

HEDIS® MEASUREMENT YEAR 2026 VOLUME 2:

# TECHNICAL SPECIFICATIONS FOR HEALTH PLANS



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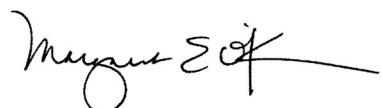
## **Acknowledgments**

NCQA is proud to release the Healthcare Effectiveness Data and Information Set for the 2026 measurement year. HEDIS Measurement Year 2026 (HEDIS MY 2026) would not have been possible without the contributions of many stakeholders, external and internal to NCQA. In particular, the members of the Committee on Performance Measurement generously donated their time, energy and intellect toward developing the final HEDIS MY 2026 specifications.

Improvements and enhancements to this volume are the result of a team effort of staff from these NCQA departments: Analysis, Measure and Data Operations, Information Systems and Performance Measurement.

HEDIS is produced with contributions of a wide range of collaborators. The members of NCQA's Measurement Advisory Panels, Technical Measurement Advisory Panel and HEDIS Expert Panels contributed greatly to HEDIS MY 2026.

Sincerely,



Margaret E. O'Kane  
President

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## **Appendices**

*Press Ctrl and click the mouse on an appendix name to navigate to the appendix.*

- Appendix 1: Glossary
- Appendix 2: Data Element Definitions
- Appendix 3: Contributors

# **Overview**

## HEDIS MY 2026

The Healthcare Effectiveness Data and Information Set (HEDIS) is one of the most widely used sets of health care performance measures in the United States. HEDIS tracks how well health care organizations perform when providing or facilitating the use of important health services to enrolled populations. HEDIS is published across several volumes. HEDIS MY 2026 includes 93 measures across 6 domains:

- Effectiveness of Care.
- Access/Availability of Care.
- Experience of Care.
- Utilization and Risk Adjusted Utilization.
- Health Plan Descriptive Information.
- Measures Reported Using Electronic Clinical Data Systems.

<b>Volume 2: Technical Specifications for Health Plans</b>	The technical specifications for the HEDIS measures for organizations, including instructions on data collection for each measure and general guidelines for calculations and sampling.
<b>Volume 3: Specifications for Survey Measures</b>	The technical specifications for HEDIS survey measures and standardized surveys from the Consumer Assessment of Healthcare Providers and Systems (CAHPS <sup>1</sup> ) program.
<b>Volume 5: HEDIS Compliance Audit: Standards, Policies and Procedures</b>	The accepted method for auditing the HEDIS production process, including an information systems capabilities assessment and an evaluation of compliance with HEDIS specifications. Standards that Certified HEDIS Compliance Auditors must use when conducting a HEDIS audit.
<b>Volume 6: Specifications for the Medicare Health Outcomes Survey</b>	The technical specifications for the Health Outcomes Survey (HOS).
<b>HEDIS Technical Specifications for Long-Term Services and Supports Measures</b>	The technical specifications for organizations providing Medicaid LTSS.

### How HEDIS Is Developed

NCQA's Committee on Performance Measurement (CPM), which includes representation from purchasers, consumers, health plans, clinicians and policy makers, oversees the evolution of the measurement set. Multiple Measurement Advisory Panels (MAP) provide clinical and technical knowledge required to develop the measures. Additional HEDIS Expert Panels and the Technical Measurement Advisory Panel (TMAP) provide invaluable assistance by identifying methodological issues and providing feedback on new and existing measures.

<sup>1</sup>CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

**What's New in Volume 2?****New measures**

- Acute Hospitalizations Following Outpatient Colonoscopy (HFC)
- Acute Hospitalizations Following Outpatient General Surgery (HFG)
- Acute Hospitalizations Following Outpatient Orthopedic Surgery (HFO)
- Acute Hospitalizations Following Outpatient Urologic Surgery (HFU)
- Lead Screening in Children (LSC-E)
- Follow-Up After Acute and Urgent Care Visits for Asthma (AAF-E)
- Statin Therapy for Patients With Cardiovascular Disease (SPC-E)
- Blood Pressure Control for Patients With Diabetes (BPD-E)
- Statin Therapy for Patients With Diabetes (SPD-E)
- Tobacco Use Screening and Cessation Intervention (TSC-E)
- Disability Description of Membership (DDM)

**Retired measures**

- Lead Screening in Children (LSC)\*
- Asthma Medication Ratio (AMR)
- Statin Therapy for Patients With Cardiovascular Disease (SPC)\*
- Statin Therapy for Patients With Diabetes (SPD)\*
- Medical Assistance With Smoking and Tobacco Use Cessation (MSC)

\*Only the LSC-E, SPC-E and SPD-E measures will be reported.

**Revised measures**

For specific revisions, refer to each measure's *Summary of Changes* for a complete summary.

**Overall changes**

- Updated the formatting of all HEDIS measures (with the exception of Health Plan Descriptive Measures and Survey Measures) to align with the FHIR® standard. These changes are intended to enable future interoperability of human-readable technical specifications, and do not modify the intent or calculation of a measure.
  - Added measurement period, copyright and disclaimer notice, clinical recommendation statement/rationale and characteristic sections.
  - Updated terminology (replaced “measurement year” with “measurement period”; “members” with “persons”; “eligible population” with “initial population”; “required exclusions” with “denominator exclusions”).
  - Reformatted the initial population section. Attribution now describes health plan enrollment criteria.
  - Removed medication list tables, where applicable. This information can be found in the Medication List Directory (MLD). The medication list tables remain only in measures where the information in the tables is required for measure calculation.
  - Reformatted the *Rules for Allowable Adjustments* sections.
  - For measures using the hybrid methodology, replaced “denominator identified via administrative specifications” with “administrative denominator.”

- Updated the data element tables to align with changes to the measure format.
- Removed Source System of Record (SSoR) reporting from all ECDS reported measures.
- Removed the Effectiveness of Care subdomain “Measures Collected Through the CAHPS Health Plan Survey” because its measures were retired.
- Moved the Health Plan Descriptive Information measure domain to fall after the ECDS measure domain.
- Removed the domain-specific guidelines for Effective of Care Measures, Access/Availability of Care Measures, Risk Adjusted Utilization and ECDS measures. Moved the applicable guidelines to the measure narratives.
- Removed the following appendices from the specifications:
  - Appendix 1: Summary Table of Measures, Product Lines.
  - Appendix 2: Technical Considerations for New Measures.
  - Appendix 6: Alphabetized List of HEDIS Measures.
  - Appendix 7: Logical Measure Groups.
- “Appendix 3: Glossary” is now “Appendix 1: Glossary”; “Appendix 4: Data Element Tables” is now “Appendix 2: Data Element Definitions”; “Appendix 5: Contributors” is now Appendix 3: Contributors.
- Added, removed and edited glossary terms in Appendix 1 (formerly Appendix 3). Separated provider type requirements from general glossary terms.

**Technical specification updates—  
HEDIS MY 2026**

NCQA will freeze the specifications for MY 2026 on March 31, 2026, with the *HEDIS MY 2026 Volume 2 Technical Update*.

*HEDIS MY 2026 Volume 2 Technical Update and Value Set Directory* (3/31/2026 release) will be available for download by customers with access to the HEDIS MY 2026 Volume 2 e-pub. Go to the “[My Downloads](#)” section of [My NCQA](#) and download the *MY 2026 Volume 2 (epub)* zipped folder, which contains the updated *MY 2026 Volume 2* file and the Value Set Directory.

Organizations are accountable for all changes included in the *Technical Update*.

**Random Number (RAND) table—  
HEDIS MY 2026**

The HEDIS MY 2026 RAND table will be available to purchasers of Volume 2 on October 15, 2026. In the [My Downloads](#) section of [My NCQA](#), download the *MY 2026 Volume 2 (epub)* zipped folder, which contains the MY 2026 RAND table.

**Medication List Directory—  
HEDIS MY 2026**

The Medication List Directory is available for free in the [NCQA Store](#).

Once ordered, the Medication List Directory for HEDIS MY 2026 will be available in the [My Downloads](#) section of [My NCQA](#).

The initial release will be available August 1, 2025. The final release will be available March 31, 2026.

Final medication list changes, if needed, will be communicated in the *HEDIS MY 2026 Volume 2 Technical Update* (3/31/2026 release).

<b>HCC Risk Adjustment tables—HEDIS MY 2026</b>	The HCC Risk Adjustment tables are available for free in the <a href="#">NCQA Store</a> . Once ordered, the HCC Risk Adjustment tables for HEDIS MY 2026 will be made available in the <a href="#">My Downloads</a> section of <a href="#">My NCQA</a> by March 31, 2026.
<b>HEDIS MY 2026 first-year measure evaluation</b>	At the conclusion of the HEDIS MY 2026 data collection period, NCQA will evaluate first-year status measures/indicators to determine if they will be publicly reported.  Any changes to the HEDIS MY 2026 first-year status measures/indicators will be communicated in a public reporting memo released on October 1, 2027.

## Referring to HEDIS Measures and Rates

HEDIS measures and resulting rates must always retain the HEDIS name. Specifically, for unadjusted measures:

- Refer to all *unadjusted* HEDIS measures as “**HEDIS Health Plan measures.**”
- Calculated measure rates that are based on *unadjusted* HEDIS specifications and *have not* been certified through NCQA’s Measure Certification Program may not be called “Health Plan HEDIS rates” until they are audited and designated reportable by an NCQA-Certified HEDIS Compliance Auditor. Refer to these rates as “**Uncertified, Unaudited Health Plan HEDIS Rates.**” Such *uncertified* rates *may only be used for internal, quality improvement purposes* (e.g., trend analysis) and no incentive payments may be made on such rates.
- Calculated measure rates that are based on *unadjusted* HEDIS specifications and have been certified through NCQA’s Measure Certification Program may not be called “Health Plan HEDIS rates” until they are audited and designated reportable by an NCQA-Certified Auditor. Refer to these rates as “**Unaudited Health Plan HEDIS rates.**”

Organizations that need assistance in determining the correct naming convention for HEDIS measures/rates should contact NCQA through [My NCQA](#).

Specifically, for *adjusted* measures pursuant to NCQA’s Rules for Allowable Adjustment of HEDIS:

- Refer to all *adjusted* HEDIS measures as “**Adjusted HEDIS measures.**”
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- Calculated measure rates that are based on *adjusted* HEDIS specifications and *have* been certified through NCQA’s Measure Certification Program may not be called “adjusted HEDIS rates” until they are audited and designated reportable by an NCQA-Certified Auditor. Refer to these rates as “**Adjusted, Unaudited HEDIS rates.**”

## If You Have Questions About the Specifications

### Policy Clarification Support

NCQA provides policy support to customers, including a function that allows customers to submit questions about policy interpretation to NCQA staff through [My NCQA](#).

### FAQs and Policy Updates

The FAQs and Policy Updates clarify HEDIS uses and specifications, and are posted to the [NCQA website](#) on the 15th of each month.

### Additional Resources

NCQA provides resources to help organizations understand measure specifications, collect data and report audited HEDIS results:

- Each organization implementing HEDIS is strongly encouraged to join NCQA's HEDIS Users Group for technical assistance and guidance on interpreting the specifications. Membership benefits include NCQA HEDIS and Accreditation publications, newsletters, online seminars and discount vouchers for HEDIS conferences and publications. For more information, email [hug@ncqa.org](mailto:hug@ncqa.org).
- HEDIS publications are available for download as electronic publications ("e-pub") and are sold by user license tiers in the [NCQA Store](#). Publications are protected Microsoft Word and Excel files displaying the publication's content.
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## Reporting Hotline for Fraud and Misconduct

NCQA does not tolerate submission of fraudulent, misleading or improper information by organizations as part of their survey process or for any NCQA program. NCQA reserves the right to publicly display the information on the reported issue, including, but not limited to, the affected organization, the specific data error and the associated resolution. We will display the information on a dedicated public-facing webpage on the NCQA website ([www.ncqa.org](http://www.ncqa.org)). NCQA may also revise affected products.

NCQA has a confidential and anonymous Reporting Hotline to provide a secure method for reporting perceived fraud or misconduct, including submission of falsified documents or fraudulent information to NCQA that could affect NCQA-related operations (including, but not limited to, the survey process, the HEDIS measures and determination of NCQA status and status level).

### How to Report

#### • Toll-Free Telephone:

- English-speaking USA and Canada: 844-440-0077 (not available from Mexico).
- Spanish-speaking North America: 800-216-1288 (from Mexico, user must dial 001-800-216-1288).

- **Website:** <https://www.lighthouse-services.com/ncqa>.
- **Email:** [reports@lighthouse-services.com](mailto:reports@lighthouse-services.com) (must include NCQA's name with the report).
- **Fax:** 215-689-3885 (must include NCQA's name with the report).

## Reporting Data Errors to NCQA

Because audited HEDIS data are used to establish plans' Accreditation status and in many NCQA programs and products, NCQA must be made aware of data problems in any previously reported rate.

Organizations must immediately report any error in a measure rate or in its component (in any previous submission, regardless of timing) that is >5% higher or lower than what was reported originally. These should be reported to NCQA via [My NCQA](#) by selecting the Product/Program Type as "HEDIS Audit" and the General Content Area as "Data Errors." The report to NCQA must include:

- A description of the issue that includes:
  - The correct rate.
  - The error's cause.
  - How the error was discovered.
  - How the error was corrected.
- The HEDIS measure year and the measures affected.
- The submissions affected.
- The impact on reported rates.

Auditors must document all findings for the year in question and the current year's corrections. Organizations are not required to submit corrected rates for additional impacted data years unless requested by NCQA. Findings must be included in the work papers, and must be noted in detail in the organization's Final Audit Report.

# **General Guidelines for Data Collection and Reporting**

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## SUMMARY OF CHANGES TO HEDIS MY 2026

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- Removed references to Medicare-Medicaid (MMP) plans because this is no longer a reporting option for MY 2026.
- Deleted *General Guideline: Date Specificity*; requirements are included in each applicable measure.
- Added *General Guideline: Which Services Count* to the *Data Collection Methods and Data Sources* section.
- Updated *General Guideline: Race and Ethnicity Stratifications* to align with the March 2024 updates to the Office of Management and Budget Standards for Maintaining, Collecting, and Presenting Federal Data on Race and Ethnicity.
- Added text to *Data refresh for the systematic sample* in *General Guideline: Obtaining Information for the Systematic Sample*.
- Deleted *General Guideline: Measures That Use Medication Lists*; requirements are included in each applicable measure.
- Deleted *General Guideline: Anchor Dates*; requirements are included in *General Guideline: Continuous Enrollment*.
- Updated *General Guideline: Data Collection Methods* to include information regarding the electronic method of reporting.
- Deleted *General Guideline: SNOMED Codes*.

## HEDIS Reporting

### ***General Guideline: Product-Line Reporting***

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Audited HEDIS results are collected and reported separately for populations covered by commercial insurance, Medicaid and Medicare.

***Note:*** A subset of HEDIS measures is collected and reported for the Exchange product line. For reporting requirements and measure specifications for Exchange reporting, refer to the Quality Rating System (QRS) Measure Technical Specifications on the CMS website. These reporting requirements must be used for only QRS reporting; Volume 2 may not be used for QRS-specific reporting.

### ***General Guideline: Product-Specific Reporting***

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Audited HEDIS results may be reported separately by product (HMO, POS, PPO, EPO) or combined (HMO/POS or PPO/EPO). To report a PPO or EPO product combined with an HMO or POS product, submit a written request for approval to PCS via [My NCQA](#). The request must address all the elements in *General Guideline: HEDIS Submission for Organizations Seeking Accreditation*.

The organization must submit data for all members for an entire product. Refer to [\*General Guideline: Reporting ASO and Self-Insured Members\*](#) for more information on allowable population exclusions.

#### **Definitions**

**HMO** Health maintenance organization. An organized health care system that is accountable for both the financing and delivery of a broad range of comprehensive health services to an enrolled population. An HMO is accountable for assessing access and ensuring quality and appropriate care.

Practitioners affiliated with the health care system render health care services. In this type of organization, members must obtain all services from affiliated practitioners and must usually comply with a predefined authorization system to receive reimbursement.

A **practitioner** is a professional who provides health care services and is usually required to be licensed as defined by law.

**POS** Point of service. An HMO with an opt-out option. In this type of organization, members may choose to receive services either within the organization's health care system (e.g., an in-network practitioner) or outside the organization's health care delivery system (e.g., an out-of-network practitioner).

The level of benefits or reimbursement is generally determined by whether the member uses in-network or out-of-network services. Common uses of "POS" include references to products that enroll each member in both an HMO (or HMO-like) system and in an indemnity product. A POS product is also referred to as an "HMO swing-out organization," an "out-of-organization benefits rider to an HMO" or an "open-ended HMO."

**PPO** Preferred provider organization. PPOs are responsible for providing health benefits-related services to covered individuals and for managing a practitioner network. They may administer health benefits programs for employers by assuming insurance risk or by providing only administrative services.

**EPO** Exclusive provider organization. A type of health insurance product that usually limits coverage to care from providers, or groups of providers, who have contracts with the health insurance issuer to be part of a network of participating providers. EPO members will generally not be reimbursed or receive benefits for out-of-network services; however, some EPOs will provide partial reimbursement for emergency situations.

### **General Guideline: HEDIS Submission for Organizations Seeking Accreditation**

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Audited HEDIS results must correspond with the product line/product combination for which the organization seeks Accreditation. NCQA defines the organization for Accreditation and HEDIS reporting as part of the Accreditation application process.

#### **How NCQA Defines an Organization for Accreditation**

NCQA considers the following when determining the Accreditable entity.

**1. Legal entity** NCQA's goal is to identify the legal entity that issues a contract for insurance for a defined population or contracts with an employer to provide managed care services to a self-insured population.

If the legal entity operates in multiple states but otherwise operates as a centralized organization (same oversight and management structure; same staff, same policies and procedures, all functions addressed in standards performed under a corporate or central structure), NCQA conducts one survey for the legal entity; however, the legal entity is required to report HEDIS/CAHPS by geographic unit, as defined below. For multiple legal entities, NCQA

may consider each legal entity as an Accreditable entity. For a legal entity without centralized operations, NCQA may determine that distinct operating units or service areas are the Accreditable entity.

If the organization consists of multiple legal entities within a state, but otherwise operates as a single statewide organization (same management structure; a single practitioner/provider network for the entire state; centralized key functions, including quality improvement, credentialing and utilization management), NCQA awards Accreditation status to each legal entity. With NCQA approval, the organization may submit one statewide HEDIS submission that is applied to each legal entity.

NCQA reserves the right to determine, at its sole discretion, an entity or organization's eligibility for Accreditation, and must approve an organization to be surveyed as one legal entity or multiple legal entities.

**2. Practitioner and provider network**

The organization must have a single practitioner or provider network. If there are separate and distinct practitioner or provider networks, NCQA may consider each network (along with the accompanying management structure) to be a different Accreditable entity.

NCQA recognizes that organizations sometimes market individual products with practitioner or provider networks that are subsets of a larger network. In this case, NCQA may define the Accreditable entity at the level of the broader network.

**3. Centralization**

NCQA considers the degree of centralization of key functions assessed by the Accreditation standards. The organization has a single QI program and a single set of policies and procedures for the functions evaluated by the standards, including population health management utilization management credentialing managing member complaints and appeals and developing member materials. If key functions are decentralized, with distinct policies and procedures, NCQA may determine that there is more than one Accreditable entity.

**4. Licensure**

The organization may have multiple licenses, especially if its service area crosses state lines.

**5. HEDIS/CAHPS reporting unit**

In general, because evaluation of HEDIS/CAHPS results is required for Accreditation and NCQA issues a unique status for each HEDIS/CAHPS reporting unit, the Accreditable entity is the same as the HEDIS/CAHPS reporting unit.

**6. Product/product line**

Product lines reflect the different populations an organization serves. HEDIS/CAHPS results must be collected and reported separately for populations covered by the following product lines:

- Commercial.
- Medicaid.
- Exchange.
- Medicare.

Off-Exchange products must be included in the commercial product line, not in the Exchange product line.

The Federal Employee Program and Tricare programs are included in the commercial product line.

An organization that is responsible for both the Medicare and Medicaid components for dual-eligible members may select Medicare or Medicaid (or both) for Accreditation purposes. Dual-eligible members must be included in the product lines selected. An organization that manages Medicaid fee-for-service members may exclude those members from its Medicaid product line. Members who have Medicare Private Fee-for-Service (PFFS) through another organization, or have unknown Medicare coverage as their primary insurer, may be excluded from the Medicaid report.

Products reflect the organizational structure (e.g., network), services and benefits offered by the organization and include HMO, POS, PPO and EPO products.

Because HEDIS reporting must match the product line for which an organization seeks Accreditation, an organization with a Children's Health Insurance Program (CHIP) population must include those members in its Medicaid product line, using Medicaid measure specifications, even if it needs separate HEDIS submissions for other purposes (e.g., state reporting). The organization must exclude CHIP members from its commercial product line to avoid affecting organization-to-organization comparison.

If the state requires the organization to report CHIP members separately, a second, state-specific CHIP-only HEDIS/CAHPS submission is required. The organization must note this state-specific requirement in the Health Organization Questionnaire (HOQ).

**7. Geographic unit**

HEDIS performance varies geographically throughout the United States. To be meaningful to consumers and purchasers, results must reflect geographic variation.

For organizations with HMO, POS and EPO products—which are generally incorporated locally and regulated individually by states—the size of the geographic unit is determined by the legal entity.

For PPO products—which may have a service area larger than a single state—the organization is required to report HEDIS/CAHPS results for geographic regions no larger than a state.

**8. Limiting states included in NCQA Accreditation**

If an organization licensed to operate in multiple states seeks Accreditation for a limited geographic area, it may not represent that an excluded state is covered by the Accreditation. For example, an organization may have most of its membership in New York and the rest in a national account in Texas. If the organization is Accredited only for New York, it may not state that it is also Accredited for Texas.

An organization with membership in a state where it is not licensed to operate includes those members in the “home” state where it is licensed to operate and has its main membership.

## Health Plan Ratings and Accreditation

Evaluation of HEDIS/CAHPS performance is separate from standards scoring. In addition to Accreditation status, Health Plan Ratings will be displayed on the NCQA Report Card as the indicator of HEDIS/CAHPS performance.

Based on the methodology, organizations earn a star rating of 0–5 (in .5-star increments) for the HEDIS/CAHPS portion of Accreditation. The methodology includes a distinct set of measures for each product line. Each measure is classified in one of three weighted categories:

### Weight

- |                               |     |
|-------------------------------|-----|
| • Process measures            | 1   |
| • Patient experience measures | 1.5 |
| • Outcome measures            | 3   |

The overall rating is the weighted average of an organization's HEDIS and CAHPS measure ratings, plus Accreditation bonus points (if the organization has NCQA Accreditation), rounded to the nearest half point.

Overall performance is measured in three subcategories (scored 0–5 in 0.5 increments and displayed as stars):

- **Patient Experience.** Patient-reported experience of care, including experience with doctors, services and customer service (measures in the Patient Experience category).
- **Rates for Clinical Measures.** The proportion of eligible members who received preventive services (prevention measures) and the proportion of eligible members who received recommended care for certain conditions (treatment measures).
- **NCQA Accreditation Standards Score.** For an organization with an Accredited or Provisional status, 0.5 bonus points are added to the overall rating before rounding to the nearest half point. An organization with an Interim status receives 0.15 bonus points before rounding to the nearest 0.5 point.

### Note

- *If an organization chooses to publicly report performance data on the HEDIS Attestation, it is scored on the data submitted and receives the Accreditation bonus points (displayed as stars).*
- *If an organization Accredited on standards only chooses not to publicly report performance data, it is not scored based on performance measurement results and is not awarded Accreditation bonus points.*
- *If an organization's membership for a reporting unit is less than 15,000, the organization:*
  - *May be scored on standards only.*
  - *May combine its membership with another HEDIS/CAHPS reporting unit to achieve the minimum reporting threshold.*
  - *May choose to be scored on HEDIS/CAHPS without meeting the minimum reporting threshold.*

Refer to the applicable ratings year on the [NCQA Health Plan Ratings](#) page for details and policies for combining entities.

