphone	oxycodone
butorphanol	levorphanol	oxymorphone
codeine	meperidine	tapentadol
dihydrocodeine	methadone	tramadol
fentanyl	morphine	

Antidepressant Medications: SNRIs, SSRIs, & TCAs

amitriptyline	duloxetine	nortriptyline
amoxapine	escitalopram	paroxetine
citalopram	fluoxetine	protriptyline
clomipramine	fluvoxamine	sertraline
desipramine	imipramine	trimipramine
desvenlafaxine	levomilnacipran	venlafaxine
doxepin	milnacipran	

SNRI = serotonin-norepinephrine reuptake inhibitors; SSRI = selective serotonin reuptake inhibitors; TCA = tricyclic antidepressants

[a] Includes combination products that contain a target medication listed and the following routes of administration: buccal, nasal, oral, transdermal, rectal, and sublingual. Injectable and inhalation routes of administration are not included (not able to accurately estimate days' supply needed for measure logic). For combination products that contain more than one target medication, each target medication (active ingredient) should be considered independently.

[b] There are no active NDCs for ethotoin or valproic acid.

[c] Includes prescription opioid cough medications.

[d] Excludes single-agent and combination buprenorphine products used to treat opioid use disorder (i.e., buprenorphine sublingual tablets, Probuphine® Implant kit subcutaneous implant, and all buprenorphine/naloxone combination products).

Note: The desired outcome for this measure is that members will not have concurrent use for ≥30 cumulative days of ≥3 unique CNS-active medications, each with ≥2 prescription claims on different dates of service during the measurement year.

Best practice recommendations

- Limit use of multiple CNS-active medications in older adults (when applicable) based on clinical scenario.
- Evaluate for periodic deprescribing attempts to assess ongoing need and/or the lowest effective dose if combination therapy cannot be avoided.

Notes

UPMC Health Plan

upmchealthplan.com

2025 PPP ADLT MSRS GD 24PV4937073 (OM) 2/27/25