## Annual Reevaluation

For organizations required to submit HEDIS/CAHPS results, NCQA recalculates Health Plan Ratings annually by product/product line, on the set of measures identified for each reporting year. Organizations must submit audited HEDIS results to NCQA each year by the reporting date specified in General Guideline: HEDIS Reporting Date. Refer to the applicable ratings year on the [Health Plan Ratings page](#) for the list of required measures.

NCQA reserves the right to modify its approach for evaluating HEDIS/CAHPS to address measure issues (e.g., retirement). NCQA gives advance notice of such changes.

## **General Guideline: HEDIS Submission for Organizations Not Seeking Accreditation**

To determine how many HEDIS reports to produce, an organization defines itself using the criteria described above. If an organization cannot determine the HEDIS reporting entity, it must submit written documentation regarding the criteria described in the *General Guideline: HEDIS Submission for Organizations Seeking Accreditation*, to the NCQA Policy Department via PCS at [My NCQA](#). NCQA reviews the organization's structure and makes a determination.

## **General Guideline: Reporting HEDIS for Medicaid**

Separate Medicaid HEDIS reports must be produced for each state with which an organization has a Medicaid contract.

If an organization contracts with a local entity (i.e., with a county, rather than with a state) and with each locality where it provides service, the state and the organization may consider providing a comprehensive Medicaid HEDIS report that encompasses all geographic areas in the state that are served by the organization.

## **General Guideline: Reporting HEDIS for Medicare**

CMS annually issues the reporting requirements for HEDIS, HOS and CAHPS to all MA organizations in a CMS memorandum addressed to all entities that must fulfill these reporting requirements. The following organizations and plan benefit packages listed below are required to report HEDIS measures for their members:

- Medicare Advantage (MA) organizations:
  - Coordinated Care Plan (CCP) (local, regional, employer and religious fraternal benefit) organizations.
  - Special Needs Plan (SNP) benefit packages, including all SNP types (Dual Eligible, Chronic or Disabling Conditions and Institutional, which includes FI-SNPs, HI-SNPs and IE-SNPs).
  - Private Fee-for-Service (PFFS) (including local, employer and religious fraternal benefit) organizations.
  - Medical Savings Account (MSA) contracts.
- Section 1876 cost organizations.

MA organizations that offer SNP benefit packages submit an additional subset of HEDIS measures that are listed in the CMS Memo. The CMS Memo also lists the required HEDIS measures by organizational type because some MA organizations report fewer HEDIS measures. CMS strongly advises that all MA organizations refer to the CMS Memo to determine which HEDIS measures are required for their organization.

**Note:** Members in hospice are excluded from HEDIS reporting.

**General Guideline: Reporting HEDIS for CHIP**

<b>CHIP</b>	States may contract with an organization to provide care to CHIP members as part of the organization's Medicaid product line or a CHIP-only product. The state enables the contracting organization to identify CHIP members, when possible.
<b>Reporting guidelines</b>	<p>For NCQA HEDIS/CAHPS reporting purposes, CHIP products must be included in the organization's Medicaid product line using Medicaid measure specifications. This applies for organizations that have other Medicaid products as well as organizations that have only CHIP products.</p> <p>If the state requires contracting organizations to report CHIP products separately, a second, state-specific CHIP-only HEDIS/CAHPS submission is required. Organizations must note this state-specific requirement in the Health Organization Questionnaire (HOQ).</p> <p>The organization must exclude CHIP products from its commercial product-line reports because including CHIP products in HEDIS reports for commercially enrolled populations may affect organization-to-organization comparison.</p>

**Natural Disaster and Cybercrime**

*This section of the specifications applies only to organizations whose operations were destroyed or severely disrupted due to natural disaster or cybercrime (e.g., impact on access to claims/enrollment files, encrypted or changed data).*

These organizations must report this to NCQA, and should contact their auditors to discuss the current state of their operations and the availability of documentation needed to meet NCQA program requirements. Specific relief will be determined on a case-by-case basis. Organizations should provide a measure-specific assessment of the following areas, as applicable:

- HEDIS and CAHPS reporting.
  - Seek guidance from CMS about CAHPS for Medicare Advantage and Part D organizations.
- Access and availability of practitioners or practitioner records or data systems.

Based on the information provided, NCQA will work with the organization to determine the appropriate level of modification for the HEDIS reporting year.

**The NCQA HEDIS Compliance Audit™**

The HEDIS Compliance Audit runs concurrent with the data collection process. The audit allows comparability across organizations and ensures validity and integrity of reported HEDIS data.

The audit is required for organizations seeking NCQA Accreditation or for reporting in NCQA public reporting products, including Quality Compass, and by CMS and many states and employer groups.

### **General Guideline: Audit Preparation**

<b>Contract with an audit firm</b>	The organization requests an application for a HEDIS Audit from an <a href="#">NCQA Licensed Organization</a> and is responsible for determining fees and entering into contracts. The first activity in audit preparation is contract execution. An organization contacts NCQA Licensed Organizations for bids and selects a firm to conduct the HEDIS audit.
	The contracting phase includes assessing measures to report, executing the contract with all the necessary ancillary agreements (e.g., confidentiality and conflict of interest) and negotiating a timeline.
	All Licensed Organizations employ or contract with Certified HEDIS Compliance Auditors (CHCA) and select an audit team for the organization.
<b>HEDIS Roadmap</b>	Each organization must complete the HEDIS Record of Administration, Data Management and Processes (Roadmap). The Roadmap contains questions about all audit standards, and describes the operational and organizational structure of the organization. Auditors use the HEDIS Roadmap to review information about an organization's systems for collecting and processing data used to produce HEDIS reports and to organize the audit review.
<b>Medical record review validation</b>	The medical record review validation (MRRV) process uses like-measure groupings for measure validation; includes hybrid measure exclusions; applies a different statistical test to the process; and defines MRR milestones clearly to ensure consistency across organizations. Refer to <i>Volume 5, HEDIS Compliance Audit: Standards, Policies and Procedures</i> .
<b>HEDIS Audit Timeline</b>	Organizations must follow the HEDIS Audit Timeline, which will be posted on the <a href="#">NCQA website</a> on March 31, 2026, and is published in <i>Volume 5, HEDIS Compliance Audit: Standards, Policies and Procedures</i> .

### **General Guideline: Reporting**

<b>Audit results</b>	HEDIS Compliance Audits result in audited rates or calculations at the measure and indicator level, and indicate if the measures can be publicly reported. All measures selected for public reporting must have a final, audited result. The auditor approves the rate or report status of each measure and survey included in the audit, as shown below.
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#### **For Performance Measures**

Rate/Result	Comment
R	<i>Reportable.</i> A reportable rate was submitted for the measure.
NA	<p><i>Small Denominator.</i> The organization followed the specifications, but the denominator was too small (e.g., less than 30) to report a valid rate.</p> <ul style="list-style-type: none"> <li>a. For Effectiveness of Care (EOC) measures, EOC-like measures and the Antibiotic Utilization for Respiratory Conditions measure, when the denominator is less than 30.</li> <li>b. For all Risk Adjusted Utilization measures, when the denominator is less than 150.</li> <li>c. For measures reported using electronic clinical data systems (ECDS), when the denominator is less than 30.</li> </ul> <p><i>NA (Not Applicable)</i> is a status, not an audit designation. Measure rates that result in NA are considered Reportable (R), but the denominator is too small to report.</p>

Rate/Result	Comment
<b>NB</b>	<i>No Benefits.</i> The organization did not offer the health benefit required by the measure (e.g., mental health, chemical dependency). Benefits are assessed at the global level, not the service level (refer to <i>General Guideline: Required Benefits</i> ).
<b>NR</b>	<i>Not Reported.</i> The organization chose not to report the measure.
<b>NQ</b>	<i>Not Required.</i> The organization was not required to report the measure. NQ is not an option for required Medicare, Exchange or Accreditation measures.
<b>BR</b>	<i>Biased Rate.</i> The calculated rate was materially biased.
<b>UN</b>	<i>Unaudited.</i> The organization chose to report a measure that is not required to be audited. This result only applies when permitted by NCQA.

**Material bias** Bias differs by measure and domain and is determined by the degree of data completeness for the data collection method used. Organizations may not report a rate for a measure that the auditor determines is biased. Auditors use a standardized set of bias assessments found in the Bias Determination appendix in *Volume 5, HEDIS Compliance Audit: Standards, Policies and Procedures*.

### **General Guideline: Marketing**

Release of HEDIS Audit results must be in accordance with NCQA's *Guidelines for Advertising and Marketing*, posted on the [NCQA website](#). Organizations may release the entire Final Audit Report without prior authorization from NCQA, but must obtain written authorization from NCQA before releasing abridged, summarized or quoted information from the Final Audit Report.

Organizations that refer to the HEDIS Audit or any HEDIS data audited by a Certified HEDIS Compliance Auditor must adhere to the Guidelines.

### **In Which Reports Do HEDIS Members Remain?**

### **General Guideline: Commercial Members**

Include members enrolled through an employer group policy or through an individual or family policy in the commercial HEDIS report. Per *General Guideline: Reporting HEDIS for CHIP*, organizations must exclude CHIP members from their commercial product-line reports because including CHIP members in HEDIS reports for commercially enrolled populations may affect organization-to-organization comparison.

### **General Guideline: Members With Dual Enrollment**

Dual enrollment is assessed using the continuous enrollment criteria in each measure. To meet criteria for dual enrollment, members must have dual enrollment at the end of the continuous enrollment period. Per *General Guideline: Members Who Switch Products/Product Lines*, if a measure allows a gap at the end of the continuous enrollment period, members must have dual enrollment as of the last enrollment segment. For measures without a continuous enrollment requirement, members must have dual enrollment on the date of service or the date of discharge.

Medicare members who have only Part D coverage do not qualify for dual enrollment.

This guideline must be applied to the following enrollment situations; all decisions based on the guideline must be used consistently across all measures.

<b>Dual commercial/ Medicaid enrollment</b>	Members with dual commercial and Medicaid enrollment must be reported in the commercial HEDIS reports. These members may be excluded from the Medicaid HEDIS reports.  For Plan All-Cause Readmissions and Acute Hospital Utilization, remove these members from Medicaid reporting and only include them in commercial reporting.
<b>Dual Medicaid enrollment</b>	Members dually enrolled in two Medicaid plans must be reported in the primary Medicaid HEDIS report. The secondary Medicaid payer may exclude a member whose primary Medicaid enrollment was offered through a different organization.
<b>Dual commercial enrollment</b>	<b>Enrollment in different organizations:</b> Do not account for coordination of benefits with other insurance carriers. If members have commercial enrollment in two organizations, both organizations must include the members in their HEDIS reports, regardless of the primary insurer. For example, dependent children who are enrolled in one organization's commercial product line under the mother's insurance, and in another organization's commercial product line under the father's insurance, are included in both HEDIS reports.  <b>Enrollment in the same organization:</b> Adhere to the following criteria for members with dual enrollment (e.g., children enrolled under each parent): <ul style="list-style-type: none"><li>• <i>If members are enrolled twice in the same product and there is only one HEDIS submission</i>, include them only once in the submission.</li><li>• <i>If products are reported separately</i>, include members with dual enrollment in both products in both HEDIS submissions.</li><li>• <i>If the different product types are reported combined</i>, include members once in the combined submission.</li></ul>
<b>Dual commercial/ Medicare enrollment</b>	Members with dual commercial and Medicare enrollment must be included only in the product line that provides their primary enrollment (commercial or Medicare).
<b>Dual Medicaid/ Medicare enrollment “dual eligible”</b>	Include these members in <i>both</i> the Medicaid and Medicare HEDIS reports <i>only</i> if they are enrolled in the organization's Medicare contract required to report HEDIS <i>and</i> in the organization's Medicaid managed-care contract. An organization with a Dual-Eligible SNP benefit package must also include these members in its SNP submission.  For Plan All-Cause Readmission and Acute Hospital Utilization, remove these members from Medicaid reporting and only include them in Medicare reporting.  Members who have Medicare Private Fee-for-Service (PFFS) through another organization or have unknown Medicare coverage as their primary insurer may be excluded from the Medicaid report.

**General Guideline: Reporting ASO and Self-Insured Members****Administrative services only (ASO) and self-insured members**

Include ASO and self-insured members in HEDIS/CAHPS reports. Organizations may use different terms for these members, including, but not limited to “no-touch,” “self-funded” or “third party administrator (TPA).” Organizations may exclude these members from HEDIS/CAHPS reports only in either of the following situations and only with **auditor approval**:

- The contract prohibits the organization from contacting members for any reason.
  - The **contractual agreement**, which is a contract or other written agreement between the organization (HMO, PPO, EPO) and the ASO client (e.g., employer), states that the organization may not contact these ASO and self-insured members under any circumstances or include them in HEDIS/CAHPS reporting.
- Note:** *Exclusion from disease management, case management or quality improvement projects does not meet criteria for exclusion from HEDIS/CAHPS.*
- The agreement to exclude members in the reporting year must be in place (fully executed by both parties, in the case of a contract, or communicated, in the case of a written agreement) by January 1 of the measurement year.
  - The organization is not responsible for administering both in-network and out-of-network claims for ASO and self-insured members (employer carve-out for both in-network and out-of-network claims).

**Note:** *If claims are administered through a third party on behalf of an organization (i.e., a claims delegation arrangement), the organization is considered responsible for administering claims and members may not be excluded.*

Organizations may not exclude members who cannot be reached (e.g., overseas military or Foreign Service members), unless one of the above situations applies. Non-ASO members may not be excluded under this guideline. Federal government instructions and guidance supersede the requirements in this guideline.

Exclusion of these members must be reviewed with the auditor, and contracts should be provided to the auditor to review and approve the exclusion. If ASO and self-insured members are excluded, they must also be excluded from HEDIS/CAHPS and from Accreditation.

**Membership Changes****General Guideline: Members Who Switch Organizations**

Members who switch to different organizations or to a sister organization may be counted as continuously enrolled if they joined an organization that assumes ownership of or responsibility for members’ administrative data and medical records for the entire period of continuous enrollment specified in the measure.

If an organization reports these members as continuously enrolled, it follows the definition of “continuous enrollment” in General Guideline *Continuous Enrollment*, and all other guidelines affecting continuous enrollment (allow switching between products [HMO, POS, PPO, EPO] or product lines [Medicaid, commercial, Medicare]) consistently, across all measures.

### **General Guideline: Members Who Switch Organizations as a Result of a Merger or Acquisition**

<b>Measures with a continuous enrollment period</b>	Members who switch organizations because of a merger that occurred during the measurement year may be counted as continuously enrolled.
<b>Measures without a continuous enrollment period</b>	The surviving organization may include members from the non-surviving entity in the initial population, starting on the official date of the merger or acquisition. For example, if the merger or acquisition occurred on March 1 of the measurement year, the surviving organization excludes members acquired from the non-surviving entity from the initial population for January and February.

This guideline must be used consistently across all measures.

### **General Guideline: Members Who Switch Products/Product Lines**

<b>Measures with a continuous enrollment requirement</b>	Members who enrolled in different products or product lines in the time specified for continuous enrollment for a measure are continuously enrolled, and are included in the product and product-line specific HEDIS report in which they were enrolled as of the end of the continuous enrollment period. For example, a member enrolled in the Medicaid product line who switches to the commercial product line during the continuous enrollment period is reported in the commercial HEDIS report. If a measure allows a gap at the end of the continuous enrollment period, report members in the product and product line-specific HEDIS report in which they were enrolled as of the last enrollment segment.  Members who “age in” to a Medicare product line mid-year are considered continuously enrolled if they were members of the organization through another product line (e.g., commercial) during the continuous enrollment period and their enrollment did not exceed allowable gaps. The organization must use claims data from all products/product lines, even when there is a gap in enrollment.
<b>Measures without a continuous enrollment requirement</b>	Members who enrolled in different products or product lines are reported in the product and product line-specific HEDIS report in which they were enrolled on the date of service (visits) or date of discharge (inpatient stays).

## **Required Enrollment Periods and Benefits**

### **General Guideline: Continuous Enrollment**

**Continuous enrollment** specifies the minimum amount of time that a member must be enrolled in an organization before becoming eligible for a measure. It ensures that the organization has enough time to render services. The continuous enrollment period and allowable gaps are specified in each measure.

To be considered continuously enrolled, a member must also be continuously enrolled with the benefit specified for each measure (e.g., pharmacy or mental health), accounting for any allowable gap.

A **gap** is the time when a member is not covered by the organization (i.e., the time between disenrollment and reenrollment). For example, if a member disenrolls on June 30 and reenrolls on July 1, there is no gap, because the member is covered by the organization on both June 30 and July 1. If the member disenrolls on June 30 and reenrolls on July 2, there is a 1-day gap because the member is without coverage on July 1.

An **allowable gap** can occur any time during continuous enrollment. For example, the Child and Adolescent Well-Care Visits measure requires continuous enrollment throughout the measurement year (January 1–December 31), and allows one gap in enrollment of up to 45 days. A member who enrolls for the first time on February 8 of the measurement year is considered continuously enrolled as long as there are no other gaps in enrollment throughout the remainder of the measurement year. The member has one 38-day gap (January 1–February 7).

If a measure requires a member to be enrolled and have a benefit on a specific date, the allowable gap must not include that date; the member must also have the benefit on that date. For example, a 70-year-old member who has only one gap in enrollment from November 30 through December 31 of the measurement year is not eligible for the Osteoporosis Screening in Older Women measure. Although the member meets the continuous enrollment criteria, they do not meet the allowable gap criterion, which requires enrollment as of the last day of the measurement year.

### **General Guideline: Medicaid Continuous Enrollment**

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If the organization applies a full-month eligibility criterion to Medicaid beneficiaries and verifies enrollment prospectively in monthly intervals (in 1-month increments), the one gap in enrollment during the continuous enrollment period may not exceed 45 days. For example, a member whose coverage lapses for 2 months (60 days) is not considered continuously enrolled.

If the organization is notified of prospective member enrollment, use the actual date of enrollment to calculate continuous enrollment, not the notification date.

**Retroactive  
eligibility**

The elapsed time between the actual date when the organization became financially responsible for the Medicaid member and the date when it received notification of the new member. For measures with a continuous enrollment requirement, members may be excluded if the retroactive eligibility period exceeds the allowable gap requirement. This guideline must be used consistently across all measures.

### **General Guideline: Continuous Enrollment Over Multiple Years**

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Unless otherwise specified, for measures that span more than 1 year, members are allowed one gap in enrollment of up to 45 days during each year of continuous enrollment. A gap in enrollment that extends over multiple years of a continuous enrollment period may exceed 45 days. For example, in the Statin Therapy for Patients With Cardiovascular Disease measure (which requires 2 years of continuous enrollment), a member who disenrolls on November 30 of the year prior to the measurement year and reenrolls on February 1 of the measurement year is considered continuously enrolled as long as there are no other gaps in enrollment during either year. The member has one gap of 31 days (December 1–31) in the year prior to the measurement year and one gap of 31 days (January 1–31) in the measurement year.

### General Guideline: Required Benefits

HEDIS measures evaluate performance and hold organizations accountable for services provided in their members' benefits package. Measure specifications include benefits (medical, pharmacy, mental health, chemical dependency) required during the continuous enrollment period. HEDIS measures do not define benefits at the service level (e.g., if the organization offers a pharmacy benefit but does not cover a specific medication class, the member has a pharmacy benefit and is included in the applicable measures requiring this benefit, similarly if the member has partial coverage of mental health services (either by service or diagnosis), they are included as having a mental health benefit). Organizations must assess benefits first at the organization level and then at the individual member level using continuous enrollment data.

<b>...at the organization level</b>	<p>Organizations report HEDIS measures requiring a specific benefit provided to members directly or through a contractor.</p> <p>Organizations are not required to report HEDIS measures specifying a benefit that it does not offer.</p> <p>Before reporting a measure specifying a benefit, the organization must be able to determine if a member has the required benefit.</p> <p>If the organization does not offer the benefit, the plan does not report the measure and receives an NB (No Benefit) audit designation. No member assessment is necessary.</p>
<b>...at the member level</b>	<p>Members who do not have a specified benefit are not counted in the measure. For example, exclude members without a pharmacy benefit from the <i>Pharmacotherapy for Opioid Use Disorder</i> measure. When members are dual enrolled, organizations must assess the benefit requirements based on the submission in which the member is included, refer to General Guideline <i>Members With Dual Enrollment</i>.</p>
<b>Exhausted benefits (optional)</b>	<p><i>For measures without a continuous enrollment criterion</i>, include only services or procedures that occurred while the member had a benefit. For a member whose benefit is lost or exhausted during the time specified in the measure, include services or procedures that occurred while the member had the benefit.</p> <p><i>For measures with a continuous enrollment criterion</i>, the required benefits must be active for the period of continuous enrollment, accounting for any allowable gap. Exclude a member if the period when the benefit is exhausted exceeds any allowable gap. For example, the Osteoporosis Screening in Older Women measure requires a pharmacy benefit during the measurement year and the year prior to the measurement year. Exclude a member whose pharmacy benefit is exhausted in September of the measurement year, because this exceeds the 45-day allowable gap period.</p>
<b>Carved-out benefits (optional)</b>	<p>Some organizations can obtain the necessary information from a carved-out entity and may include these members in their measures. For example, an employer contracts directly with a pharmacy benefit manager (PBM), which shares pharmacy information with the organization. The employer's members may be included in the measure.</p>

This guideline must be used consistently across all measures.

### **General Guideline: Accessing Medical Records Prior to Enrollment**

Data that can be accessed from a medical record are used to calculate a measure. If data from a medical record cannot be accessed because data were updated before the member was enrolled, the organization calculates the measure with the data that are available.

### **HEDIS Data Submission and Reporting**

#### **General Guideline: HEDIS Reporting Date**

For HEDIS MY 2026, all organizations reporting audited data to NCQA through the IDSS must submit data on or before **June 15, 2027**.

**Note:** Organizations must submit and “plan-lock” audited HEDIS data to allow auditors sufficient time to review, approve and audit lock all submissions by the June 15 deadline. For HEDIS MY 2026 reporting, organizations are required to “plan-lock” audited HEDIS data no later than **June 1, 2027**.

### **Data Collection Methods and Data Sources**

#### **General Guideline: Data Collection Methods**

HEDIS measures are specified for one or more data collection methods:

- Administrative Method.
- Hybrid Method.
- Survey Method.
- Electronic Clinical Data Systems (ECDS) Method.

Each measure specifies the data collection methods that must be used. If a measure includes both the Administrative and Hybrid Methods, either method may be used.

<b>Administrative Method</b>	Transaction data or other administrative data are used to identify the initial population, denominator exclusions, denominator and numerator. The reported rate is based on all members who meet the denominator criteria and who are found through administrative data to have received the service required for the numerator.
<b>Hybrid Method</b>	Organizations look for numerator compliance in both administrative and medical record data. The hybrid denominator consists of a systematic sample of members drawn from the measure’s administrative denominator. <sup>2</sup> Organizations review administrative data to determine if members in the systematic sample received the service and review medical record data for members who do not meet the numerator criteria through administrative data. The reported rate is based on members in the sample who received the service required for the numerator.
<b>Survey Method</b>	Requires organizations to collect data through a survey. Specifications for survey measures are included in <i>HEDIS Volume 3: Specifications for Survey Measures</i> and <i>HEDIS Volume 6: Specifications for the Medicare Health Outcomes Survey</i> .

<sup>2</sup>For hybrid reported measures, the administrative denominator is not a reported data element, but equals the initial population minus exclusions.

**ECDS Method**

Measures reported using ECDS are specified for the electronic method of data collection.

Data sets for ECDS reporting must contain data that have been structured to be able to be queried by a HEDIS digital quality measure (dQM). Each electronic data source used for HEDIS ECDS reporting must have:

- Policies and procedures for establishing and maintaining database management systems.
- Standard layout requirements.
- An automated process for extraction, transformation and loading of all data elements to the master file.

The proof-of-service and validation requirements are outlined in *General Guideline: Supplemental Data*.

Administrative and non-administrative data may be used to identify the initial population.

To qualify for HEDIS ECDS reporting, data must use standard layouts, meet the measure's technical specification requirements and be accessible by the care team upon request. Organizations meet this requirement if they can provide the requested information (e.g., phone, secure email, direct feed, provider portal, file request) to providers. Organizations should have documented processes for tracking these requests, to be reviewed as part of the HEDIS audit.

Practitioners or practitioner groups that are accountable for clinical services provided to individuals must not be prevented from accessing data used by an organization for quality measure reporting.

Organizations may use several data sources to provide complete information about the quality of health services. Data systems that may be eligible for HEDIS ECDS reporting include, but are not limited to, member eligibility files, EHRs, personal health records (PHR), clinical registries, health information exchanges (HIE), administrative claims systems, electronic laboratory reports (ELR), electronic pharmacy systems, immunization information systems (IIS) and disease/case management registries.

The data in these systems come in a variety of formats. The format type determines how the source is audited. Self-reported services are acceptable if the information is recorded, dated and maintained in the legal health record.

The self-reported data must follow *General Guideline: Self-Reported Services and Biometric Values*.

**Note**

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- For administrative and hybrid methods, supplemental data are considered an administrative data source; however, for the EOC measures and Utilization measures similar to EOC (W30 and WCV), numerator events identified using supplemental data are reported separately from numerator events identified by administrative (claims/ encounter) and medical record data, as indicated in the applicable Data Elements for Reporting tables.
- For administrative and hybrid methods, any data found in a supplemental data source are considered a supplemental data hit if the person would not be compliant for the measure/indicator without the data source. If supplemental data are not used, report zero in the "Numerator events by supplemental data" element. For all other measures, numerator events identified using supplemental data are

reported in the “Numerator events by administrative data” element. Refer to [General Guideline: Supplemental Data](#).

- For the Transitions of Care measure, there are two numerators where administrative reporting is not available; only medical record data or supplemental data may be used. Supplemental data must include all elements required by the measure’s hybrid specifications for these indicators; once they are validated, the organization must determine how to integrate the results for reporting. Organizations should work with their vendors and the process should be reviewed and approved by the auditor. Supplemental data for Notification of Inpatient Admission and Receipt of Discharge Information indicators must be reported in the “Numerator events by supplemental data” data element in IDSS.

### **General Guideline: Supplemental Data**

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<b>Supplemental data uses</b>	Organizations may find information about services in administrative data, medical records and other data sources. When evidence to support the measure is found in multiple data sources, a hierarchy is applied. Supplemental data are considered last as long as the specifications are followed as written (e.g., if the organization uses a combination of data sources to identify the Glycemic Status <8.0% indicator in the Glycemic Status Assessment for Patients With Diabetes measure, the most recent test must be used, regardless of data source).
<b>For administrative-only measures, medical record data are considered supplemental data.</b>	
<b>Supplemental data may help determine:</b>	<ul style="list-style-type: none"><li>• Numerators that are labeled as <i>numerators</i> in the specification.</li><li>• Persons in hospice and persons who have died.</li><li>• Exclusions that are labeled as <i>denominator exclusions</i> in the specification.</li></ul>
<b>Supplemental data may not be used for:</b>	<ul style="list-style-type: none"><li>• Initial population events. Organizations may not create and use records to identify initial population events, other than for denominator exclusions.</li><li>• Clinical conditions that change. Organizations may not create and use records, on an ongoing basis, for exclusions for clinical conditions that change.</li><li>• Correcting bills or identifying valid data errors. Organizations may not use supplemental data to adjust incorrect billing practices or to identify valid data errors. This practice results in a change in claims data and is not allowed.</li><li>• Measures where the specification specifically indicates supplemental data cannot be used, except for applying the hospice exclusion and the death exclusion.</li></ul>

#### **Supplemental Data Definitions**

The auditor determines the classification of all supplemental data, not the organization.

**Standard supplemental data** Electronically generated files that come from service providers (providers who rendered the service). Production of these files follows clear policies and procedures; standard file layouts remain stable from year to year.

**Audit requirements.** Standard supplemental data are not required to be accompanied by proof-of-service documents and the audit does not require primary source verification, unless requested by the auditor.

**Note:** Prior years' validated historic hybrid medical record result files are loaded as administrative data.

**Nonstandard supplemental data** Data used to capture missing service data not received through administrative sources (claims or encounters) or in the standard electronically generated files described above, whether collected by a plan, an organization, a provider or a contracted vendor. These types of data might be collected from sources on an irregular basis and could be in files or formats that are not stable over time.

Organizations must have clear policies and procedures that describe how the data are collected and by whom, how they are validated and used for HEDIS reporting.

Organizations *may not* conduct phone calls to individuals or providers to collect information about services already rendered.

**Audit requirements.** All nonstandard supplemental data must be substantiated by proof-of-service documentation from the legal health record. Proof-of-service documentation is required for only a sample, selected by the auditor, as part of the audit's annual primary source verification.

Proof-of-service documentation that *is allowed* for primary source verification:

- A copy of the information from the individual's chart from the service provider or the PCP.
- A copy of the clinical report or clinical summary from the visit for service, such as lab or radiology reports (i.e., forms from the rendering provider proving the service occurred).
- A screen shot of:
  - Online EHR records.
  - State- or county-sponsored immunization registry records.

Proof-of-service documentation that is *not allowed* for primary source verification:

- Surveys. Organizations and providers may not use information obtained from surveys or other documents completed by the individual, except for data collected for Language Description of Membership and Race/Ethnicity Description of Membership.
- Phone calls. Recorded phone calls to collect information about services rendered are not proof of service.

**CCDs** Continuity of Care Documents. CCDs are used for the electronic exchange of clinical data without loss of meaning. The files provide a summary of a patient's care as a snapshot in time, but they are not a replacement for an EHR. These files are typically XML-based and are considered nonstandard supplemental data for at least the first year of use. The organization must demonstrate the accuracy of these (through PSV) to ensure that the data in the file match the EHR. This data source must meet both criteria:

- There is completed Roadmap documentation.
- The Roadmap must include a description of how the CCD is created and by whom (e.g., produced by the provider in the office and sent to the plan or created by a vendor), the validation process and how the data are transmitted.

**Audit requirements.** The auditor confirms that the data meet all requirements. Primary source verification is required (e.g., go back to each unique EHR) to validate the CCDs' accuracy. This level of validation is required for at least the first year, or the first submission by the EHR, but may continue in subsequent years until the auditor is certain the data are accurate, reliable and unchanged.

**NCQA DAV data** For data from an NCQA-Validated Data Aggregator Validation (DAV) entity, the auditor must:

- Receive completed Roadmap documentation from the reporting entity using the data. The Roadmap must explain how data from the validated DAV entity are transferred in an outbound file to the organization, and what is done to the data. No documentation is required from the DAV validated entity unless the entity processes the validated CCD.
  - If the validated CCD is processed in any way after receipt, the auditor may (but is not required to) perform secondary source validation (SSV): examine processed data back to the validated and conformed CCD files. SSV does not include PSV back to the original source on any of these data sources. PSV is not to be performed.
- Note: This applies only to CCDs.
- If the reporting entity receives validated data formatted using FHIR standards from the DAV entity, the conformed data formatted using FHIR standards cannot be processed in any way. Processing the data formatted using FHIR standards to another format compromises the DAV status.
- Receive the final validation report of validated data cases and clusters, and the date when they were validated.
- Refer to NCQA's Data Aggregator Validation [directory](#) to ensure that the NCQA validated entity is approved to share validated data. Organizations with a "Validated Data Stream" evaluation product with a validated status and expiration date may share data and contribute to reducing audit burden. Organizations with a "Certified Data Partner" evaluation product may not share data.

Data from ingestion sites or clusters that failed validation may not be shared as standard supplemental data. These data are considered nonstandard supplemental data, and must be audited accordingly.

### Required Data Elements

<b>Standard supplemental data</b>	Organizations must have policies and procedures for using data files as standard supplemental data. Data files must have standard file layouts, standard data fields and industry standard codes, and must include all elements required by measure specifications, including payment status when applicable, and evidence that tests or services were performed and not merely ordered.
<b>Nonstandard supplemental data</b>	Nonstandard supplemental data must have all data elements required to meet criteria specified by the measure specifications, including: <ul style="list-style-type: none"><li>• Payment status when applicable.</li><li>• Evidence that tests or services were performed, not just ordered.<ul style="list-style-type: none"><li>– When data are abstracted from medical record sources to be used as supplemental data, codes alone (without additional documentation of</li></ul></li></ul>

the service provided) do not meet criteria for proof of service. If a provider performs a service, it is expected that there is additional documentation in the medical record or in the primary source document. Auditors must validate, through primary source verification, all elements required by the measure specification.

- Evidence of provider accountability from the practitioner or practitioner group (signed contracts with accountability tied to passwords, signatures or TIN/NPI data). For home visits, if clinical services are rendered, there must be evidence of accountability by the practitioner, and at a minimum include the date, name and signature on each in-home form. Documentation of the practitioner's TIN/NPI is not required; however, documentation of TIN/NPI with date, name and signature is preferred.
- More than a simple yes or no attestation on provider forms. Forms must have all necessary data elements and be signed by the rendering practitioner.
- All data elements for a measure must be captured for self-reported services (date and place of service, procedure, prescription, test result or finding, practitioner type). When using supplemental data derived from medical records to meet administrative specifications, documentation must be clinically synonymous with the codes included in the measure's value sets. Refer to [General Guideline: Self-Reported Services and Biometric Values](#).

**All supplemental data**

All proof-of-service documents must show that services were rendered by the deadline established for the measure.

When pharmacy data are classified as supplemental data, all of the following data elements must be present: the generic name (or brand name), strength/dose, route and date when the medication was dispensed or shipped to the person. For mail order prescriptions "shipped date" meets criteria for dispense date. "Start date" documented in the medical record does not meet criteria. Data elements must map to a medication listed in the Medication List Directory to be eligible for use. Generic documentation in the medical record (e.g., that a patient "was prescribed" or "is taking" a medication) that does not include drug name, strength/dose and dispense date does not meet criteria.

All supplemental data used to show eligibility for exclusions must follow the requirements for exclusions in each measure.

***Supplemental Data Timeline***

Supplemental data may be collected during the measurement year and into the beginning of the reporting year. Supplemental data collection and use must adhere to all applicable deadlines in the Audit Timeline posted on NCQA's website on March 31, 2026.

***Identifying and Validating Supplemental Data***

All supplemental data (standard and nonstandard) must be identifiable. Because supplemental data can affect reporting and incentives, plans or vendors that use supplemental data for HEDIS reporting must mark the data files, regardless of the source. Auditors must be able to assess the contribution of each supplemental data source to the applicable components of the measure (numerator events or appropriate exclusions).

Auditors must review all supplemental data annually—there are no exceptions. At a minimum, the annual review includes the following for each supplemental data source:

- Completed HEDIS Roadmap documentation.
- Impact of supplemental data source by measure (e.g., lists of numerator-positive hits from the supplemental data, by measure; year-to-year comparisons of percentage increases associated with supplemental data; proportion of numerator compliance from supplemental data).
- Primary source verification where required or requested by the auditor.

Supplemental data that do not pass all audit validation steps by the deadline may not be used to calculate HEDIS rates. Organizations may wait to load supplemental data until primary source verification is complete and the source is approved.

For additional information about audit requirements for supplemental data, refer to *Volume 5, HEDIS Compliance Audit: Standards, Policies and Procedures*.

### ***General Guideline: Which Services Count?***

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Each measure has its own requirements for using transactional data and administrative claims to report measure components. Information on which services count are located in the measure's *Guidance* section.

If a measure requires that all paid, suspended, pending and denied claims be used for reporting, report all services, whether or not the organization paid for them. For example, report services paid for by a third party, such as a community center, or services for which payment was denied because they were not authorized.

*Count the service as paid or expected to be paid if:*

- The organization paid the full amount **or** a portion of the amount.
- The member paid for the service as part of the benefit offering (e.g., to meet a deductible), **or**
- The service was covered under a PMPM payment.

*Count the service as denied if:*

- The organization denied the service for any reason, unless the member paid for the service as part of the benefit offering (e.g., to meet a deductible), **or**
- The claim for the service was rejected because it was missing information, or was invalid for another reason.

Organizations may decide to include reversed claims when reporting services. If an organization includes reversals, it must include these claims in all measures, and avoid double counting services (e.g., if a subsequent claim is filed, use only the corrected or adjudicated claim).

### ***General Guideline: Obtaining Information for the Systematic Sample***

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Organizations (and their contractors) that use the Hybrid Method are responsible for determining compliance with HEDIS measurement specifications. Information may be abstracted from the member's legal health record by designated medical record review (MRR) staff. Abstraction of data for members in the systematic sample is performed by entities or vendors who adhere to training, policies and procedures, use of appropriate tools, oversight and all other audit components.

MRR abstractors count a service if the legal health record contains the date of the service and evidence that the service occurred. All services must be rendered and documented in the medical record by the deadline established in the measure.

Organizations must be able to determine that a test or service was *performed* within the time frame specified, not merely ordered. Only completed events count toward HEDIS compliance. Documentation in a medical record of a diagnosis or procedure code alone does not comply with the numerator criteria.

Processes used to determine the validity and integrity of abstracted data, including interrater reliability, quality control and rater-to-standard results, are reviewed by the certified HEDIS Compliance Auditor.

<b>Data refresh for the systematic sample</b>	<p>Because NCQA requires that the systematic sample be stable and reproducible, organizations may not change the sample after it is created. If an organization refreshes the HEDIS repository after the sample is drawn and chart review is in progress, it should follow the guidelines below to use the newer administrative data for all hybrid measures.</p> <p>The InitialPopulation, NumeratorByAdminDenom and Exclusions data elements should be locked after the sample is pulled; the MRSS is fixed, and these administrative data elements must not change during an administrative data refresh.</p> <p>Exclusions found through administrative data in a data refresh must be reported in the “ExclusionValidDataErrors” data element. Members identified as valid data errors must be reported in the InitialPopulation data element, but are removed from the sample.</p> <p><b>Note:</b> Organizations may elect to refresh data for administrative-only measures, but must apply the refresh to all applicable measures.</p>
<b>Manually updating the sample</b>	<p>Organizations may compare only the numerator-negative members in the sample to screen shots of the refreshed data; they are not required to update every measure manually or to reassess denominator compliance for every member in the sample.</p> <p>Records used for numerator compliance are subject to medical record review validation.</p>
<b>Automated updates to the sample</b>	<p>Organizations may use an automated process that loads the entire sample for each measure and compares it to the refreshed data. All data must be used consistently in the samples.</p> <ul style="list-style-type: none"><li>• If recent data contradict numerator compliance, those data must be used.</li><li>• If recent data exclude a member, those data must be used and the oversample must provide a substitute member.</li><li>• If the oversample is exhausted, the organization must use the Sampling Guidelines to ensure meeting the minimum required sample size (MRSS) is possible.</li><li>• The auditor must review and approve the timing, processes and results of the refresh, but does not need to include the records used for numerator compliance in the medical record review validation.</li></ul>

## General Guideline: Race and Ethnicity Stratifications

This guideline provides instructions on how organizations categorize Medicare, Medicaid and commercial members by the race and ethnicity stratification (RES) when it is included in a measure.

<b>Reporting categories</b>	<p>NCQA requires reporting race and ethnicity as defined by the Office of Management and Budget (OMB) 1997 and 2024 Standards for Maintaining, Collecting, and Presenting Federal Data on Race and Ethnicity, and best practices identified in the March 2024 updates.<sup>3,4</sup></p>
	<p>Race and ethnicity values must be rolled up into the OMB categories specified in this guideline. NCQA supports efforts to collect data that are more detailed than the minimum OMB reporting categories. If more detailed race and ethnicity data are collected, data must be aggregated and reported in the categories provided. For health plans using the CMS classification scheme for race and ethnicity, refer to Table RES-A-1/2/3 for a crosswalk to HEDIS reporting. Report member race and ethnicity separately. If a combined race/ethnicity category question is used to collect data, data must be disaggregated, and race and ethnicity categories must be reported separately. When using the combined race/ethnicity data format for collection, refer to Table RES-B-1/2/3 for a crosswalk of reporting categories.</p>
	<p>Tables RES-C-1/2/3 and RES-D-1/2/3 crosswalk the HEDIS reporting categories to code values specified by the Race and Ethnicity extensions of the HL7 US Core Implementation Guide. Organizations must use or map to the documented direct reference codes and value sets described here. Code values originate from two code systems:</p> <ul style="list-style-type: none"><li>• “Race &amp; Ethnicity – CDC” (CDCREC) is used to report race and ethnicity categories.</li><li>• “Asked But No Answer” and “Unknown” use the HL7 version 3 NullFlavor code system.</li></ul>
<b>Determining race reporting category</b>	<p>For each product line, report members in only one of the ten race stratifications listed below and the total.</p>
	<ul style="list-style-type: none"><li>• <i>American Indian or Alaska Native</i>: Identification with any of the original peoples of North, Central and South America. Examples of these groups include, but are not limited to, people who identify as “American Indian” or “Alaska Native” and includes groups such as Navajo Nation, Blackfeet Tribe of the Blackfeet Indian Reservation of Montana, Native Village of Barrow Inupiat Traditional Government, Nome Eskimo Community, Aztec and Maya.</li><li>• <i>Asian</i>: Identification with one or more nationalities or ethnic groups originating in any of the original peoples of Central, East, Southeast or South Asia. Examples of these groups include, but are not limited to, Chinese, Asian Indian, Filipino, Vietnamese, Korean, Japanese, Pakistani, Cambodian, Hmong, Thai, Bengali and Mien.</li><li>• <i>Black or African American</i>: Identification with one or more nationalities or ethnic groups originating in any of the Black racial groups of Africa.</li></ul>

<sup>3</sup>Office of Management and Budget Revisions to the Standards for the Classification of Federal Data on Race and Ethnicity. <https://www.govinfo.gov/content/pkg/FR-2024-03-29/pdf/2024-06469.pdf>

<sup>4</sup>OMB Statistical Policy Directive No. 15 on Race and Ethnicity Data Standards: Categories and Definitions: <https://spd15revision.gov/content/spd15revision/en/2024-spd15/categories-definitions.html>

Examples of these groups include, but are not limited to, African American, Jamaican, Haitian, Nigerian, Ethiopian, Somali, Ghanaian, South African, Barbadian, Kenyan, Liberian and Bahamian.

- *Middle Eastern or North African*: Identification with one or more nationalities or ethnic groups originating in the Middle East or North Africa. Examples of these groups include, but are not limited to, Lebanese, Iranian, Egyptian, Syrian, Iraqi and Israeli.
- *Native Hawaiian or Pacific Islander*: Identification with one or more nationalities or ethnic groups originating in Hawaii, Guam, Samoa, or other Pacific Islands. Examples of these groups include, but are not limited to, Native Hawaiian, Samoan, Chamorro, Tongan, Fijian, Marshallese, Palauan, Tahitian, Chuukese, Pohnpeian, Saipanese and Yapese.
- *White*: Identification with one or more nationalities or ethnic groups originating in Europe. Examples of these groups include, but are not limited to, English, German, Irish, Italian, Polish, Scottish, French, Slavic and Cajun.
- *Some Other Race*: People whose race information has been collected but does not fit into any of the specified race categories.
- *Two or More Races*: People with any combination of races, including "Some Other Race."
- *Asked But No Answer*: People who the organization asked to identify race but who declined to provide a response.
- *Unknown*: People for whom the organization did not obtain race information and for whom the organization did not receive a declined response ("Asked But No Answer").
- *Total*: Total of all categories above.

#### Determining ethnicity reporting category

For each product line, report members in only one of the four ethnicity stratifications listed below and the total.

- *Hispanic or Latino*: Identification with one or more nationalities or ethnic groups originating in Mexico, Puerto Rico, El Salvador, Cuba, Dominican Republic, Guatemala and other Central and South American countries and other Spanish cultures. Examples of these groups include, but are not limited to, Mexican or Mexican American, Puerto Rican, Salvadoran, Cuban, Dominican, Guatemalan and Colombian.
- *Not Hispanic or Latino*: People not of Hispanic, Latino or Spanish culture or origin.
- *Asked But No Answer*: People who the organization asked to identify ethnicity but who declined to provide a response.
- *Unknown*: People for whom the organization did not obtain ethnicity information and for whom the organization did not receive a declined response ("Asked But No Answer").
- *Total*: Total of all categories above.

<b>Data source</b>	<p>Reporting the data collection source is only required for the Race/Ethnicity Description of Membership (RDM) measure.</p> <p>Approved data sources include data collected directly from members and data obtained through imputation methods. In cases where a plan has a race or ethnicity value but no data source, the plan must report using the “Unknown” data source category. In cases where the race or ethnicity value and the source are missing, plans must record this as no data. NCQA strongly encourages plans to report directly collected data when available and emphasizes the importance of improving completeness of directly collected member race and ethnicity data. Additionally, NCQA strongly encourages plans to track the source of their race and ethnicity data in order to facilitate valid disparities assessments.</p> <p>For the RDM measure, plans will report each race and ethnicity value by data source. Plans will report the number of members from the direct, imputed, unknown and no data source categories. IDSS will calculate the direct total for source and the total for the measure.</p> <p>Supplemental data may be used as a data source for the race and ethnicity stratification.</p>
<b>Direct data</b>	<p>Data collected directly from members method reflects members’ self-identification and is the preferred data source.</p> <p>Directly collected data include any source for which the member self-identified race or ethnicity. This includes member self-reported data collected directly from members under the full control of the health plan (i.e., no data were obtained through an intermediary), as well as third-party data collected directly from a member by another entity (e.g., the state, CMS, Health Information Exchanges [HIE] or clinical feeds). Direct sources may include, but are not limited to:</p> <ul style="list-style-type: none"><li>• Surveys.</li><li>• Health risk assessments.</li><li>• Disease management registries.</li><li>• Case management systems.</li><li>• EHRs.</li><li>• CMS/state databases.</li><li>• Enrollment information furnished by enrolling entities (e.g., state Medicaid agencies, employers).</li><li>• CCDs.</li><li>• HIEs.</li></ul>
	<p><i>Note: The “Asked But No Answer” category is only reported using direct data.</i></p> <p><b>Imputed data</b> Plans may choose to report race and ethnicity data supplemented by imputed methods. Imputed assignment of race and ethnicity values include using an alternate data source (e.g., nationally representative data obtained from databases like the American Community Survey) to assign a race or ethnicity value to a member based on their primary location of residence. Some commonly used imputed methods combine geographic data with additional imputation methods such as surname analysis.</p>

NCQA reiterates that directly collected race and ethnicity is considered the gold standard and is highly preferred to imputed race and ethnicity. For plans choosing to use imputed methods to report the HEDIS race and ethnicity stratification, NCQA emphasizes the following:

- When applying imputed methods that involve assignment of race or ethnicity based on geographic data and member's location of residence, the smallest geographic unit possible is preferred. For example, geographic assignment at the census block level is likely to be more accurate than assignment using census tract or ZIP code-level data.
- Imputed data sources and methods should be evaluated for reliability and validity and selection of a source and method should be prioritized based on demonstrated validity and reliability for the population in which it will be applied (e.g., age group, geography, product line).
- Imputed methods of race and ethnicity assignment are to be used for population-level reporting and analysis but are not appropriate for member-level intervention.

<b>Unknown data</b>	When the reported value for race or for ethnicity is known, but the source is unknown (i.e., cases where an organization has a race or ethnicity value on file from a legacy system but does not know the source).
<b>No data</b>	When both the race or ethnicity value and the source are missing.
	<i>Note: The “Unknown” category is only reported using the “No Data Source” category because unknown values cannot be attributed to a particular data source.</i>
<b>Sampling</b>	For measures collected using the Hybrid Method with the race and ethnicity stratification, follow the guidelines for sampling outlined in <i>Guidelines for Calculation and Sampling Guidelines for the Hybrid Method</i> . The race and ethnicity stratifications are applied to the denominator after hybrid sampling.
<b>Reporting</b>	Reporting of the race and ethnicity stratification follows the parameters for denominator size outlined in <i>General Guideline: Reporting</i> .

Table RES-A-1/2/3: CMS Categories Crosswalked to HEDIS/OMB Race and Ethnicity

CMS Category	HEDIS/OMB Race	HEDIS/OMB Ethnicity
American Indian/Alaska Native	American Indian or Alaska Native	Unknown
Asian/Pacific Islander	Asian	Unknown
Black	Black	Unknown
(No equivalent category)	Middle Eastern or North African	Unknown
White	White	Unknown
Hispanic	Unknown	Hispanic or Latino
Other	Some Other Race	Unknown
Unknown	Unknown	Unknown
(No equivalent category)	Native Hawaiian or Pacific Islander	Unknown
(No equivalent category)	Two or more races	Unknown

**Table RES-B-1/2/3: Combined Categories Crosswalked to HEDIS/OMB Race and Ethnicity**

Race/Ethnicity Combined Category (examples) <sup>5</sup>	HEDIS/OMB Race	HEDIS/OMB Ethnicity
American Indian/Alaska Native	American Indian or Alaska Native	Not Hispanic or Latino
Asian	Asian	Not Hispanic or Latino
Black	Black	Not Hispanic or Latino
Middle Eastern or North African	Middle Eastern or North African	Not Hispanic or Latino
Native Hawaiian or Pacific Islander	Native Hawaiian or Pacific Islander	Not Hispanic or Latino
White	White	Not Hispanic or Latino
Hispanic/Latino	Some Other Race	Hispanic or Latino
Hispanic/Latino/Black	Black	Hispanic or Latino
Hispanic/Latino/White	White	Hispanic or Latino
Other	Some Other Race	Unknown
Multiple races marked	Two or More Races	Unknown
Unknown	Unknown	Unknown

**Table RES-C-1/2/3: HEDIS/OMB Race Crosswalked for Use With HEDIS Reporting Categories**

HEDIS/OMB Race	CDCREC OMB Category: Direct Reference Code*	CDCREC Detailed Category: Value Set
American Indian or Alaska Native	1002-5	<u>American Indian or Alaska Native</u> <u>Detailed Race Value Set</u>
Asian	2028-9	Asian Detailed Race Value Set
Black	2054-5	<u>Black or African American Detailed</u> <u>Race Value Set</u>
Middle Eastern or North African	NA	<u>Middle Eastern or North African</u> <u>Detailed Race Value Set</u>
Native Hawaiian or Pacific Islander	2076-8	<u>Native Hawaiian or Pacific Islander</u> <u>Detailed Race Value Set</u>
White	2106-3	White Detailed Race Value Set
Some Other Race	2131-1	NA
Two or More Races	NA***	NA
Asked But No Answer	ASKU**	NA
Unknown	UNK**	NA

\*Codes to identify race and ethnicity are from the CDC Race and Ethnicity code system developed by the U.S. Centers for Disease Control and Prevention (CDC). They resemble, but are not, LOINC codes.

\*\*HL7 v3 Code System NullFlavor.

\*\*\*This value is defined by the measure calculation logic as the presence of two or more distinct CDCREC category codes and does not map to a specific direct reference code or value set.

<sup>5</sup> Does not reflect the full set of possible combinations but provides examples of how categories should be handled when a combined data collection question is used.

**Table RES-D-1/2/3: HEDIS/OMB Ethnicity Crosswalked for Use With HEDIS Reporting Categories**

HEDIS/OMB Race	CDCREC OMB Category: Direct Reference Code*	CDCREC Detailed Category: Value Set
Hispanic or Latino	2135-2	Hispanic or Latino Detailed Ethnicity
Not Hispanic or Latino	2186-5	NA
Asked But No Answer	ASKU**	NA
Unknown	UNK**	NA

\*Codes to identify race and ethnicity are from the CDC Race and Ethnicity code system developed by the U.S. Centers for Disease Control and Prevention (CDC). They resemble, but are not, LOINC codes.

\*\*The NullFlavor concepts “Asked But No Answer” and “Unknown” are not included in the terminology binding for the US Core Ethnicity FHIR extension on which this digital logic is structured. NCQA allows these concepts to express ethnicity data to align with bound values for the US Core Race extension.

### Note

- Race and ethnicity are social constructs, not biological; stratifying HEDIS measures by race and ethnicity is intended to further understanding of racial and ethnic disparities in care and to hold health plans accountable to address such disparities, with the goal of achieving equitable health care and outcomes. Data are not to be used to further bias in health care or to suggest that race and ethnicity are biological determinants of health.*
- When multiple sources of data are used for race and ethnicity, there may be disagreements in the data collected. When this happens, data sources should be prioritized based on evaluation of anticipated accuracy. This includes use of specific categories over nonspecific categories, most frequent or consistently reported category and selection of data with clear provenance (source, method of collection) over data without clear provenance. Known data sources should be prioritized over unknown data sources, and data collected directly by the organization should be prioritized over all other data sources.*
- Race and ethnicity data may come from different categories of data source (direct, imputed, unknown, no data). In such cases, use the data source that applies to the data element (race, ethnicity). If the same data element is received from two different data sources, prioritize data sources based on the second bullet above.*

### General Guideline: Medicare Socioeconomic Status Stratifications

- SES stratification** The following measures instruct the organization to categorize Medicare members by socioeconomic status (SES) stratification.
- Breast Cancer Screening.
  - Colorectal Cancer Screening.
  - Eye Exam for Patients With Diabetes.
  - Plan All-Cause Readmissions.

Report Medicare members in only one of the six stratifications listed below. Use the LIS History (LISHIST) file corresponding to the continuous enrollment period to assess if the member meets the definition for the LIS/DE status.

Use the Monthly Membership Detail Data Report (MMDR) file for the Original Reason for Entitlement Code (OREC) Item 48 to determine age and disability status.

Assess continuous enrollment eligibility before assessing SES stratification.

- *Non-LIS/DE, Non-disability:* Member is eligible for Medicare due to age only (does not receive LIS, is not DE for Medicaid, does not have disability status).
- *LIS/DE:* Member is eligible for Medicare due to age and receives LIS (includes members eligible for Medicare due to DE) and does not have disability status.
- *Disability:* Member is eligible for Medicare due to disability status only.
- *LIS/DE and Disability:* Member is eligible for Medicare due to age, receives LIS **and** has disability status.
- *Other:* Member has ESRD-only status or is assigned “9—none of the above.”
- *Unknown:* Member’s SES is unknown. May be >0 only for Puerto Rico plans, or if the auditor approved a small number of unassigned members\*.
- *Total Medicare:* Total of all categories above.

*\*Plans must work with auditors to uncover anomalies early (e.g., during preliminary rate review) and attempt to resolve the cause. Medicare members in Puerto Rico must be counted in the “Unknown” category.*

*Except for plans in Puerto Rico, which report all members in “Unknown,” it is expected that the member count in this category will be at or below 1%. If more than 1% of eligible members are assigned to “Unknown,” the plan must work with the auditor to identify why members are being categorized as “Unknown.”*

Use the SES Stratification Logic table below to determine the member’s stratification at any time during the measure’s continuous enrollment period.

**Table 1: SES Stratifications Logic Using the MMDR (for OREC) and the LISHIST File (for LIS)**

Strata	Logic	Rationale
Non-LIS/DE, Non-disability	No LISHIST record and item 48 = 0	No LISHIST record, no disability status, no ESRD.
LIS/DE	LISHIST record and item 48 = 0	LISHIST record; counts only payments due to age.
Disability	No LISHIST record and item 48 = 1 or 3	No LISHIST record; counts only payments with disability status (code 1 or 3).
LIS/DE and Disability	LISHIST record and item 48 = 1 or 3	LISHIST record; counts only payments with disability status (code 1 or 3).
Other	Item 48 = 2 (ESRD) or 9 (None of the above)	Counts ESRD and 9 (None of the above). LISHIST does not get evaluated if item 48 = 2 or 9.
Unknown	Item 48 = blank	Count members with no values assigned in the MMDR. Subject to auditor review and approval.
Total	Sum of the above.	

### Determining LIS Status

To determine the LIS status, use the monthly LISHIST file. This file provides a comprehensive list of an organization's current LIS membership, with a record for every enrollee who has a subsidy. The data in the record about each beneficiary spans through the most recent 36 consecutive months of contract enrollment. This report also informs organizations whether a beneficiary is LIS in the next calendar year.

The LISHIST file will contain only beneficiaries (past, present and future) who are or were deemed eligible for a low-income subsidy. The file will not show beneficiaries who do not or have not had any LIS periods.

To use the LISHIST file, select the last monthly file issued during the measure's continuous enrollment period. If the member is in the LISHIST file and the "Low Income Period End Date" is blank or falls within the continuous enrollment period, count the member as LIS eligible. If the member has no record in the LISHIST file or their end date is before the continuous enrollment period, count the member as not eligible.

### Determining OREC

To determine the OREC value, select the files in the MMDR issued during the measure's continuous enrollment period, based on the file's run date. Following the guidance in the Logic Table above, use Item 48 in that file to determine the OREC value and count the member in the appropriate SES strata.

*Note: Although it is rare that a beneficiary's OREC value is blank or changes during the continuous enrollment period, if the last month's value is missing, use the last available value during the continuous enrollment period.*

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### General Guideline: Date of Service for Laboratory Tests

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Laboratory tests can have multiple dates of service: an order date (the date when the provider ordered the test), a collection date (the date when the specimen was drawn), a result/reported date (the date when results were calculated and reported), a claim date (the date of service on the claim) and a documented date (the date when the provider documented the result in the medical record).

Order date and documented date are not eligible for use in HEDIS reporting.

For laboratory tests identified using claims data (numerator events by administrative data), use the claim date of service.

When abstracting laboratory tests from the medical record for use in hybrid reporting or for nonstandard supplemental data, the documentation must include the test date and the result (or evidence that the test was performed). The result/reported date may be used as the test date.

Organizations may consider all events with dates no more than 7 days apart to be the same test and may use the collected date for reporting. For example:

- If a sample is collected on December 28 of the measurement year and the result is documented on January 2 of the year after the measurement year, the dates are within 7 days and can be considered the same test. The result is present and the collection date is eligible for use, making the person numerator compliant.
- If a sample is collected on December 28 of the measurement year and the result is documented on January 15 of the year after the measurement year, the dates are not within 7 days and cannot be considered the same test. There is no result for the lead test collected on December 28 and the person is not numerator compliant.
- If a test had a collection date of December 1 and a reported date of December 8, these dates are not more than 7 days apart and can be considered the same test.

- If a test had a collection date of December 1 and a reported date of December 9, these dates are more than 7 days apart and cannot be considered the same test.

### **General Guideline: Collecting Data for Measures With Multiple Numerator Events**

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The following measures require more than one event to satisfy the numerator:

- Adult Immunization Status.
- Childhood Immunization Status.
- Immunizations for Adolescents.
- Topical Fluoride for Children.
- Well-Child Visits in the First 30 Months of Life.

For only the measures listed above, all events must be at least 14 days apart.

For example, the organization may count two influenza vaccines identified through administrative data if the dates of service are at least 14 days apart; if the service date for the first vaccine was February 1, then the service date for the second vaccine must be on or after February 15.

### **General Guideline: Self-Collected Samples**

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Test results from self-collected samples processed by a laboratory or provider's office may be used for reporting.

### **General Guideline: Self-Reported Services and Biometric Values**

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Self-reported services and biometric values (height, weight, BMI percentile) are acceptable only if the information is collected by a primary care practitioner (refer to [Appendix 1](#) for the definition of PCP) or specialist, if the specialist is providing a primary care service related to the condition being assessed while taking a patient's history. The information must be recorded, dated and maintained in the person's legal health record.

**Note:** *It is a best practice to collect data directly from members for the Language Description of Membership, Race/Ethnicity Description of Membership and Disability Description of Membership measures; therefore, a PCP or specialist is not required to collect this information as part of the patient's history for these measures only.*

## **HEDIS Coding Conventions**

### **General Guideline: Using Claims to Identify Events in Conjunction With Diagnoses or other Events**

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Many measures' administrative specifications require that a visit code or procedure code be used in conjunction with a diagnosis code. Some measures (e.g., Osteoporosis Management in Women Who Had a Fracture) require that a visit code be used in conjunction with another procedure code (e.g., fracture fixation).

Except for inpatient stays (as described below) and unless noted otherwise in a measure specification, when a measure requires a code be in conjunction with another code the codes must be from the same visit. The organization develops a method for identifying claims from the same visit (e.g., the same outpatient visit, the same inpatient stay). The method is subject to review by the HEDIS auditor.

Identifying acute or nonacute inpatient stays is a two-step process. The first step uses the Inpatient Stay Value Set to identify all acute and nonacute inpatient stays. The second step uses the Nonacute Inpatient Stay Value Set to identify stays that were nonacute. When identifying nonacute codes in step 2, the nonacute code must be on the same claim that was identified in step 1. In addition, any required diagnosis or procedure must be on the same claim.

### **General Guideline: Visits That Result in an Inpatient Stay**

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Some measures require exclusion of visits that result in an inpatient stay or observation stay.

A visit results in a stay when the visit date of service occurs on the day prior to the admission date or any time during the admission (admission date through discharge date).

### **General Guideline: Principal vs. Secondary Diagnosis**

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Principal and secondary diagnoses are mentioned throughout HEDIS. Generally, a **principal diagnosis** (or primary diagnosis) is the diagnosis given at discharge and the one listed first on a claim form. A diagnosis listed on a claim or encounter form that is not classified as the principal diagnosis is a **secondary diagnosis**. A claim form can contain multiple secondary diagnoses. Organizations follow the measure specifications to determine whether a diagnosis must be principal or can be secondary. If the specification does not specify that the principal diagnosis must be used, any applicable diagnosis is used.

Some measures require a specific principal diagnosis for eligibility; other measures allow any diagnosis (principal or secondary). For example, Persistence of Beta-Blocker Treatment After a Heart Attack specifies that any diagnosis of an AMI is eligible. If a person's claim lists the principal diagnosis as "severe head injury trauma," but an AMI is listed as a secondary diagnosis on the same claim form, the person is included in the measure.

The concept of "principal" and "secondary" diagnoses is unique to claims data. Supplemental data (such as EHR data) may not include this concept. Therefore, when using supplemental data to identify a "principal" diagnosis, use any diagnosis.

### **General Guideline: Code Modifiers**

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**Modifiers** are two-digit extensions that, when added to CPT or HCPCS codes, provide additional information about a service or procedure.

Unless otherwise specified, if a CPT or HCPCS code specified in HEDIS appears in the organization's database with any modifier, the code may be counted in the HEDIS measure.

### **General Guideline: Uniform Bill Code Specificity**

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HEDIS reporting requires the four-digit version of Uniform Bill (UB) type of bill codes. Organizations whose data includes three-digit versions of the codes must convert the codes to four-digit codes by adding a leading zero.

### **General Guideline: Mapping Proprietary or Other Codes**

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Organizations may only map the following codes for use in HEDIS reporting:

- *State-specific codes.* The organization must provide the auditor with evidence that the codes are required by the state.

- *NDC codes.* An NDC code that is not in a medication list can be mapped if its generic name (or brand name), strength/dose and route match those of a code in the medication list. NDC codes that identify immunizations can be mapped to codes in value sets that identify immunizations.
- *RxNorm codes.* An RxNorm code that is not in the medication list can be mapped if its generic name (or brand name), strength/dose and route match those of a code in the medication list.
- *ICD-9 codes:* ICD-9 codes can be mapped to ICD-10 codes only for concepts with a time frame that looks back “any time during the person’s history.”

For audit purposes, the organization documents the method used to map codes. At a minimum, documentation includes a crosswalk containing the relevant codes, descriptions and clinical information.

The organization documents the process for implementing codes. Auditors may request additional information.

### **General Guideline: Retiring Codes**

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NCQA annually tracks codes that are designated obsolete. NCQA does not remove codes in the year in which they receive the designation of obsolete because of the look-back period in many HEDIS measures. Obsolete codes are deleted from the HEDIS specifications after the look-back period has passed.

## **HEDIS Specification Tables**

### **General Guideline: Table Names**

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Measure specifications contain two types of tables: one to present medication lists and one used by organizations to submit data. Tables use a standardized naming system.

<b>Medication tables</b>	Medication tables are labeled with the corresponding medication list name found in the Medication List Directory.
<b>Reporting tables</b>	Data element tables begin with the measure’s three-character abbreviation. Each product line is assigned a number; for example: <ul style="list-style-type: none"><li>• AAB-1 (Medicaid).</li><li>• AAB-2 (commercial).</li><li>• AAB-3 (Medicare).</li></ul>

If more than one table will be reported for a product line, the table is assigned an uppercase letter. For example, the tables for the Controlling High Blood Pressure measure are CBP-A-1/2/3, CBP-B-1/2/3 and CBP-C-1/2/3.

### **General Guideline: Reporting Tables**

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The reporting tables in the measure specifications outline the data elements required for reporting. Refer to Appendix 2: *Data Element Definitions*.

<b>Format</b>	The reporting tables in the measure specifications follow a standard format corresponding to the structure of the IDSS submission XML file: <ul style="list-style-type: none"><li>• <i>Metric:</i> For single-metric measures, the metric describes the subject of the measure. For multi-metric measures, the metrics describe the various</li></ul>
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concepts evaluated in the measure (e.g., Screening, Follow-up, Influenza, Tdap). For wide tables, the metric column may be shown above the table.

- **Stratification:** Only applies to measures that include one or more stratifications (e.g., age, gender). For measures with multiple stratifications, the reporting instructions apply for all stratification combinations.
- **Data Element:** The data elements required for reporting (depending on data collection method).
- **Reporting Instructions:** Specify how the data elements must be reported (e.g., for each metric, repeat per metric), or the units or formula for IDSS calculated data elements.
- **Column A:** Used in hybrid measures to indicate which data elements are required for Administrative Method reporting. All data elements must be reported for the Hybrid Method unless otherwise specified in the measure specifications.
- For administrative-only measures, all data elements must be reported.

### Coding

*Example Data Elements for Reporting Table*

Metric	Stratifications 1	Stratifications 2	Data Element	Reporting Instructions	A
Metric1	Level1	Level1	DataElement1	Instruction1	✓
Metric2	Level2	Level2	DataElement2	Instruction2	✓
	Total	Level3	DataElement3	Instruction3	
		Total	DataElement4	Instruction4	
			DataElement5	Instruction5	✓
			DataElement6	Instruction6	
			Rate	Calculation / (Units)	✓

HEDIS measures consist of one-to-many indicators for reporting. Each indicator corresponds to a unique combination of a metric and any stratifications (if applicable). For example, a measure with two metrics, three age stratifications and a total, and two gender stratifications and a total consists of twenty-four indicators.

*Example:*

$$\# \text{ of indicators} = \# \text{ of metrics} \times (\# \text{ of stratifications 1 + total}) \times (\# \text{ of stratifications 2 + total})$$

### Shading

Cells in the data element tables are shaded according to how data are reported:

- **No shading:** Data are reported by the organization.
- **Light gray shading:** Data are calculated by IDSS.
- **Solid black shading:** Data are not used or reported.

Reported by the organization
Calculated by IDSS
Data not used

**Measures Reportable With a Partial Year of Data**

If an organization licenses a new product or product line during the measurement period, a number of HEDIS measures may be reported with a partial year of data. In general, a measure without a continuous enrollment requirement is reportable with less than a full measurement period of data.

# **Guidelines for Calculations and Sampling**

This section contains guidelines for calculating rates based on the Administrative and Hybrid Methods, as well as specifications for sampling when using the Hybrid Method. Organizations that use the Hybrid Method must follow the systematic sampling methodology described in this section or receive written authorization from NCQA for an alternative sort or sampling method; written authorization from NCQA is required annually. Proper use and implementation of these methods is assessed as part of NCQA's HEDIS Compliance Audit.

## SUMMARY OF CHANGES TO HEDIS MY 2026

- Updated the steps in *How to Use the Administrative Method* to align with changes to the measure templates.
- Replaced references to “eligible population” with “denominator” in the *Guidelines for the Hybrid Method*.
- Removed references to the Lead Screening in Children measure from the *Guidelines for Calculations and Sampling* because this measure no longer includes the Hybrid reporting method.
- In *Determining the required sample size*, clarified that the sample is drawn from the administrative denominator.
- Renamed “eligible member (EM)” to “administrative denominator member (ADM).”
- Removed the oversample requests to NCQA requirement in the Systematic Sampling Methodology.

### How to Use the Administrative Method

- Step 1** Identify the initial population.
- Step 2** Identify denominator exclusions.
- Step 3** Subtract denominator exclusions from the initial population to identify the final denominator.
- Step 4** Search administrative systems to identify numerator events for all members in the denominator.
- Step 5** Calculate the rate.

### Guidelines for the Hybrid Method

Measures that can be collected using the Hybrid Method are listed in Table 1. Each hybrid measure can be classified into one of the following categories:

- *Membership-dependent denominator*. Defined by membership data only (e.g., members 66 years of age and older, for Care for Older Adults), **or**
- *Claims-dependent denominator*. Defined by membership and claims data (e.g., members who were diagnosed with hypertension, for Controlling High Blood Pressure).

**Drawing the sample prior to the reporting year**

Organizations are strongly encouraged to draw samples no earlier than January 2027 for the 2026 measurement year. This increases the accuracy and completeness of the denominator from which the sample is drawn.

Organizations must adhere to the following guidelines if samples are drawn prior to these dates.

**Membership-dependent denominators**

The denominator for the following measure is determined through membership data. Do not draw the sample prior to December 1 of the measurement year.

- Care for Older Adults.

An organization that draws its sample on or between December 1 and December 31 of the measurement year must perform the following tasks:

- Oversample to account for individuals included in the sample who were found to be noncompliant with the denominator criteria, subsequent to December 31 of the measurement year.
- On or after December 31 of the measurement year, verify that members included in the sample remain eligible for the particular measure. Another record must be substituted for a member who does not meet all the denominator criteria.
  - *For example*, on December 5 of the measurement year, an organization draws a sample. On or after December 31 of the measurement year, the organization must ensure that all members included in the sample remain eligible for the measure.
  - Any ineligible member (i.e., does not meet one or more denominator criteria) must be excluded and replaced by an eligible member from the oversample group.

**Claim-dependent denominators**

The denominator for the following measure is determined through membership data and claims data. Do not draw the sample before the end of the measurement year.

- Transitions of Care.

To be drawn from a complete denominator, the sample must be selected no earlier than January of the reporting year. Allow claims incurred through December 31 to be captured in administrative systems before identifying the denominator and drawing the sample.

The denominator for the following measures is determined through membership data and claims data. Organizations may draw the sample for these measures as early as December 1 of the measurement year. If an organization draws the sample on or between December 1 and December 31 of the measurement year, it must perform the tasks in [Membership-dependent denominators](#) (oversample as necessary and verify that members remain eligible on or after December 31 of the measurement year):

- Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents.
- Controlling High Blood Pressure.
- Glycemic Status Assessment for Patients With Diabetes.
- Blood Pressure Control for Patients With Diabetes.
- Prenatal and Postpartum Care.

**Determining the required sample size**

Using the Hybrid Method to collect and report a measure requires a sample to be drawn from the administrative denominator. Use Table 1 to determine the appropriate sample size for measures.

- For hybrid measures reported in the prior year, use the last column of Table 1 to determine whether the prior year's audited result can be used to reduce the current year's sample size.
- For measures with stratifications, use the total rate when reducing sample sizes.
- For measures with multiple indicators and stratifications, use the lowest total rate across indicators when reducing sample sizes.

Use Table 2 if the prior year's rate is used to determine the current year's sample. The organization may also use the product line-specific rate derived from administrative data for the current measurement year and Table 2 to reduce the required sample size. The required sample size decreases as the organization's rate improves.

For example, the organization calculates a 77% administrative rate for the commercial product line for a new measure and decides to implement the Hybrid Method. Instead of using a sample size of 411, the organization reduces the sample size for this measure for its commercial product line by using the 77% administrative rate and Table 2. According to Table 2, the minimum required sample size is 296. The sample size can be reduced even when the original administrative denominator<sup>6</sup> member (ADM) population is less than 411.

#### **Organization responsibility for chart review**

An organization that uses the Hybrid Method for a measure should attempt to pursue charts for all noncompliant members in the systematic sample, to preserve the integrity of the sample and its representative rate. Chart pursuit is recommended, but is determined by the organization.

After the systematic sample is generated and chart pursuit has started, the sample may be reduced on rare occasions, such as after a natural disaster. Removing uninvestigated members from the sample in this situation is an alternative sampling method, and the organization must submit a request for approval to PCS via [My NCQA](#) that includes the reason for not completing chart review, and the auditor's approval showing that the members to be removed are distributed systematically across the larger sample and the hybrid results from the reduced sample are reportable.

#### **Statistical assumptions for sample size**

Sample size is calculated assuming a two-tailed test of significance between two proportions ( $\alpha = .05$ , 80% power, two-tailed test of significance). A normal approximation to the binomial with a continuity correction was employed in the sample size calculation. The worst-case assumption of a 50% expected value was assumed.

The detectable difference for most measures is 10 percentage points. This was chosen because it is a big enough difference to be actionable, it is not a burden for data collection and it is not so small as to be "swamped" by nonsampling error.

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<sup>6</sup>For hybrid reported measures, the administrative denominator is not a reported data element. It equals the initial population minus exclusions.

**Table 1: Sample Size Information for Hybrid Measures**

<b>Measure</b>	<b>Medicaid</b>	<b>Commercial</b>	<b>Medicare</b>	<b>Prior Year's Rate May Be Used to Reduce MY 2026 Sample Size<sup>1</sup></b>
<b>Effectiveness of Care</b>				
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents	411	411	NA	Y <sup>2,5</sup>
Care for Older Adults	NA	NA	411	Y <sup>2,5</sup>
Controlling High Blood Pressure	411	411	411	Y <sup>5</sup>
Glycemic Status Assessment for Patients With Diabetes	411	411	411	Y <sup>3,5</sup>
Blood Pressure Control for Patients With Diabetes	411	411	411	Y <sup>3</sup>
Transitions of Care	NA	NA	411	Y <sup>4,5</sup>
<b>Access/Availability of Care</b>				
Prenatal and Postpartum Care	411	411	NA	Y <sup>2,5</sup>

<sup>1</sup>Refer to *Table 2: Sample Sizes When Data Are Available on the Product Line Being Measured* in this section to determine the minimum required sample size.

<sup>2</sup>If reducing the sample size based on the current year's administrative rate or the prior year's product line-specific rate for this measure, the lowest rate from all the indicators must be used.

<sup>3</sup>If the same sample is used for the two diabetes measures, the organization must first take the inverse of the Glycemic Status >9.0% rate (100 minus the Glycemic Status >9.0% rate) and then reduce using the lowest rate among all the reported indicators of the two diabetes measures (the Glycemic Status <8.0%, Glycemic Status >9.0% indicators of the GSD measure and the BPD measure). If separate samples are used for these measures, organizations may reduce the sample based on the product line-specific current measurement year's administrative rate or the prior year's audited, product line-specific rate for the measure.

<sup>4</sup>Organizations may reduce the sample size based only on the prior year's audited, product line-specific rate for the lowest rate of all TRC indicators. The current year's administrative rate may not be used for sample size reduction.

<sup>5</sup>For measures with stratifications, use the total rate for reducing sample sizes. For measures with multiple indicators and stratifications, use the lowest total rate across indicators when reducing sample sizes.

Organizations may use a rate calculated from the current year's administrative rate or the prior year's reported rate to determine the sample size. Table 1: Sample Size Information for Hybrid Measures must be used first to determine if a prior year's rate can be used to reduce the sample size for a particular measure.

**Table 2: Sample Sizes When Data Are Available on the Product Line Being Measured**

If the Current Year's Administrative Rate or the Prior Year's Reported Rate Is...	...the Minimum Sample Size Is:	If the Current Year's Administrative Rate or the Prior Year's Reported Rate Is...	...the Minimum Sample Size Is:
≤51%	411	74%	321
52%	410	75%	313
53%	410	76%	305
54%	409	77%	296
55%	407	78%	288
56%	405	79%	279
57%	403	80%	270
58%	401	81%	260
59%	398	82%	250
60%	395	83%	240
61%	392	84%	229
62%	388	85%	219
63%	384	86%	207
64%	380	87%	196
65%	376	88%	184
66%	371	89%	172
67%	366	90%	159
68%	360	91%	147
69%	354	92%	134
70%	348	93%	120
71%	342	94%	106
72%	335	≥95%	100
73%	328		

### Note

- Table 2 reflects the MRSS. When reducing, an organization's sample size may be between the allowed minimum sample size in Table 2 and 411.
- Truncate the decimal portion of the rate to obtain a whole number.

## Systematic Sampling Methodology

NCQA implemented a systematic sampling methodology for the Hybrid Method. Proper use and implementation of this method ensures ongoing integrity of collected data and supports increasing requests for audited data. Complete the following steps for each hybrid measure.

**Step 1** Determine the ADM population. Develop a list of ADMs, including full name (last, first), date of birth and event (if applicable). An organization that reports on combined HMO/POS or HMO/POS/PPO/EPO products must include all ADMs from all products.

**Step 2** Determine the MRSS from Table 1 or Table 2. This number becomes the hybrid denominator for the measure. Use either Table 1 or Table 2, as appropriate, to determine the MRSS. (Refer to [Determining the required sample size](#) for instructions.) If the ADM is  $\leq$ MRSS, proceed to step 4.

To use a larger MRSS, an organization must provide written rationale to NCQA through PCS via [My NCQA](#).

**Step 3** Determine the oversample. The oversample should be an adequate number of additional records to make substitutions. Oversample only enough to guarantee that the MRSS is met; keep substitution criteria in mind.

The oversample records should be used, and reported, only to replace cases taken out of the MRSS because of valid data errors, false positives and so on; otherwise, these records should not be reported on in the final denominator.

**Step 4**

- If ADM  $\leq$ MRSS, all ADMs are included in the sample. The MRSS must be reported as the ADM.
- If ADM  $>$ MRSS + all oversample records, go to step 5.
- If MRSS  $<$ ADM  $\leq$ MRSS + all oversample records, proceed to step 8.

**Step 5** Sort the list of ADMs in alphabetical order (by applicable measurement year) by last name, first name, date of birth and event (if applicable). If the organization reports on combined products, it must alphabetize the combined ADM population.

Sort ADMs from A to Z in even measurement years and from Z to A in odd measurement years.

For example, for HEDIS MY 2026, sort the list of ADMs from A to Z. For HEDIS MY 2027, sort the list from Z to A.

**Note:** Sort order applies to all components. For HEDIS MY 2026, sort all fields by ascending order (i.e., last name ascending, first name ascending, date of birth ascending, event ascending).

**Step 6** Calculate  $N = \text{ADM}/(\text{MRSS} + \text{all oversample records})$ . Round down to a whole number.

Determine N, which is used in the formula to determine which member will start your sample. N is calculated using the equation:

$$N = \text{ADM}/(\text{MRSS} + \text{all oversample records})$$

where ADM = the administrative denominator (step 1) and MRSS = the minimum required sample size (step 2).

- Step 7** Calculate START = (RAND × N). Before choosing members, determine the member to start with (START). It is important that the sample be selected from a single pass through the member list. START can have many values and still allow only one pass.

Use the Random Number (RAND) table for the appropriate measurement year that lists a value between 0 and 1 for each measure where the Hybrid Method is applicable. Refer to this table to determine the RAND to be used when determining START. The RAND for each measure is used to calculate the starting point from which to draw the final sample.

Calculate the number from which to start drawing the final sample as follows:

$$\text{START} = (\text{RAND} \times N)$$

(round per the .5 rule to the nearest whole number greater than 0), where RAND = the random number for each respective measure identified in the RAND table.

- Step 8** Select the sample, choosing every  $i^{\text{th}}$  member using the formula:

$$i^{\text{th}} \text{ member} = \text{START} + [(i-1) \times \text{ADM}/(\text{MRSS} + \text{all oversample records})]$$

(rounding  $[(i-1) \times (\text{ADM}/\text{MRSS} + \text{all oversample records})]$  per the .5 rule to the nearest whole number greater than 0).

For  $i = 2, 3, 4, \dots$ , MRSS where ADM = administrative denominator (step 1). MRSS = the minimum required sample size (step 2).

Starting with the member corresponding to the number START, choose every  $i^{\text{th}}$  member until the MRSS is met. This becomes the primary list of sampled members.

Continue choosing every  $i^{\text{th}}$  member until the oversample is met. This set of members becomes the oversample. The oversample records should be used and reported only to replace cases taken out of the MRSS because of valid data errors, false positives and so on; otherwise, these records should not be reported in the final denominator.

**Note:** From step 4, if  $\text{MRSS} < \text{ADM} \leq \text{MRSS} + \text{all oversample records}$ , sort the ADMs in alphabetical order (by applicable measurement year) by last name, first name, date of birth and event (if applicable). Choose the first MRSS ADMs as the primary sample and the remaining s as the oversample.

The oversample list is only used to replace exclusions. All exclusions must be documented because they may be subject to audit.

#### Oversampling methodology

For hybrid measures, the starting sample size must be higher than the designated sample size because medical records must be substituted if a member is ineligible for the measure; for example, if a member was incorrectly identified as a diabetic through administrative data or meets exclusion criteria for the measure.

To adjust for this, divide the sample size by the percentage of charts expected to be inappropriate for review. Suppose 10% of charts are expected to be inappropriate for the measure.

To determine the oversample, multiply the MRSS by the oversample percentage and round up to the nearest whole number.

$$411 \times 0.10 = 41.1 \\ (\text{rounded up to } 42 = \text{oversample}).$$

The recommended methodology for substitution is:

- Replace the member's chart with that of the first member in the oversample list.
- Continue replacing each ineligible member with the next consecutive member of the oversample list.

Organizations must only use the oversample for substitution and must report all measures using their MRSS.

**Note:** Many factors must be considered when determining the initial sample size and oversampling percentage—such as previous years' data, frequency of exclusions and claims lag.

### **Example 1**

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The ADM for the commercial product line for Prenatal and Postpartum Care is 9,000. Reduce the minimum required sample size using the commercial rate from the prior year's HEDIS submission, which was 77%. Based on experience, estimate a 5% oversample rate. Follow the systematic sampling methodology.

**Step 1** ADM = 9,000.

**Step 2** From Table 2, the MRSS is 296.

**Step 3** Oversample =  $296 \times .05 = 14.8$  (the next whole number *above* is 15, so oversample = 15).

**Step 4** Because  $9,000 > 296$  (MRSS) and  $311$  ( $296 + \text{oversample}$ ), go to step 5.

**Step 5** Sort the list alphabetically and in this order: last name, first name, date of birth.

**Step 6**  $N = 9,000/311$  (MRSS + oversample) = 28.

**Step 7** For this example, assume that RAND = 0.66, so START =  $0.66 \times 28 = 18.48$ .

- Rounding using the .5 rule, START = 18.
- The 18th sorted member is chosen *first*.
- The 2nd member chosen is the  $18 + [(2-1) \times (9,000/311)] = 18 + 29 = 47$ th sorted member, after rounding the term  $[(2-1) \times (9,000/311)]$  to 29, using the .5 rule.
- The 3rd member chosen is the  $18 + [(3-1) \times (9,000/311)] = 18 + 58 = 76$ th sorted member.
- The 296th member (the last one in the primary list) is the  $18 + [(296-1) \times (9,000/311)] = 18 + 8,537 = 8,555$ th sorted member.
- The last member in the oversample\* is the  $18 + [(311-1) \times (9,000/311)] = 18 + 8,971 = 8,989$ th sorted member.

\*Remember, members in the oversample are used only to replace members excluded from the sample.

### Example 2

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The ADM for Controlling High Blood Pressure is 389. This measure was not collected last year, nor will the administrative rate from this year be used to reduce the sample size. Follow the systematic sampling methodology.

**Step 1** ADM = 389.

**Step 2** From Table 1, the MRSS is 411. Because  $389 < 411$ , skip to step 4.

**Step 3** *Skip this step.*

**Step 4** Include all 389 members in your primary list.

### Example 3

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The ADM for Care for Older Adults is 436. The sample size will not be adjusted using this year's administrative rate. Based on experience with this population, about 10% of the members from the primary sample will have to be excluded. Follow the systematic sampling methodology.

**Step 1** ADM = 436.

**Step 2** From Table 1, the MRSS is 411.

**Step 3** Oversample =  $411 \times .10 = 41.1$  (the next whole number *above* is 42, so oversample = 42).

**Step 4** Because  $411 < 436 \leq (411 + 42)$ , skip to step 8.

**Step 5** *Skip this step.*

**Step 6** *Skip this step.*

**Step 7** *Skip this step.*

**Step 8** Sort the list and choose the first 411 as the primary list. The remaining 25 members become the oversample list\*.

\*Remember, members in the oversample are used only to replace members excluded from the sample.

### Example 4

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The ADM for the commercial product line for Blood Pressure Control for Patients With Diabetes is 400. Reduce the minimum required sample size using the commercial rate from the prior year's HEDIS submission, which was 62%. Based on experience, estimate a 5% oversample rate. Follow the systematic sampling methodology.

**Step 1** ADM = 400.

**Step 2** From Table 2, the MRSS is 388.

**Step 3** Oversample =  $388 \times .05 = 19.4$  (the next whole number *above* is 20, so oversample = 20).

**Step 4** Because  $388 < 400 \leq (388 + 20)$ , skip to step 8.

**Step 5** *Skip this step.*

**Step 6** *Skip this step.*

**Step 7** *Skip this step.*

**Step 8** Sort the list and choose the first 388 as the primary list. The remaining 12 members become the oversample list\*.

\*Remember, members in the oversample are used only to replace members excluded from the sample.

## Complex Probability Sampling

### Organization responsibility

Properly applied, other techniques (e.g., stratified sampling, cluster sampling and other complex probability approaches) can improve precision and increase sampling efficiency. To use a probability sampling approach different from the one specified, submit a written rationale and documentation of the approach to NCQA through PCS via [My NCQA](#). The organization must demonstrate that the sampling approach is auditable and does not introduce bias against specific members. An NCQA committee of statisticians and health policy experts reviews the approach. Written notification of NCQA approval or disapproval is provided within 10 business days.

If complex sampling methods are used, report the estimated rate, in addition to any information required to perform a valid test of significance between that rate and another organization's rate.

Report the sample size (if different from the HEDIS recommendation) and document the method used in the calculation (including software used, if applicable). Consult a statistician before implementing a complex sampling methodology.

## Substituting Medical Records

### Acceptable circumstances for substitution

Organizations must specify the number of substituted records. Members who are noncompliant because they refused the service or because the organization cannot access their chart may not be substituted. Unless otherwise noted in the specifications for a particular measure, members or events may not be dropped from the sample or substituted, except under the following circumstances described below.

#### 1. Errors in sampling data

Chart review reveals that a member or event does not meet the eligibility criteria for inclusion in the sample. Data errors can be caused by incorrect member or clinical information. Examples of valid data errors:

- A member selected for the Care for Older Adults sample is found to be 22 years old.
- A member in the sample for any measure has a notation entered by the deadline established for the measure, explaining the reason for the erroneous inclusion and stating the member does not have the condition.

The medical record must have evidence that a member does not meet the criteria for the measure. A chart that does not contain a notation that substantiates or refutes the diagnosis is not evidence that the member does not have the condition being measured.

Members may also be identified as valid data errors if administrative data refresh finds they meet exclusion criteria. Report these members as valid data errors.

**2. Employee/  
dependent was  
selected for the  
sample**

An employee of the organization or the vendor, or the employee's dependent, was selected for the sample, and the medical record must be reviewed to determine compliance with the measure. The organization or vendor may exclude employees and their dependents in this situation *only*. Employees and employee dependents are not excluded from administrative reporting, and should not be removed before the sample is drawn.

**References**

Deming, W.E. On the interpretation of censuses as samples. 1941. *Journal of the American Statistical Association*. 36: 45–9.

Fleiss, L. *Statistical Methods for Rates and Proportions*. 2nd Ed. (New York: John Wiley & Sons, Inc.): 38–42.

# **Guidelines for the Rules for Allowable Adjustments of HEDIS**

## SUMMARY OF CHANGES TO HEDIS MY 2026

- Removed *Guideline 3: Stratifications for Telehealth Services*, *Guideline 6: Supplemental Data*, *Guideline 13: Allowable Adjustments for Risk Adjusted Utilization Measures*, and incorporated these into the measure's Allowable Adjustments sections. Renumbered remaining guidelines.

### About the Rules for Allowable Adjustments of HEDIS

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

**Note:** Measures that do not include Rules for Allowable Adjustments may not be adjusted.

### Overview of Rules for Allowable Adjustments

A HEDIS measure specification consists of defined sets and subsets of criteria needed to identify and calculate the concept being measured. At a basic level, a measure includes a description of services counted (the numerator), the definition of an initial population, a list of exclusions, coding or value sets for each factor, reporting instructions and calculation logic. Each measure component is subject to assessment of importance (evidence), reliability, validity, feasibility and usability during development, and is monitored over time. Adjustments to any measure component may pose threats to the methodological soundness and evidence alignment of a measure.

HEDIS measures were originally developed, tested and specified at the health plan level. These Rules specify how HEDIS measures may be adapted for use outside the traditional health plan setting for different purposes and levels of analysis (e.g., population health management, quality improvement) and still maintain their clinical intent. The Rules also note where measure specifications may not be adjusted to ensure they maintain alignment with the intended specifications and related clinical guidelines.

### Referring to Adjusted HEDIS Measures and Rates

Any measure may be explained in terms of the components needed to produce it, specifically for collecting, calculating and reporting. Only when a measure is used as prescribed by its HEDIS specifications can it be used for auditing and reporting to NCQA and other NCQA-approved programs (e.g., state Medicaid or commercial reports).

**Calculated HEDIS measure results (“rates”) from *adjusted HEDIS measures* may not be used for HEDIS reporting and comparison. Additionally, any HEDIS measure rates, including those from *adjusted HEDIS measures*, may not be reported or displayed externally without first obtaining an appropriate license with, or permission from, NCQA.**

Further, the Rules ensure that adjusted measures and resulting rates can maintain the HEDIS name:

- All HEDIS measures adjusted according to the Rules should be referred to as “**Adjusted HEDIS measures**.”
- A calculated measure result rate from a HEDIS measure that has not been certified via NCQA’s Measure Certification Program, and is based on *adjusted HEDIS* specifications, may not be called an “**Adjusted HEDIS rate**” until it is audited and designated reportable by an NCQA-Certified HEDIS Compliance Auditor. Until such time, such measure rates shall be designated or referred to as “**Adjusted, Uncertified, Unaudited HEDIS rates**” and may only be used for internal,

quality improvement purposes (e.g., trend analysis) and no incentive payments may be made on such rates.

- A calculated measure rate from a HEDIS measure that has been certified via NCQA's Measure Certification Program, and is based on *adjusted* HEDIS specifications, may not be called an “**Adjusted HEDIS rate**” until it is audited and designated reportable by an NCQA-Certified HEDIS Compliance Auditor. Until such time, applicable measure rates shall be designated or referred to as “**Adjusted, Unaudited HEDIS rates**.”

## Considerations and Guidelines for the Rules for Allowable Adjustments of HEDIS

Organizations must consider all HEDIS General Guidelines and the specific guidelines below when using the Rules. The following are guidelines about measure criteria that may be adjusted; however, each measure that is allowed to be adjusted must be considered individually with respect to national clinical guidelines.

### 1. Allowable Adjustment Measure Structure

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The Rules for Allowable Adjustments of HEDIS tables in applicable measures consist of both clinical and nonclinical components:

#### 1. Nonclinical components

- Nonclinical initial population criteria:
  - Product lines.
  - Attribution basis (benefits, continuous enrollment, allowable gaps).

#### 2. Clinical components

- Clinical criteria:
  - Initial population event criteria.
  - Ages.
  - Denominator exclusion criteria.
  - Numerator criteria.
  - Value sets.
  - Medication lists.
  - Direct reference codes.

Each measure in this volume that is allowed to be adjusted has a section titled *Rules for Allowable Adjustments of HEDIS*, which includes a table that identifies components that may be adjusted without changing the measure’s intention or underlying clinical logic.

### 2. Non-Adjustable Measure Components Steps

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To protect the integrity of the measure and ensure alignment with clinical guidelines, the following components may not be changed:

- *Event*: In determining the initial population, the clinical criteria (ages, value sets, medication lists [if applicable] and logic) may not be changed.
- *Numerators*: The value sets, medication lists (if applicable) and associated logic may not be changed.
- *Hybrid Method*: The Rules do not apply to the hybrid portion of the measure; only the administrative sections may be changed.

**Note:** In general, organizations may not adjust any clinical logic to identify the initial population event or the numerator; however, narrowing the population to a subset is acceptable. For example, organizations may choose to assess children with only one or two vaccines already administered, for the Childhood Immunization Status measure, or assess children at 1 year of age to determine if lead screening has been performed, for the Lead Screening in Children measure. Using the clinical criteria, but looking at an appropriate subset, is allowed.

### 3. Exclusions

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**Denominator exclusions:** For measures with denominator exclusions, exclusions must be applied as written as part of identifying the denominator.

**Exclusions for hospice, death, palliative care, I-SNP, LTI, advanced illness and/or frailty:** The palliative care, advanced illness, frailty and long-term nursing home residence exclusions are specified in HEDIS measures where the services being captured may not be of benefit for this population or may not be in line with patients' goals of care. These exclusions may be removed, but organizations should first consider why they apply to HEDIS measures. If organizations choose to apply these exclusions, they must be applied as written in the specifications.

**Note:** For Risk Adjusted Utilization measures, hospice, death, palliative care, I-SNP, LTI, advanced illness and/or frailty exclusions (where applicable) must be applied to the Rules for Allowable Adjustments for Risk-Adjusted Measurement, but may be removed from the Rules for Allowable Adjustments for Observed Measurement for Risk Adjusted Utilization measures.

### 4. Age Adjustments

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For the majority of HEDIS measures, NCQA specifies age ranges based on current clinical guidelines and recommendations for the specific treatment or condition. These recommendations often align with U.S. Preventive Services Task Force (USPSTF) Preventive Care Recommendations or other guidelines.

Determining age ranges for any measure is based on the best available clinical evidence and is intended to promote standards of care and accuracy in interpreting evidence. For allowed adjustments, organizations may change determination dates (e.g., age 18 by the last day of the measurement period); but to maintain alignment with clinical guidelines and the approved measure specifications, adjustments to age ranges outside of those stated in the HEDIS specifications may be made only if specified in a measure's Rules for Allowable Adjustments.

An organization may choose different age groups within a specified age range or remove the age stratification within a measure but should not adjust the actual age range limits unless otherwise specified.

For measures that include medications, the organization should account for FDA labels when considering an age adjustment.

When changing a measurement period, an organization may also affect the age determination date (e.g., in Appropriate Testing for Pharyngitis, the age determination day is July 1). Changing the measurement period or its determination date can affect other date-dependent events. Organizations should account for the impact of any change.

### 5. Measurement Period Adjustments

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HEDIS recognizes the need to identify and address care gaps, and allows adjustments to the measurement period; however, changes to this parameter may affect the logic in the events/diagnoses determination and the numerator events. Changes must consider relative timing.

If organizations make changes to the measurement period, results should be used with caution. For Risk Adjusted Utilization measures, organizations may only change the measurement period and associated classification periods by 1 year.

## **6. Timing Relationships**

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Measures that use events with relative timing (e.g., events tied to a specific episode of care) include specific guidance for allowed changes. Some measures allow adjustments to measure elements, but the order and relationship of dependent events may not be modified (e.g., the duration of a negative medication history after an episode). Changing the relationship of events would change the intent of the measure and is not allowed.

## **7. Measures With Multiple Rates**

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For measures with multiple rates (indicators), organizations may calculate a single rate or a combination of rates. For example, an organization may choose to calculate only the BMI Percentile rate within the Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents measure.

*Note: Organizations should consider whether the rates in a measure are dependent on each other. For example, for the Statin Therapy for Patients With Cardiovascular Disease measure, the denominator for the Rate 2—Statin Adherence 80% indicator relies on the numerator for Rate 1—Received Statin Therapy indicator. These indicators should not be calculated separately.*

## **8. Denominator Size**

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Organizations should assess reliability when the denominator is less than 30 for all measures except Risk Adjusted Utilization measures. For Risk-Adjusted Utilization measures, organizations should assess reliability when the denominator is less than 150.

## **9. Measure Trending**

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NCQA encourages consistent adjustments and assessments of measures to trend performance over time. Organizations that use allowable adjustments should use caution when trending across multiple years.

## **10. Measures With Special Considerations for Allowable Adjustments**

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The Rules for Allowable Adjustments do not apply and were not added to:

- Survey measures.
- Health Plan Descriptive Information measures.

## **11. Attribution Methods**

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NCQA does not specify, test or approve any attribution methods at this time. The organization defines how it attributes patient services to clinicians, practices or medical groups, including for PCPs and specialists. Organizations often use different methods for attributing care to clinicians for cost, resource use or utilization analyses and for quality analyses. For quality of care attribution, methods may differ between PCPs and specialists.

# **Effectiveness of Care Measures**

## ***Prevention and Screening***

## **Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)**

<b>Measure title</b>	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents	<b>Measure ID</b>	WCC
<b>Description</b>	<p>The percentage of persons 3–17 years of age who had an outpatient visit with a PCP or OB/GYN and who had evidence of the following during the measurement period:</p> <ul style="list-style-type: none"> <li>• BMI Percentile*.</li> <li>• Counseling for Nutrition.</li> <li>• Counseling for Physical Activity.</li> </ul> <p><i>*Because BMI norms for youth vary with age and gender, this measure evaluates whether BMI percentile is assessed rather than an absolute BMI value.</i></p>		
<b>Measurement period</b>	January 1–December 31.		
<b>Copyright and disclaimer notice</b>	<p>Refer to the complete copyright and disclaimer information at the front of this publication.</p> <p>NCQA website: <a href="http://www.ncqa.org">www.ncqa.org</a>.</p> <p>Submit policy clarification support questions via My NCQA (<a href="https://my.ncqa.org">https://my.ncqa.org</a>).</p>		
<b>Clinical recommendation statement/ rationale</b>	<p>The American Academy of Pediatrics (AAP) recommends providers assess the BMI percentile, nutrition, and physical activity status of children and adolescents aged 3 to 17 to promote healthy weight management and activity. The Centers for Disease Control and Prevention (CDC) and the AAP recommend that health care practitioners in primary care settings in the United States use the 2000 CDC Growth Reference Charts to monitor the growth of children and teens aged between 2 and 20 years.</p>		
<b>Citations</b>	<p>Hagan, J.F., J.S. Shaw, and P.M. Duncan, eds. <i>Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents</i>. Fourth edition. Elk Grove Village, IL: Bright Futures/American Academy of Pediatrics, 2017.</p> <p>“Overview of the CDC Growth Charts for Use in the United States Among Children and Teens Aged 2 Years to 20 Years CDC,” December 13, 2022. <a href="https://www.cdc.gov/nccdphp/dnpao/growthcharts/training/overview/index.html">https://www.cdc.gov/nccdphp/dnpao/growthcharts/training/overview/index.html</a></p>		
<b>Characteristics</b>			
<b>Scoring</b>	Proportion.		
<b>Type</b>	Process.		

<b>Product lines</b>	<ul style="list-style-type: none"> <li>Commercial.</li> <li>Medicaid.</li> </ul>
<b>Stratifications</b>	<p>Age as of the last day of the measurement period.</p> <ul style="list-style-type: none"> <li>3–11 years.</li> <li>12–17 years.</li> </ul>
<b>Risk adjustment</b>	None.
<b>Improvement notation</b>	Increased score indicates improvement.
<b>Guidance</b>	<p><b>Data collection methodology:</b> Administrative and hybrid. Refer to <a href="#">General Guideline: Data Collection Methods</a> for additional information.</p> <p><b>Date specificity:</b> Dates must be specific enough to determine the event occurred in the period being measured.</p> <p><b>Which services count?</b> When using claims, include all paid, suspended, pending and denied claims.</p> <p><b>Other guidance:</b> Refer to <a href="#">Appendix 1</a> for the definition of PCP and OB/GYN and other prenatal care practitioner.</p>
<b>Definitions</b>	
<b>BMI percentile</b>	The percentile ranking based on the CDC's BMI-for-age growth charts, which indicates the relative position of a person's BMI number among others of the same gender and age.
<b>Initial population</b>	<p><i>Measure item count:</i> Person.</p> <p><i>Attribution basis:</i> Enrollment.</p> <ul style="list-style-type: none"> <li><i>Benefits:</i> Medical.</li> <li><i>Continuous enrollment:</i> The measurement period.</li> <li><i>Allowable gap:</i> No more than one gap of ≤45 days during the measurement period. No gaps on the last day of the measurement period.</li> </ul> <p><i>Ages:</i> 3–17 years of age as of the last day of the measurement period.</p> <p><b>Event: Persons with an outpatient visit with a PCP or an OB/GYN.</b></p> <p>An outpatient visit (<a href="#">Outpatient Value Set</a>) with a PCP or an OB/GYN during the measurement period.</p>
<b>Denominator exclusions</b>	<b>Persons with a date of death.</b> Death in the measurement period, identified using data sources determined by the organization. Method and data sources are subject to review during the HEDIS audit.

	<p><b>Persons in hospice or using hospice services.</b> Persons who use hospice services (<u>Hospice Encounter Value Set</u>; <u>Hospice Intervention Value Set</u>) or elect to use a hospice benefit any time during the measurement period. Organizations that use the Monthly Membership Detail Data File to identify these persons must use only the run date of the file.</p> <p><b>Diagnosis of pregnancy.</b> Persons with a diagnosis of pregnancy (<u>Pregnancy Value Set*</u>) any time during the measurement period.</p> <p><b>Coding Guidance</b> *Do not include laboratory claims (claims with POS code 81).</p>
<b>Denominator</b>	<p><b>ADMINISTRATIVE</b> The initial population minus denominator exclusions.</p> <p><b>HYBRID</b> A systematic sample drawn from the administrative denominator for each product line for the total age band (3–17 years). The total sample is stratified by age to report rates for the 3–11 and 12–17 age stratifications.  Organizations may reduce the sample size using the current year's administrative rate or the prior year's audited, product line-specific rate for the lowest of the three indicator rates for the total age band. Refer to the <a href="#">Guidelines for Calculations and Sampling</a> for information on reducing the sample size.</p>
<b>Numerator</b>	<p><b>ADMINISTRATIVE</b></p> <p><b>Numerator 1: BMI percentile.</b> Persons with BMI percentile (<u>BMI Percentile Value Set*</u>) assessed during the measurement period.</p> <p><b>Numerator 2: Counseling for nutrition.</b> Persons who received counseling for nutrition (<u>Nutrition Counseling Value Set</u>, ICD10CM code Z71.3*) during the measurement period.</p> <p><b>Numerator 3: Counseling for physical activity.</b> Persons who received counseling for physical activity (<u>Physical Activity Counseling Value Set</u>, <u>Encounter for Physical Activity Counseling Value Set*</u>) during the measurement period.</p> <p><b>Coding Guidance</b> *Do not include laboratory claims (claims with POS code 81).</p> <p><b>HYBRID</b> <i>Administrative:</i> Refer to the administrative specifications to identify positive numerator hits from administrative data.</p> <p><b>Numerator 1: BMI percentile.</b> BMI percentile during the measurement period as identified by administrative data or medical record review.</p> <p><i>Medical record:</i> Documentation must include height, weight and BMI percentile during the measurement period. The height, weight and BMI percentile must be from the same data source.</p>

Either of the following meets criteria for BMI percentile:

- BMI percentile documented as a value (e.g., 85th percentile).
- BMI percentile plotted on an age-growth chart.

Only evidence of the BMI percentile or BMI percentile plotted on an age-growth chart meets criteria.

Member-collected biometric values (height, weight, BMI percentile) that meet the requirements of *General Guideline: Self-Reported Services and Biometric Values* are eligible for use in reporting.

Ranges and thresholds do not meet criteria for this indicator. A distinct BMI percentile is required for numerator compliance. Documentation of >99% or <1% meets criteria because a distinct BMI percentile is evident (i.e., 100% or 0%).

**Numerator 2: Counseling for nutrition.**

Documentation of counseling for nutrition or referral for nutrition education during the measurement period as identified by administrative data or medical record review.

*Medical record:* Documentation must include a note indicating the date and at least one of the following:

- Discussion of current nutrition behaviors (e.g., eating habits, dieting behaviors).
- Checklist indicating nutrition was addressed.
- Counseling or referral for nutrition education.
- Received educational materials on nutrition during a face-to-face visit.
- Anticipatory guidance specific to nutrition.
- Weight or obesity counseling.

**Numerator 3: Counseling for physical activity.**

Documentation of counseling for physical activity or referral for physical activity during the measurement period as identified by administrative data or medical record review.

*Medical record:* Documentation must include a note indicating the date and at least one of the following:

- Discussion of current physical activity behaviors (e.g., exercise routine, participation in sports activities, exam for sports participation).
- Checklist indicating physical activity was addressed.
- Counseling or referral for physical activity.
- Received educational materials on physical activity during a face-to-face visit.
- Anticipatory guidance specific to physical activity.
- Weight or obesity counseling.

**Note**

- The following notations or examples of documentation do not count as numerator compliant:
  - **BMI**
    - No BMI percentile documented in medical record or plotted on age-growth chart.
    - Notation of BMI value only.
    - Notation of height and weight only.
  - **Nutrition**
    - No counseling/education on nutrition and diet.
    - Counseling/education before or after the measurement period.
    - Notation of “health education” or “anticipatory guidance” without specific mention of nutrition.
    - A physical exam finding or observation alone (e.g., well-nourished) is not compliant because it does not indicate counseling for nutrition.
    - Documentation related to “appetite” does not meet criteria.
  - **Physical Activity**
    - No counseling/education on physical activity.
    - Notation of “cleared for gym class” alone without documentation of a discussion.
    - Counseling/education before or after the measurement period.
    - Notation of “health education” or “anticipatory guidance” without specific mention of physical activity.
    - Notation of anticipatory guidance related solely to safety (e.g., wears helmet or water safety) without specific mention of physical activity recommendations.
    - Notation solely related to screen time (computer or television) without specific mention of physical activity.
- Services may be rendered during a visit other than a well-child visit. These services count if the specified documentation is present, regardless of the primary intent of the visit; however, services specific to the assessment or treatment of an acute or chronic condition do not count toward the Counseling for Nutrition and Counseling for Physical Activity indicators.
- The following documentation is specific to the assessment or treatment of an acute or chronic condition and does not meet criteria:
  - Notation that a person with chronic knee pain is able to run without limping.
  - Notation that a person has exercise-induced asthma.
  - Notation that a person with diarrhea is following the BRAT diet.
  - Notation that a person has decreased appetite as a result of an acute or chronic condition.
- Services rendered for obesity or eating disorders may be used to meet criteria for the Counseling for Nutrition and Counseling for Physical Activity indicators if the specified documentation is present.
- Referral to the Special Supplemental Nutrition Program for Women, Infants and Children (WIC) may be used to meet criteria for the Counseling for Nutrition indicator.

	<ul style="list-style-type: none"> <li>The BMI Percentile, Counseling for Nutrition and Counseling for Physical Activity indicators do not require a specific setting; therefore, services rendered during a telephone visit, e-visit or virtual check-in meet criteria.</li> </ul>																																																																																					
<b>Summary of changes</b>	<ul style="list-style-type: none"> <li>No changes to this measure.</li> </ul>																																																																																					
<b>Data element tables</b>	<p>Organizations that submit HEDIS data to NCQA must provide the following data elements.</p> <p><b>Table WCC-1/2: Data Elements for Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents</b></p> <table border="1"> <thead> <tr> <th></th> <th>Age</th> <th>Data Element</th> <th>Reporting Instructions</th> <th>A</th> </tr> </thead> <tbody> <tr> <td>BMIPercentile</td> <td>3-11</td> <td>CollectionMethod</td> <td>For each Metric, repeat per Stratification</td> <td>✓</td> </tr> <tr> <td>NutritionCounseling</td> <td>12-17</td> <td>InitialPopulation*</td> <td>For each Metric and Stratification</td> <td>✓</td> </tr> <tr> <td>PhysicalActivityCounseling</td> <td>Total</td> <td>Exclusions*</td> <td>For each Metric and Stratification</td> <td>✓</td> </tr> <tr> <td></td> <td></td> <td>Denominator*</td> <td>For each Stratification, repeat per Metric</td> <td>✓</td> </tr> <tr> <td></td> <td></td> <td>NumeratorByAdminDenom</td> <td>For each Metric and Stratification</td> <td></td> </tr> <tr> <td></td> <td></td> <td>CYAR</td> <td>Only for Total (Percent)</td> <td></td> </tr> <tr> <td></td> <td></td> <td>MinReqSampleSize</td> <td>Repeat per Metric and Stratification</td> <td></td> </tr> <tr> <td></td> <td></td> <td>OversampleRate</td> <td>Repeat per Metric and Stratification</td> <td></td> </tr> <tr> <td></td> <td></td> <td>OversampleRecordsNumber</td> <td>(Count)</td> <td></td> </tr> <tr> <td></td> <td></td> <td>ExclusionValidDataErrors</td> <td>Repeat per Metric and Stratification</td> <td></td> </tr> <tr> <td></td> <td></td> <td>ExclusionEmployeeOrDep</td> <td>Repeat per Metric and Stratification</td> <td></td> </tr> <tr> <td></td> <td></td> <td>OversampleRecsAdded</td> <td>Repeat per Metric and Stratification</td> <td></td> </tr> <tr> <td></td> <td></td> <td>NumeratorByAdmin</td> <td>For each Metric and Stratification</td> <td>✓</td> </tr> <tr> <td></td> <td></td> <td>NumeratorByMedicalRecords</td> <td>For each Metric and Stratification</td> <td></td> </tr> <tr> <td></td> <td></td> <td>NumeratorBySupplemental</td> <td>For each Metric and Stratification</td> <td>✓</td> </tr> <tr> <td></td> <td></td> <td>Rate</td> <td>(Percent)</td> <td>✓</td> </tr> </tbody> </table> <p>*Repeat the InitialPopulation, Exclusions and Denominator values for metrics using the Administrative Method.</p>		Age	Data Element	Reporting Instructions	A	BMIPercentile	3-11	CollectionMethod	For each Metric, repeat per Stratification	✓	NutritionCounseling	12-17	InitialPopulation*	For each Metric and Stratification	✓	PhysicalActivityCounseling	Total	Exclusions*	For each Metric and Stratification	✓			Denominator*	For each Stratification, repeat per Metric	✓			NumeratorByAdminDenom	For each Metric and Stratification				CYAR	Only for Total (Percent)				MinReqSampleSize	Repeat per Metric and Stratification				OversampleRate	Repeat per Metric and Stratification				OversampleRecordsNumber	(Count)				ExclusionValidDataErrors	Repeat per Metric and Stratification				ExclusionEmployeeOrDep	Repeat per Metric and Stratification				OversampleRecsAdded	Repeat per Metric and Stratification				NumeratorByAdmin	For each Metric and Stratification	✓			NumeratorByMedicalRecords	For each Metric and Stratification				NumeratorBySupplemental	For each Metric and Stratification	✓			Rate	(Percent)	✓
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**Rules for Allowable Adjustments**

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

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

**The Rules do not apply to the hybrid portion of the measure; only the administrative sections may be changed.**

**ADJUSTMENTS ALLOWED**

- *Product lines.* Organizations are not required to use product line criteria; product lines may be combined, and all (or no) product line criteria may be used.
- *Attribution.* Organizations are not required to use enrollment criteria.
- *Benefits.* Organizations are not required to use a benefit.
- *Other.* Organizations may use additional initial population criteria to focus on an area of interest defined by gender, race, ethnicity, socioeconomic or sociodemographic characteristics, geographic region or another characteristic.
- *Measurement period adjustments.* Organizations may adjust the measurement period.
- *Exclusions.* Hospice and deceased persons exclusions are not required.
- *Telehealth.* Services/events that allow the use of synchronous telehealth visits, telephone visits and asynchronous telehealth (e-visits, virtual check-ins) may be stratified to identify services performed via telehealth. This adjustment is not allowed for numerators and exclusions that do not allow the use of telehealth.
- *Supplemental data.* Supplemental data may be used to identify initial population, denominator, exclusion and numerator events.

**ADJUSTMENTS ALLOWED WITH LIMITS**

- *Ages.* Organizations must consult USPSTF guidelines when considering whether to expand age ranges outside the current thresholds. Age determination dates may be changed (e.g., select, “age as of June 30”). The denominator age may be changed if the range is within the specified age range (3–17 years).

**ADJUSTMENTS NOT ALLOWED**

- *Initial population:* Event. Value sets and logic may not be changed.
- *Exclusions.* The pregnancy exclusion must be applied. Value sets may not be changed.
- *Numerator.* Value sets and logic may not be changed.

## ***Chlamydia Screening (CHL)***

<b>Measure title</b>	Chlamydia Screening	<b>Measure ID</b>	CHL
<b>Description</b>	The percentage of persons 16–24 years of age who were recommended for routine chlamydia screening, were identified as sexually active and had at least one test for chlamydia during the measurement period.		
<b>Measurement period</b>	January 1–December 31.		
<b>Copyright and disclaimer notice</b>	<p>Refer to the complete copyright and disclaimer information at the front of this publication.</p> <p>NCQA website: <a href="http://www.ncqa.org">www.ncqa.org</a>.</p> <p>Submit policy clarification support questions via My NCQA (<a href="https://my.ncqa.org">https://my.ncqa.org</a>).</p>		
<b>Clinical recommendation statement/ rationale</b>	The U.S. Preventive Services Task Force recommends screening for chlamydia in all sexually active women 24 years or younger and in women 25 years or older who are at increased risk for infection. (B recommendation)		
<b>Citations</b>	<p>U.S. Preventive Services Task Force. September 14, 2021. “Screening for Chlamydia and Gonorrhea: US Preventive Services Task Force Recommendation Statement,” <i>JAMA</i> 326, no. 10: 949–56, <a href="https://doi.org/10.1001/jama.2021.14081">https://doi.org/10.1001/jama.2021.14081</a></p> <p>Centers for Disease Control and Prevention. 2019. “Sexually Transmitted Disease Surveillance 2018.” Atlanta: U.S. Department of Health and Human Services. <a href="https://doi.org/10.15620/cdc.79370">https://doi.org/10.15620/cdc.79370</a></p> <p>Thompson, J. March 2021. “Medical Care of Trans and Gender Diverse Adults” (Boston: Fenway Health).</p> <p>E. Coleman et al. August 19, 2022. “Standards of Care for the Health of Transgender and Gender Diverse People, Version 8.” <i>International Journal of Transgender Health</i> 23, no. sup1: S1–259. <a href="https://doi.org/10.1080/26895269.2022.2100644">https://doi.org/10.1080/26895269.2022.2100644</a></p>		
<b>Characteristics</b>			
<b>Scoring</b>	Proportion.		
<b>Type</b>	Process.		
<b>Product lines</b>	<ul style="list-style-type: none"> <li>• Commercial.</li> <li>• Medicaid.</li> </ul>		
<b>Stratifications</b>	<p>Age as of the last day of the measurement period.</p> <ul style="list-style-type: none"> <li>• 16–20 years.</li> <li>• 21–24 years.</li> </ul>		

<b>Risk adjustment</b>	None.
<b>Improvement notation</b>	Increased score indicates improvement.
<b>Guidance</b>	<p><b>Data collection methodology:</b> Administrative. Refer to <a href="#">General Guideline: Data Collection Methods</a> for additional information.</p> <p><b>Date specificity:</b> Dates must be specific enough to determine the event occurred in the period being measured.</p> <p><b>Which services count?</b> When using claims, include all paid, suspended, pending and denied claims.</p> <p><b>Supplemental data exceptions:</b> Do not include supplemental data when identifying the initial population, except when identifying the gender/sex criteria (persons recommended for routine chlamydia screening).</p>
<b>Initial population</b>	<p><b>Measure item count:</b> Person.</p> <p><b>Attribution basis:</b> Enrollment.</p> <ul style="list-style-type: none"> <li>• <b>Benefits:</b> Medical.</li> <li>• <b>Continuous enrollment:</b> The measurement period.</li> <li>• <b>Allowable gap:</b> No more than one gap of ≤45 days during the measurement period. No gaps on the last day of the measurement period.</li> </ul> <p><b>Ages:</b> 16–24 years of age as of the last day of the measurement period.</p> <p><b>Gender/sex criteria (persons recommended for routine chlamydia screening):</b></p> <ul style="list-style-type: none"> <li>• Administrative Gender of Female (AdministrativeGender code Female) any time in the person's history.</li> <li>• Sex assigned at birth (LOINC code 76689-9) of Female (<a href="#">Female Value Set</a>) any time in the person's history.</li> <li>• Sex Parameter for Clinical Use of Female (SexParameterForClinicalUse code female-typical) during the measurement period.</li> </ul> <p><b>Event: Persons recommended for routine chlamydia screening.</b></p> <p><b>Step 1.</b> Identify persons who were recommended for routine chlamydia screening and are sexually active. Either of the following meets criteria:</p> <ul style="list-style-type: none"> <li>• <b>Claim/encounter data.</b> Persons with a claim or encounter indicating sexual activity (<a href="#">Diagnoses Indicating Sexual Activity Value Set*</a>, <a href="#">Procedures Indicating Sexual Activity Value Set</a>, <a href="#">Pregnancy Tests Value Set</a>) during the measurement period.</li> <li>• <b>Pharmacy data.</b> Persons with at least one contraceptive medication dispensing event (<a href="#">Contraceptive Medications List</a>) during the measurement period.</li> </ul> <p><b>Step 2.</b> For persons identified in step 1 based on <a href="#">Pregnancy Tests Value Set</a> alone, remove persons with either of the following:</p> <ul style="list-style-type: none"> <li>• A pregnancy test (<a href="#">Pregnancy Tests Value Set</a>) during the measurement period and a prescription for isotretinoin (<a href="#">Retinoid Medications List</a>) on the date of the pregnancy test through 6 days after the pregnancy test.</li> </ul>

	<ul style="list-style-type: none"> <li>A pregnancy test (<a href="#">Pregnancy Tests Value Set</a>) during the measurement period and an x-ray (<a href="#">Diagnostic Radiology Value Set</a>) on the date of the pregnancy test through 6 days after the pregnancy test.</li> </ul> <p><b>Coding Guidance</b> *Do not include laboratory claims (claims with POS code 81).</p>																												
<b>Denominator exclusions</b>	<p><b>Persons with a date of death.</b> Death in the measurement period, identified using data sources determined by the organization. Method and data sources are subject to review during the HEDIS audit.</p> <p><b>Persons in hospice or using hospice services.</b> Persons who use hospice services (<a href="#">Hospice Encounter Value Set</a>; <a href="#">Hospice Intervention Value Set</a>) or elect to use a hospice benefit any time during the measurement period. Organizations that use the Monthly Membership Detail Data File to identify these persons must use only the run date of the file.</p> <p><b>Persons with a sex assigned at birth of male.</b> Sex Assigned at Birth (LOINC code 76689-9) Male (<a href="#">Male Value Set</a>) any time in the person's history through the last day of the measurement period.</p>																												
<b>Denominator</b>	The initial population minus denominator exclusions.																												
<b>Numerator</b>	<p><b>Persons with a chlamydia test.</b> At least one chlamydia test (<a href="#">Chlamydia Tests Value Set</a>) during the measurement period.</p>																												
<b>Summary of changes</b>	<ul style="list-style-type: none"> <li>No changes to this measure.</li> </ul>																												
<b>Data element tables</b>	<p>Organizations that submit HEDIS data to NCQA must provide the following data elements.</p> <p><i>Table CHL-1/2: Data Elements for Chlamydia Screening</i></p> <table border="1"> <thead> <tr> <th>Metric</th> <th>Age</th> <th>Data Element</th> <th>Reporting Instructions</th> </tr> </thead> <tbody> <tr> <td>ChlamydiaScreening</td> <td>16-20</td> <td>InitialPopulation</td> <td>For each Stratification</td> </tr> <tr> <td></td> <td>21-24</td> <td>Exclusions</td> <td>For each Stratification</td> </tr> <tr> <td></td> <td>Total</td> <td>Denominator</td> <td>For each Stratification</td> </tr> <tr> <td></td> <td></td> <td>NumeratorByAdmin</td> <td>For each Stratification</td> </tr> <tr> <td></td> <td></td> <td>NumeratorBySupplemental</td> <td>For each Stratification</td> </tr> <tr> <td></td> <td></td> <td>Rate</td> <td>(Percent)</td> </tr> </tbody> </table>	Metric	Age	Data Element	Reporting Instructions	ChlamydiaScreening	16-20	InitialPopulation	For each Stratification		21-24	Exclusions	For each Stratification		Total	Denominator	For each Stratification			NumeratorByAdmin	For each Stratification			NumeratorBySupplemental	For each Stratification			Rate	(Percent)
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	<b>ADJUSTMENTS ALLOWED</b>
	<ul style="list-style-type: none"><li>• <i>Product lines.</i> Organizations are not required to use product line criteria; product lines may be combined, and all (or no) product line criteria may be used.</li><li>• <i>Attribution.</i> Organizations are not required to use enrollment criteria.</li><li>• <i>Benefits.</i> Organizations are not required to use a benefit.</li><li>• <i>Other.</i> Organizations may use additional initial population criteria to focus on an area of interest defined by gender, race, ethnicity, socioeconomic or sociodemographic characteristics, geographic region, or another characteristic.</li><li>• <i>Measurement period adjustments.</i> Organizations may adjust the measurement period.</li><li>• <i>Exclusions.</i> Hospice and deceased persons exclusions are not required.</li><li>• <i>Telehealth.</i> Services/events that allow the use of synchronous telehealth visits, telephone visits and asynchronous telehealth (e-visits, virtual check-ins) may be stratified to identify services performed via telehealth. This adjustment is not allowed for events, numerators and exclusions that do not allow the use of telehealth.</li><li>• <i>Supplemental data.</i> Supplemental data may be used to identify initial population, denominator, exclusion and numerator events.</li></ul>
	<b>ADJUSTMENTS ALLOWED WITH LIMITS</b>
	<ul style="list-style-type: none"><li>• <i>Ages.</i> Age determination dates may be changed (e.g., select, "age as of June 30"). The denominator age range may not be expanded.</li><li>• <i>Initial population:</i> Event. Organizations may choose to only use one method to identify sexual activity (only claims/ encounter data <b>or</b> only pharmacy data). Only events that contain (or map to) codes in medication lists and value sets may be used to identify sexual activity. Medication lists, value sets and logic may not be changed.</li></ul>
	<b>ADJUSTMENTS NOT ALLOWED</b>
	<ul style="list-style-type: none"><li>• <i>Exclusions.</i> The male sex assigned at birth exclusion must be applied.</li><li>• <i>Numerator.</i> The logic may not be changed.</li></ul>

## Care for Older Adults (COA)

Measure title	Care for Older Adults	Measure ID	COA
<b>Description</b>	<p>The percentage of persons 66 years of age and older who had both of the following during the measurement period:</p> <ul style="list-style-type: none"> <li>• Medication Review.</li> <li>• Functional Status Assessment.</li> </ul>		
<b>Measurement period</b>	January 1–December 31.		
<b>Copyright and disclaimer notice</b>	<p>Refer to the complete copyright and disclaimer information at the front of this publication.</p> <p>NCQA website: <a href="http://www.ncqa.org">www.ncqa.org</a>.</p> <p>Submit policy clarification support questions via My NCQA (<a href="https://my.ncqa.org">https://my.ncqa.org</a>).</p>		
<b>Clinical recommendation statement/ rationale</b>	<p>As the population ages, physical function decreases and cognitive ability can decrease. Decline in physical function is often an initial symptom of illness in older people, and early detection of functional decline allows earlier treatment or intervention.</p> <p>Poor medication management can lead to adverse drug events, overdoses and underutilization of drugs; all can result in increased hospitalizations. Assessing functional status and completing a medication review can ensure that older adults receive comprehensive care that prevents further health status decline and considers their wishes.</p>		
<b>Citations</b>	<p>Brown, Rebecca T., Kara Zamora, Anael Rizzo, Malena J. Spar, Kathy Z. Fung, Lea Santiago, Annie Campbell, and Francesca M. Nicosia. 2024. “Improving Measurement of Functional Status among Older Adults in Primary Care: A Pilot Study.” PLOS ONE 19 (5): e0303402. <a href="https://doi.org/10.1371/journal.pone.0303402">https://doi.org/10.1371/journal.pone.0303402</a></p> <p>Frangos, Emilia, Christophe Graf, and Nikolaos Samaras. 2023. “Functional Aging: Integrating Functionality to a Multidimensional Assessment of Healthy Aging.” Current Gerontology and Geriatrics Research 2023 (January):9409918. <a href="https://doi.org/10.1155/2023/9409918">https://doi.org/10.1155/2023/9409918</a></p> <p>Kiel, Whitney J., and Shaun W. Phillips. 2017. “Impact of Pharmacist-Conducted Comprehensive Medication Reviews for Older Adult Patients to Reduce Medication Related Problems.” Pharmacy: Journal of Pharmacy Education and Practice 6 (1): 2. <a href="https://doi.org/10.3390/pharmacy6010002">https://doi.org/10.3390/pharmacy6010002</a></p>		
<b>Characteristics</b>			
<b>Scoring Type</b>	<p>Proportion.</p> <p>Process.</p>		

<b>Product lines</b>	Medicare (only SNP benefit packages).
<b>Stratifications</b>	None.
<b>Risk adjustment</b>	None.
<b>Improvement notation</b>	Increased score indicates improvement.
<b>Guidance</b>	<p><b>Data collection methodology:</b> Administrative and hybrid. Refer to <a href="#">General Guideline: Data Collection Methods</a> for additional information.</p> <p><b>Date specificity:</b> Dates must be specific enough to determine the event occurred in the period being measured.</p> <p><b>Which services count?</b> When using claims, include all paid, suspended, pending and denied claims.</p> <p><b>Other guidance:</b> Refer to <a href="#">Appendix 1</a> for the definition of <i>clinical pharmacist</i> and <i>prescribing practitioner</i>.</p>

## Definitions

<b>Medication list</b>	A list of medications in the medical record. May include medication names, or may include dosages, frequency, over-the-counter (OTC) medications and herbal or supplemental therapies.
<b>Medication review</b>	A review of all the person's medications, including prescription medications, OTC medications and herbal or supplemental therapies.
<b>Standardized tool</b>	A set of structured questions that elicit the person's information. May include person-reported outcome measures, screening or assessment tools or standardized questionnaires developed by the health plan to assess risks and needs.
<b>Initial population</b>	<p><b>Measure item count:</b> Person.</p> <p><b>Attribution basis:</b> Enrollment.</p> <ul style="list-style-type: none"> <li>• <b>Benefits:</b> Medical.</li> <li>• <b>Continuous enrollment:</b> The measurement period.</li> <li>• <b>Allowable gap:</b> No more than one gap of ≤45 days during the measurement period. No gaps on the last day of the measurement period.</li> </ul> <p><b>Ages:</b> 66 years of age and older as of the last day of the measurement period.</p> <p><b>Event:</b> None.</p>
<b>Denominator exclusions</b>	<b>Persons with a date of death.</b> Death in the measurement period, identified using data sources determined by the organization. Method and data sources are subject to review during the HEDIS audit.

	<p><b>Persons in hospice or using hospice services.</b>      Persons who use hospice services (<a href="#">Hospice Encounter Value Set</a>; <a href="#">Hospice Intervention Value Set</a>) or elect to use a hospice benefit any time during the measurement period. Organizations that use the Monthly Membership Detail Data File to identify these persons must use only the run date of the file.</p>
<b>Denominator</b>	<p><b>ADMINISTRATIVE</b>      The initial population minus denominator exclusions.</p> <p><b>HYBRID</b>      A systematic sample drawn from the administrative denominator. Organizations may reduce the sample size using the current year's administrative rate or the prior year's audited, product line-specific rate. Refer to the <a href="#">Guidelines for Calculations and Sampling</a> for information on reducing the sample size.</p>
<b>Numerator</b>	<p><b>ADMINISTRATIVE</b></p> <p><b>Numerator 1: Medication review.</b>      Either of the following meets numerator criteria:</p> <ul style="list-style-type: none"> <li>• Both of the following during the same visit during the measurement period where the provider type is a prescribing practitioner or clinical pharmacist:           <ul style="list-style-type: none"> <li>– At least one medication review (<a href="#">Medication Review Value Set†</a>).</li> <li>– The presence of a medication list in the medical record (<a href="#">Medication List Value Set†</a>).</li> </ul> </li> <li>• Transitional care management services (<a href="#">Transitional Care Management Services Value Set</a>) during the measurement period.</li> </ul> <p>Do not include services provided in an acute inpatient setting (<a href="#">Acute Inpatient Value Set</a>; <a href="#">Acute Inpatient POS Value Set</a>).</p> <p><b>Numerator 2: Functional status assessment.</b>      Functional status assessment (<a href="#">Functional Status Assessment Value Set†</a>) during the measurement period.</p> <p>Do not include services provided in an acute inpatient setting (<a href="#">Acute Inpatient Value Set</a>; <a href="#">Acute Inpatient POS Value Set</a>).</p> <p><b>Coding Guidance</b>      †Do not use codes with a modifier (<a href="#">CPT CAT II Modifier Value Set</a>).</p> <p><b>HYBRID</b></p> <p><i>Administrative:</i> Refer to the administrative specifications to identify positive numerator hits from administrative data.</p> <p><b>Numerator 1: Medication review.</b>      At least one medication review conducted by a prescribing practitioner or clinical pharmacist during the measurement period <b>and</b> the presence of a medication list in the medical record, as documented through either administrative data or medical record review.</p>

A medication list, signed and dated during the measurement period by the appropriate practitioner type (prescribing practitioner or clinical pharmacist), meets criteria (the practitioner's signature is considered evidence that the medications were reviewed).

*Medical record:* Documentation must come from the same medical record and must include one of the following:

- A medication list in the medical record **and** evidence of a medication review by a prescribing practitioner or clinical pharmacist and the date when it was performed.
- Notation that the person is not taking any medication and the date when it was noted.

A review of side effects for a single medication at the time of prescription alone is not sufficient. An outpatient visit is not required to meet criteria. Do not include medication lists or medication reviews performed in an acute inpatient setting.

**Note:** A medication review performed without the person present meets criteria.

#### **Numerator 2: Functional status assessment.**

At least one functional status assessment during the measurement period, as documented through either administrative data or medical record review.

*Medical record:* Documentation in the medical record must include evidence of a complete functional status assessment and the date when it was performed.

Notations for a complete functional status assessment must include one of the following:

- Notation that Activities of Daily Living (ADL) were assessed or that at least five of the following were assessed: bathing, dressing, eating, transferring (e.g., getting in and out of chairs), using toilet, walking.
- Notation that Instrumental Activities of Daily Living (IADL) were assessed or at least four of the following were assessed: shopping for groceries, driving or using public transportation, using the telephone, cooking or meal preparation, housework, home repair, laundry, taking medications, handling finances.
- Result of assessment using a standardized functional status assessment tool, not limited to:
  - SF-36®.
  - Assessment of Living Skills and Resources (ALSAR).
  - Barthel ADL Index Physical Self-Maintenance (ADLS) Scale®.
  - Bayer ADL (B-ADL) Scale.
  - Barthel Index®.
  - Edmonton Frail Scale®.
  - Extended ADL (EADL) Scale.
  - Groningen Frailty Index.
  - Independent Living Scale (ILS).
  - Katz Index of Independence in ADL®.

	<ul style="list-style-type: none"> <li>– Kenny Self-Care Evaluation.</li> <li>– Klein-Bell ADL Scale.</li> <li>– Kohlman Evaluation of Living Skills (KELS).</li> <li>– Lawton &amp; Brody's IADL scales<sup>©</sup>.</li> <li>– Patient Reported Outcome Measurement Information System (PROMIS) Global or Physical Function Scales<sup>©</sup>.</li> </ul> <p>A functional status assessment limited to an acute or single condition, event or body system (e.g., lower back, leg) does not meet criteria for a comprehensive functional status assessment. The components of the functional status assessment numerator may take place during separate visits within the measurement period. Do not include comprehensive functional status assessments performed in an acute inpatient setting.</p> <p><b>Note:</b> The Functional Status Assessment indicator does not require a specific setting; therefore, services rendered during a telephone visit, e-visit or virtual check-in meet criteria.</p>																																																																				
<b>Summary of changes</b>	<ul style="list-style-type: none"> <li>• Removed MMP benefit packages.</li> </ul>																																																																				
<b>Data element tables</b>	<p>Organizations that submit HEDIS data to NCQA must provide the following data elements.</p> <p><b>Table COA-3: Data Elements for Care for Older Adults</b></p> <table border="1"> <thead> <tr> <th>Metric</th> <th>Data Element</th> <th>Reporting Instructions</th> <th>A</th> </tr> </thead> <tbody> <tr> <td>MedicationReview</td> <td>CollectionMethod</td> <td>For each Metric</td> <td>✓</td> </tr> <tr> <td>FunctionalStatusAssessment</td> <td>InitialPopulation*</td> <td>For each Metric</td> <td>✓</td> </tr> <tr> <td></td> <td>Exclusions*</td> <td>For each Metric</td> <td>✓</td> </tr> <tr> <td></td> <td>Denominator*</td> <td>Repeat each Metric</td> <td>✓</td> </tr> <tr> <td></td> <td>NumeratorByAdminDenom</td> <td>For each Metric</td> <td></td> </tr> <tr> <td></td> <td>CYAR</td> <td>(Percent)</td> <td></td> </tr> <tr> <td></td> <td>MinReqSampleSize</td> <td>Repeat per Metric</td> <td></td> </tr> <tr> <td></td> <td>OversampleRate</td> <td>Repeat per Metric</td> <td></td> </tr> <tr> <td></td> <td>OversampleRecordsNumber</td> <td>(Count)</td> <td></td> </tr> <tr> <td></td> <td>ExclusionValidDataErrors</td> <td>Repeat per Metric</td> <td></td> </tr> <tr> <td></td> <td>ExclusionEmployeeOrDep</td> <td>Repeat per Metric</td> <td></td> </tr> <tr> <td></td> <td>OversampleRecsAdded</td> <td>Repeat per Metric</td> <td></td> </tr> <tr> <td></td> <td>NumeratorByAdmin</td> <td>For each Metric</td> <td>✓</td> </tr> <tr> <td></td> <td>NumeratorByMedicalRecords</td> <td>For each Metric</td> <td></td> </tr> <tr> <td></td> <td>NumeratorBySupplemental</td> <td>For each Metric</td> <td>✓</td> </tr> <tr> <td></td> <td>Rate</td> <td>(Percent)</td> <td>✓</td> </tr> </tbody> </table> <p>*Repeat the InitialPopulation, Exclusions and Denominator values for metrics using the Administrative Method.</p>	Metric	Data Element	Reporting Instructions	A	MedicationReview	CollectionMethod	For each Metric	✓	FunctionalStatusAssessment	InitialPopulation*	For each Metric	✓		Exclusions*	For each Metric	✓		Denominator*	Repeat each Metric	✓		NumeratorByAdminDenom	For each Metric			CYAR	(Percent)			MinReqSampleSize	Repeat per Metric			OversampleRate	Repeat per Metric			OversampleRecordsNumber	(Count)			ExclusionValidDataErrors	Repeat per Metric			ExclusionEmployeeOrDep	Repeat per Metric			OversampleRecsAdded	Repeat per Metric			NumeratorByAdmin	For each Metric	✓		NumeratorByMedicalRecords	For each Metric			NumeratorBySupplemental	For each Metric	✓		Rate	(Percent)	✓
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	Rate	(Percent)	✓																																																																		

**Rules for Allowable Adjustments**

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

**The Rules do not apply to the hybrid portion of the measure; only the administrative sections may be changed.**

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

**ADJUSTMENTS ALLOWED**

- *Product lines.* Organizations are not required to use product line criteria; product lines may be combined, and all (or no) product line criteria may be used.
- *Attribution.* Organizations are not required to use enrollment criteria.
- *Benefits.* Organizations are not required to use a benefit.
- *Other.* Organizations may use additional initial population criteria to focus on an area of interest defined by gender, race, ethnicity, socioeconomic or sociodemographic characteristics, geographic region or another characteristic.
- *Measurement period adjustments.* Organizations may adjust the measurement period.
- *Exclusions.* Hospice and deceased person exclusions are not required.
- *Telehealth.* Services/events that allow the use of synchronous telehealth visits, telephone visits and asynchronous telehealth (e-visits, virtual check-ins) may be stratified to identify services performed via telehealth. This adjustment is not allowed for events, numerators and exclusions that do not allow the use of telehealth.
- *Supplemental data.* Supplemental data may be used to identify initial population, denominator, exclusion and numerator events.

**ADJUSTMENTS ALLOWED WITH LIMITS**

- *Ages.* Age determination dates may be changed (e.g., select, “age as of June 30”). The denominator age for both indicators may be changed within the specified age range (66 years and older). The denominator age for the measure may be expanded to 18 years of age and older only for dual-eligible enrollees and Medicaid LTSS enrollees.

**ADJUSTMENTS NOT ALLOWED**

- *Numerator.* Value sets and logic may not be changed.

## ***Oral Evaluation, Dental Services (OED)***

<b>Measure title</b>	Oral Evaluation, Dental Services*	<b>Measure ID</b>	OED
<b>Description</b>	The percentage of persons under 21 years of age who received a comprehensive or periodic oral evaluation with a dental provider during the measurement period.		
<b>Measurement period</b>	January 1–December 31.		
<b>Copyright and disclaimer notice</b>	<p><i>*This measure has been adapted for HEDIS, with permission, from a measure owned by the American Dental Association (ADA) on behalf of the Dental Quality Alliance (DQA). ©ADA (on behalf of DQA).</i></p> <p>Refer to the complete copyright and disclaimer information at the front of this publication.</p> <p>NCQA website: <a href="http://www.ncqa.org">www.ncqa.org</a>.</p> <p>Submit policy clarification support questions via My NCQA (<a href="https://my.ncqa.org">https://my.ncqa.org</a>).</p>		
<b>Clinical recommendation statement/ rationale</b>	The American Academy of Pediatric Dentistry (AAPD) recommends that children receive their first clinical oral examination at the time of their first tooth eruption and no later than their first birthday; thereafter, it is recommended that the frequency of examinations be based on the child's individual needs and susceptibility to disease.		
<b>Citations</b>	AAPD. 2018. Periodicity of Examination, Preventive Dental Services, "Anticipatory Guidance/Counseling, and Oral Treatment for Infants, Children, and Adolescents." <i>The Reference Manual of Pediatric Dentistry</i> 232–42.		
<b>Characteristics</b>			
<b>Scoring</b>	Proportion.		
<b>Type</b>	Process.		
<b>Product lines</b>	Medicaid.		
<b>Stratifications</b>	<p>Age as of the last day of the measurement period.</p> <ul style="list-style-type: none"> <li>• 0–2 years.</li> <li>• 3–5 years.</li> <li>• 6–14 years.</li> <li>• 15–20 years.</li> </ul>		
<b>Risk adjustment</b>	None.		
<b>Improvement notation</b>	Increased score indicates better performance.		

<b>Guidance</b>	<p><b>Data collection methodology:</b> Administrative. Refer to <a href="#">General Guideline: Data Collection Methods</a> for additional information.</p> <p><b>Date specificity:</b> Dates must be specific enough to determine the event occurred in the period being measured.</p> <p><b>Which services count?</b> Use all paid, suspended, pending and denied claims.</p> <p><b>Other guidance:</b> For persons who meet the 180-day continuous enrollment requirement for two different Medicaid products in the measurement period, report them in both HEDIS reports.</p>																				
<b>Initial population</b>	<p><b>Measure item count:</b> Person.</p> <p><b>Attribution basis:</b> Enrollment.</p> <ul style="list-style-type: none"> <li>• <b>Benefits:</b> Dental.</li> <li>• <b>Continuous enrollment:</b> 180 days during the measurement period.</li> <li>• <b>Allowable gap:</b> None.</li> </ul> <p><b>Ages:</b> Under 21 years of age as of the last day of the measurement period.</p> <p><b>Event:</b> None.</p>																				
<b>Denominator exclusions</b>	<p><b>Persons with a date of death.</b> Death in the measurement period, identified using data sources determined by the organization. Method and data sources are subject to review during the HEDIS audit.</p> <p><b>Persons in hospice or using hospice services.</b> Persons who use hospice services (<a href="#">Hospice Encounter Value Set</a>; <a href="#">Hospice Intervention Value Set</a>) or elect to use a hospice benefit any time during the measurement period. Organizations that use the Monthly Membership Detail Data File to identify these persons must use only the run date of the file.</p>																				
<b>Denominator</b>	The initial population minus denominator exclusions.																				
<b>Numerator</b>	<p><b>A comprehensive or periodic oral evaluation.</b> A comprehensive or periodic oral evaluation (<a href="#">Oral Evaluation Value Set</a>) with a dental provider (<a href="#">Dental Provider Value Set</a>) during the measurement period.</p>																				
<b>Summary of changes</b>	<ul style="list-style-type: none"> <li>• Revised the continuous enrollment criteria.</li> </ul>																				
<b>Data element tables</b>	<p>Organizations that submit HEDIS data to NCQA must provide the following data elements.</p> <p><b>Table OED-1: Data Elements for Oral Evaluation, Dental Services</b></p> <table border="1"> <thead> <tr> <th>Metric</th> <th>Age</th> <th>Data Element</th> <th>Reporting Instructions</th> </tr> </thead> <tbody> <tr> <td>OralEvaluationDentalServices</td> <td>0-2</td> <td>Benefit</td> <td>Metadata</td> </tr> <tr> <td></td> <td>3-5</td> <td>InitialPopulation</td> <td>For each Stratification</td> </tr> <tr> <td></td> <td>6-14</td> <td>Exclusions</td> <td>For each Stratification</td> </tr> <tr> <td></td> <td>15-20</td> <td>Denominator</td> <td>For each Stratification</td> </tr> </tbody> </table>	Metric	Age	Data Element	Reporting Instructions	OralEvaluationDentalServices	0-2	Benefit	Metadata		3-5	InitialPopulation	For each Stratification		6-14	Exclusions	For each Stratification		15-20	Denominator	For each Stratification
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	Metric	Age	Data Element	Reporting Instructions
		Total	NumeratorByAdmin	For each Stratification
			NumeratorBySupplemental	For each Stratification
			Rate	(Percent)
Rules for Allowable Adjustments	<p><b>Copyright and use:</b> The “Rules for Allowable Adjustments of HEDIS” (the “Rules”) describe how NCQA’s HEDIS measure specifications can be adjusted for other populations, if applicable. The Rules, reviewed and approved by NCQA measure experts, provide for expanded use of HEDIS measures without changing their clinical intent.</p> <p><b>Adjusted HEDIS measures may not be used for HEDIS health plan reporting.</b></p> <p><b>ADJUSTMENTS ALLOWED</b></p> <ul style="list-style-type: none"> <li>• <i>Product lines.</i> Organizations are not required to use product line criteria; product lines may be combined, and all (or no) product line criteria may be used.</li> <li>• <i>Attribution.</i> Organizations are not required to use enrollment criteria.</li> <li>• <i>Benefits.</i> Organizations are not required to use a benefit.</li> <li>• <i>Ages.</i> The denominator age range may be expanded. The age determination dates may be changed (e.g., select, “age as of June 30”).</li> <li>• <i>Other.</i> Organizations may use additional initial population criteria to focus on an area of interest defined by gender, race, ethnicity, socioeconomic or sociodemographic characteristics, geographic region or another characteristic.</li> <li>• <i>Measurement period adjustments.</i> Organizations may adjust the measurement period.</li> <li>• <i>Exclusions.</i> The hospice and deceased person exclusions are not required.</li> <li>• <i>Telehealth.</i> Services/events that allow the use of synchronous telehealth visits, telephone visits and asynchronous telehealth (e-visits, virtual check-ins) may be stratified to identify services performed via telehealth. This adjustment is not allowed for events, numerators and exclusions that do not allow the use of telehealth.</li> <li>• <i>Supplemental data.</i> Supplemental data may be used to identify initial population, denominator, exclusion and numerator events.</li> </ul> <p><b>ADJUSTMENTS NOT ALLOWED</b></p> <ul style="list-style-type: none"> <li>• <i>Numerator.</i> The value sets and logic may not be changed.</li> </ul>			

## ***Topical Fluoride for Children (TFC)***

<b>Measure title</b>	Topical Fluoride for Children*	<b>Measure ID</b>	TFC
<b>Description</b>	The percentage of persons 1–4 years of age who received at least two fluoride varnish applications during the measurement period.		
<b>Measurement period</b>	January 1–December 31.		
<b>Copyright and disclaimer notice</b>	<p>* <i>This measure has been adapted for HEDIS, with permission, from a measure owned by the American Dental Association (ADA) on behalf of the Dental Quality Alliance (DQA). ©ADA (on behalf of DQA).</i></p> <p>Refer to the complete copyright and disclaimer information at the front of this publication.</p> <p>NCQA website: <a href="http://www.ncqa.org">www.ncqa.org</a>.</p> <p>Submit policy clarification support questions via My NCQA (<a href="https://my.ncqa.org">https://my.ncqa.org</a>).</p>		
<b>Clinical recommendation statement/ rationale</b>	<p>The U.S. Preventive Services Task Force (USPSTF) recommends that primary care clinicians prescribe oral fluoride supplementation for children younger than 5, starting at 6 months for those whose water supply is deficient in fluoride, and apply varnish to the primary teeth of all infants and children, starting at the age of primary tooth eruption. The AAPD recommends that topical fluoride treatments be provided every 6 months, or at an interval appropriate to the child's individual needs, starting at 12–24 months and continuing into adolescence.</p>		
<b>Citations</b>	<p>United States Preventive Services Taskforce. December 7, 2021. <i>Final Recommendation: Prevention of Dental Caries in Children Younger Than 5 Years: Screening and Interventions.</i> <a href="https://www.uspreventiveservicestaskforce.org/uspstf/draft-recommendation/prevention-of-dental-caries-in-children-younger-than-age-5-years-screening-and-interventions1">https://www.uspreventiveservicestaskforce.org/uspstf/draft-recommendation/prevention-of-dental-caries-in-children-younger-than-age-5-years-screening-and-interventions1</a></p> <p>AAPD. 2018. “Periodicity of Examination, Preventive Dental Services, Anticipatory Guidance/Counseling, and Oral Treatment for Infants, Children, and Adolescents.” <i>The Reference Manual of Pediatric Dentistry</i> 232–42.</p>		
<b>Characteristics</b>			
<b>Scoring</b>	Proportion.		
<b>Type</b>	Process.		
<b>Product lines</b>	Medicaid.		
<b>Stratifications</b>	<p>Age as of the last day of the measurement period.</p> <ul style="list-style-type: none"> <li>• 1–2 years.</li> <li>• 3–4 years.</li> </ul>		

<b>Risk adjustment</b>	None.
<b>Improvement notation</b>	Increased score indicates improvement.
<b>Guidance</b>	<p><b>Data collection methodology:</b> Administrative. Refer to <a href="#">General Guideline: Data Collection Methods</a> for additional information.</p> <p><b>Date specificity:</b> Dates must be specific enough to determine the event occurred in the period being measured.</p> <p><b>Which services count?</b> When using claims, include all paid, suspended, pending and denied claims.</p>
<b>Initial population</b>	<p><i>Measure item count:</i> Person.</p> <p><i>Attribution basis:</i> Enrollment.</p> <ul style="list-style-type: none"> <li>• <b>Benefits:</b> Medical or Dental.</li> <li>• <b>Continuous enrollment:</b> The measurement period.</li> <li>• <b>Allowable gap:</b> No more than one gap of ≤45 days during the measurement period. No gaps on the last day of the measurement period.</li> </ul> <p><i>Ages:</i> 1–4 years of age as of the last day of the measurement period.</p> <p><i>Event:</i> None.</p>
<b>Denominator exclusions</b>	<p><b>Persons with a date of death.</b> Death in the measurement period, identified using data sources determined by the organization. Method and data sources are subject to review during the HEDIS audit.</p> <p><b>Persons in hospice or using hospice services.</b> Persons who use hospice services (<a href="#">Hospice Encounter Value Set</a>; <a href="#">Hospice Intervention Value Set</a>) or elect to use a hospice benefit any time during the measurement period. Organizations that use the Monthly Membership Detail Data File to identify these persons must use only the run date of the file.</p>
<b>Denominator</b>	The initial population minus denominator exclusions.
<b>Numerator</b>	<p><b>Persons with two or more fluoride varnish applications.</b> Persons with two or more fluoride varnish applications (<a href="#">Application of Fluoride Varnish Value Set</a>) during the measurement period, on different dates of service.</p>
<b>Summary of changes</b>	<ul style="list-style-type: none"> <li>• No changes to this measure.</li> </ul>

<b>Data element tables</b>	<p>Organizations that submit HEDIS data to NCQA must provide the following data elements.</p> <p><b>Table TFC-1: Data Elements for Topical Fluoride for Children</b></p> <table border="1" data-bbox="491 333 1470 656"> <thead> <tr> <th>Metric</th><th>Age</th><th>Data Element</th><th>Reporting Instructions</th></tr> </thead> <tbody> <tr> <td rowspan="6">TopicalFluorideForChildren</td><td>1-2</td><td>InitialPopulation</td><td>For each Stratification</td></tr> <tr> <td>3-4</td><td>Exclusions</td><td>For each Stratification</td></tr> <tr> <td>Total</td><td>Denominator</td><td>For each Stratification</td></tr> <tr> <td></td><td>NumeratorByAdmin</td><td>For each Stratification</td></tr> <tr> <td></td><td>NumeratorBySupplemental</td><td>For each Stratification</td></tr> <tr> <td></td><td>Rate</td><td>(Percent)</td></tr> </tbody> </table>	Metric	Age	Data Element	Reporting Instructions	TopicalFluorideForChildren	1-2	InitialPopulation	For each Stratification	3-4	Exclusions	For each Stratification	Total	Denominator	For each Stratification		NumeratorByAdmin	For each Stratification		NumeratorBySupplemental	For each Stratification		Rate	(Percent)
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<b>Rules for Allowable Adjustments</b>	<p><b>Copyright and use:</b> The “Rules for Allowable Adjustments of HEDIS” (the “Rules”) describe how NCQA’s HEDIS measure specifications can be adjusted for other populations, if applicable. The Rules, reviewed and approved by NCQA measure experts, provide for expanded use of HEDIS measures without changing their clinical intent.</p> <p><b>Adjusted HEDIS measures may not be used for HEDIS health plan reporting.</b></p> <p><b>ADJUSTMENTS ALLOWED</b></p> <ul style="list-style-type: none"> <li>• <i>Product lines.</i> Organizations are not required to use product line criteria; product lines may be combined, and all (or no) product line criteria may be used.</li> <li>• <i>Attribution.</i> Organizations are not required to use enrollment criteria.</li> <li>• <i>Benefits.</i> Organizations are not required to use a benefit.</li> <li>• <i>Ages.</i> The denominator age range may be expanded. The age determination dates may be changed (e.g., select, “age as of June 30”).</li> <li>• <i>Other.</i> Organizations may use additional initial population criteria to focus on an area of interest defined by gender, race, ethnicity, socioeconomic or sociodemographic characteristics, geographic region or another characteristic.</li> <li>• <i>Exclusions.</i> The hospice and deceased person exclusions are not required.</li> <li>• <i>Telehealth.</i> Services/events that allow the use of synchronous telehealth visits, telephone visits and asynchronous telehealth (e-visits, virtual check-ins) may be stratified to identify services performed via telehealth. This adjustment is not allowed for events, numerators and exclusions that do not allow the use of telehealth.</li> <li>• <i>Supplemental data.</i> Supplemental data may be used to identify initial population, denominator, exclusion and numerator events.</li> </ul> <p><b>ADJUSTMENTS NOT ALLOWED</b></p> <ul style="list-style-type: none"> <li>• <i>Numerator.</i> Value sets and logic may not be changed.</li> </ul>																							

# *Respiratory Conditions*

## ***Appropriate Testing for Pharyngitis (CWP)***

<b>Measure title</b>	Appropriate Testing for Pharyngitis	<b>Measure ID</b>	CWP
<b>Description</b>	The percentage of episodes for persons 3 years and older where the person was diagnosed with pharyngitis, dispensed an antibiotic and received a group A streptococcus (strep) test for the episode.		
<b>Measurement period</b>	January 1–December 31.		
<b>Copyright and disclaimer notice</b>	<p>Refer to the complete copyright and disclaimer information at the front of this publication.</p> <p>NCQA website: <a href="http://www.ncqa.org">www.ncqa.org</a>.</p> <p>Submit policy clarification support questions via My NCQA (<a href="https://my.ncqa.org">https://my.ncqa.org</a>).</p>		
<b>Clinical recommendation statement/ rationale</b>	<p>Pharyngitis is one of the most common causes of ambulatory health care utilization and can be caused by both bacterial and viral infection. While pharyngitis is typically caused by a viral infection, it can also be caused by a bacterial infection of group A streptococcus. To limit unnecessary antibiotic use for pharyngitis caused by viruses, clinical practice guidelines recommend that patients presenting with pharyngitis only receive antibiotics if a group A streptococcal test indicates bacterial infection. A quality measure that links testing for group A streptococcus with antibiotic prescriptions for pharyngitis can help to limit antibiotic use for pharyngitis caused by viruses, reducing the risk of antibiotic-resistant infections, negative clinical events and unnecessary costs in the United States.</p>		
<b>Citations</b>	<p>Clinical Guidance for Group A Streptococcal Pharyngitis. Centers for Disease Control and Prevention. Updated March 1, 2024. Accessed April 7, 2025. <a href="https://www.cdc.gov/group-a-strep/hcp/clinical-guidance/strep-throat.html">https://www.cdc.gov/group-a-strep/hcp/clinical-guidance/strep-throat.html</a></p> <p>Mustafa, Z. &amp; M. Ghaffari. 2020. "Diagnostic Methods, Clinical Guidelines, and Antibiotic Treatment for Group A Streptococcal Pharyngitis: A Narrative Review." <i>Front Cell Infect Microbiol</i> 10:563627. doi: 10.3389/fcimb.2020.563627.</p>		
<b>Characteristics</b>			
<b>Scoring</b>	Proportion.		
<b>Type</b>	Process.		
<b>Product lines</b>	<ul style="list-style-type: none"> <li>• Commercial.</li> <li>• Medicaid.</li> <li>• Medicare.</li> </ul>		

<b>Stratifications</b>	Ages as of the episode date. <ul style="list-style-type: none"> <li>• 3–17 years.</li> <li>• 18–64 years.</li> <li>• 65 years and older.</li> </ul>
<b>Risk adjustment</b>	None.
<b>Improvement notation</b>	Increased score indicates improvement.
<b>Guidance</b>	<p><b>Data collection methodology:</b> Administrative. Refer to <a href="#">General Guideline: Data Collection Methods</a> for additional information.</p> <p><b>Date specificity:</b> Dates must be specific enough to determine the event occurred in the period being measured.</p> <p><b>Which services count?</b> When using claims, include all paid, suspended, pending and denied claims.</p> <p><b>Other guidance:</b> The measure is based on episodes; therefore, it is possible for the denominator to include multiple events for the same person.</p>

<b>Definitions</b>	
<b>Episode date</b>	The date of service for any outpatient, telephone or ED visit, e-visit or virtual check-in during the intake period with a diagnosis of pharyngitis.
<b>Intake period</b>	July 1 of the year prior to the measurement period to June 30 of the measurement period. The intake period captures eligible episodes of treatment.
<b>Negative comorbid condition history</b>	A period of 365 days prior to and including the episode date when the person had no claims/encounters with any diagnosis for a comorbid condition (366 days total).
<b>Negative competing diagnosis</b>	The episode date and 3 days following the episode date when the person had no claims/encounters with a competing diagnosis.
<b>Negative medication history</b>	<p>To qualify for negative medication history, the following criteria must be met:</p> <ul style="list-style-type: none"> <li>• A period of 30 days prior to the episode date when the person had no pharmacy claims for either new or refill prescriptions for a listed antibiotic drug.</li> <li>• No prescriptions dispensed more than 30 days prior to the episode date that are active on the episode date.</li> </ul> <p>A prescription is considered active if the “days supply” indicated on the date when the person was dispensed the prescription is the number of days or more between that date and the relevant service date. The 30-day look-back period for pharmacy data includes the 30 days prior to the intake period.</p>
<b>Initial population</b>	<p><b>Measure item count:</b> Episode.</p> <p><b>Attribution basis:</b> Enrollment.</p> <ul style="list-style-type: none"> <li>• <b>Benefits:</b> Medical and pharmacy.</li> </ul>

	<ul style="list-style-type: none"><li>• <b>Continuous enrollment:</b> 30 days prior to the episode date through 3 days after the episode date (34 total days).</li><li>• <b>Allowable gap:</b> None.</li></ul> <p><b>Ages:</b> 3 years of age or older as of the episode date.</p> <p><b>Event: Episodes of pharyngitis diagnosis where an antibiotic was dispensed.</b></p> <p><b>Step 1.</b> Identify all persons who had an outpatient, ED, telephone or e-visit or virtual check-in (<u>Outpatient, ED and Telehealth Value Set</u>) during the intake period with a diagnosis of pharyngitis (<u>Pharyngitis Value Set</u>).</p> <p><b>Step 2.</b> Determine all pharyngitis episode dates for each person identified in step 1. Exclude visits that result in an inpatient stay (<u>Inpatient Stay Value Set</u>).</p> <p><b>Step 3.</b> Determine if antibiotics (<u>CWP Antibiotic Medications List</u>) were dispensed for any of the episode dates. For each episode date with a qualifying diagnosis, determine if antibiotics were dispensed on or up to 3 days after. Remove episode dates if the person did not receive antibiotics on or up to 3 days after the episode date.</p> <p><b>Step 4.</b> Test for negative comorbid condition history. Remove episode dates where the person had a claim/encounter with any diagnosis for a comorbid condition (<u>Comorbid Conditions Value Set*</u>) during the 365 days prior to or on the episode date (366 days total).</p> <p><b>Step 5.</b> Test for negative medication history. Remove episode dates where a new or refill prescription for an antibiotic medication (<u>CWP Antibiotic Medications List</u>) was dispensed 30 days prior to the episode date or was active on the episode date.</p> <p><b>Step 6.</b> Test for negative competing diagnosis. Remove episode dates where the person had a claim/encounter with a competing diagnosis (<u>Competing Diagnosis Value Set*</u>) on or 3 days after the episode date.</p> <p><b>Step 7.</b> Calculate continuous enrollment.</p> <p><b>Step 8.</b> Deduplicate eligible episodes. If a person has more than one eligible episode in a 31-day period, include only the first eligible episode. Identify visits chronologically including only one per 31-day period.</p> <ul style="list-style-type: none"><li>• <i>For example</i>, if a person has an eligible episode on January 1, include the January 1 visit and do not include eligible episodes that occur on or between January 2 and January 31; then, if applicable, include the next eligible episode that occurs on or after February 1.</li></ul> <p><b>Coding Guidance</b> *Do not include laboratory claims (claims with POS code 81).</p>
<b>Denominator exclusions</b>	<p><b>Persons with a date of death.</b> Death in the measurement period, identified using data sources determined by the organization. Method and data sources are subject to review during the HEDIS audit.</p>

	<p><b>Persons in hospice or using hospice services.</b>      Persons who use hospice services (<u>Hospice Encounter Value Set</u>; <u>Hospice Intervention Value Set</u>) or elect to use a hospice benefit any time during the measurement period. Organizations that use the Monthly Membership Detail Data File to identify these persons must use only the run date of the file.</p>																																
<b>Denominator</b>	The initial population minus denominator exclusions.																																
<b>Numerator</b>	<p><b>Group A streptococcus testing.</b>      Episodes for which a group A streptococcus test (<u>Group A Strep Tests Value Set</u>) occurred in the 7-day period from 3 days prior to the episode date through 3 days after the episode date.</p>																																
<b>Summary of changes</b>	<ul style="list-style-type: none"> <li>No changes to this measure.</li> </ul>																																
<b>Data element tables</b>	<p>Organizations that submit HEDIS data to NCQA must provide the following data elements.</p> <p><b>Table CWP-1/2/3: Data Elements for Appropriate Testing for Pharyngitis</b></p> <table border="1"> <thead> <tr> <th>Metric</th> <th>Age</th> <th>Data Element</th> <th>Reporting Instructions</th> </tr> </thead> <tbody> <tr> <td>AppropriatePharyngitisTesting</td> <td>3-17</td> <td>Benefit</td> <td>Metadata</td> </tr> <tr> <td></td> <td>18-64</td> <td>InitialPopulation</td> <td>For each Stratification</td> </tr> <tr> <td></td> <td>65+</td> <td>Exclusions</td> <td>For each Stratification</td> </tr> <tr> <td></td> <td>Total</td> <td>Denominator</td> <td>For each Stratification</td> </tr> <tr> <td></td> <td></td> <td>NumeratorByAdmin</td> <td>For each Stratification</td> </tr> <tr> <td></td> <td></td> <td>NumeratorBySupplemental</td> <td>For each Stratification</td> </tr> <tr> <td></td> <td></td> <td>Rate</td> <td>(Percent)</td> </tr> </tbody> </table>	Metric	Age	Data Element	Reporting Instructions	AppropriatePharyngitisTesting	3-17	Benefit	Metadata		18-64	InitialPopulation	For each Stratification		65+	Exclusions	For each Stratification		Total	Denominator	For each Stratification			NumeratorByAdmin	For each Stratification			NumeratorBySupplemental	For each Stratification			Rate	(Percent)
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<b>Rules for Allowable Adjustments</b>	<p><b>Copyright and use:</b> The “Rules for Allowable Adjustments of HEDIS” (the “Rules”) describe how NCQA’s HEDIS measure specifications can be adjusted for other populations, if applicable. The Rules, reviewed and approved by NCQA measure experts, provide for expanded use of HEDIS measures without changing their clinical intent.</p> <p><b>Adjusted HEDIS measures may not be used for HEDIS health plan reporting.</b></p> <p><b>ADJUSTMENTS ALLOWED</b></p> <ul style="list-style-type: none"> <li><b>Product lines.</b> Organizations are not required to use product line criteria; product lines may be combined, and all (or no) product line criteria may be used.</li> <li><b>Attribution.</b> Organizations are not required to use enrollment criteria.</li> <li><b>Benefits.</b> Organizations are not required to use a benefit.</li> </ul>																																

- *Other.* Organizations may use additional initial population criteria to focus on an area of interest as defined by gender, race, ethnicity, socioeconomic or sociodemographic characteristics, geographic region or another characteristic.
- *Measurement period adjustments.* Organizations may adjust the measurement period.
- *Exclusions.* The hospice and deceased person exclusions are not required.
- *Telehealth.* Services/events that allow the use of synchronous telehealth visits, telephone visits and asynchronous telehealth (e-visits, virtual check-ins) may be stratified to identify services performed via telehealth. This adjustment is not allowed for events, numerators and exclusions that do not allow the use of telehealth.
- *Supplemental data.* Supplemental data may be used to identify initial population, denominator, exclusion and numerator events.

**ADJUSTMENTS ALLOWED WITH LIMITS**

- *Ages.* Age determination dates may be changed (e.g., select “age as of January 1”). The denominator age may be changed if the range is within the specified age range. The denominator age may not be expanded.

**ADJUSTMENTS NOT ALLOWED**

- *Initial population:* Event. The medication lists, value sets and logic may not be changed.
- *Numerator.* Value sets and logic may not be changed.

## **Pharmacotherapy Management of COPD Exacerbation (PCE)**

<b>Measure title</b>	Pharmacotherapy Management of COPD Exacerbation	<b>Measure ID</b>	PCE
<b>Description</b>	<p>The percentage of COPD exacerbations for persons 40 years of age and older who had an acute inpatient discharge or ED visit on or between January 1–November 30 of the measurement period and were dispensed appropriate medications. Two rates are reported:</p> <ol style="list-style-type: none"> <li>1. Dispensed a systemic corticosteroid (or there was evidence of an active prescription) within 14 days of the event.</li> <li>2. Dispensed a bronchodilator (or there was evidence of an active prescription) within 30 days of the event.</li> </ol>		
<b>Measurement period</b>	January 1–December 31.		
<b>Copyright and disclaimer notice</b>	<p>Refer to the complete copyright and disclaimer information at the front of this publication.  NCQA website: <a href="http://www.ncqa.org">www.ncqa.org</a>.  Submit policy clarification support questions via My NCQA (<a href="https://my.ncqa.org">https://my.ncqa.org</a>).</p>		
<b>Clinical recommendation statement/ rationale</b>	<p>Patients with chronic obstructive pulmonary disorder (COPD) who experience exacerbations are at higher risk for repeat exacerbations, more rapid decline in lung function, and reduced exercise capacity, and these effects are more pronounced for patients with severe COPD. Proper and timely therapy following an exacerbation, including pharmacotherapy, can slow disease progression and reduce the risk of future exacerbations. Guidelines recommend the use of bronchodilators and systemic steroids as treatment for COPD exacerbations.</p>		
<b>Citations</b>	<p>Donaldson, G.C., T.A.R. Seemungal, A. Bhowmik, and J.A. Wedzicha. 2002. “Relationship Between Exacerbation Frequency and Lung Function Decline in Chronic Obstructive Pulmonary Disease.” <i>Thorax</i> 57:847–52.</p> <p>Spencer, S., P.M.A. Calverley, P.S. Burge, and P.W. Jones. 2004. “Impact of Preventing Exacerbations on Deterioration of Health Status in COPD.” <i>European Respiratory Journal</i> 23:698–702.</p> <p>Global Initiative for Chronic Obstructive Lung Disease (GOLD). 2020. “Global Strategy for the Diagnosis, Management, and Prevention of Chronic Obstructive Pulmonary Disease.” <a href="https://goldcopd.org/wp-content/uploads/2019/11/GOLD-2020-REPORT-ver1.0wms.pdf">https://goldcopd.org/wp-content/uploads/2019/11/GOLD-2020-REPORT-ver1.0wms.pdf</a></p>		
<b>Characteristics</b>			
<b>Scoring Type</b>	<p>Proportion.</p> <p>Process.</p>		

<b>Product lines</b>	<ul style="list-style-type: none"> <li>• Commercial.</li> <li>• Medicaid.</li> <li>• Medicare.</li> </ul>
<b>Stratifications</b>	None.
<b>Risk adjustment</b>	None.
<b>Improvement notation</b>	Increased score indicates improvement.
<b>Guidance</b>	<p><b>Data collection methodology:</b> Administrative. Refer to <a href="#">General Guideline: Data Collection Methods</a> for additional information.</p> <p><b>Date specificity:</b> Dates must be specific enough to determine the event occurred in the period being measured.</p> <p><b>Which services count?</b> When using claims, use all paid, suspended, pending and denied claims.</p> <p><b>Other guidance:</b> The measure is based on episodes; therefore, it is possible for the denominator to include multiple events for the same person.</p>
<b>Definitions</b>	
<b>Active prescription</b>	<p>A prescription is considered active if the “days supply” indicated on the date when the person was dispensed the prescription is the number of days or more between that date and the relevant date.</p> <p><i>For an acute inpatient stay</i>, the relevant date is the date of admission.</p> <p><i>For an ED visit</i>, the relevant date is the date of service.</p>
<b>Direct transfer</b>	<p>When the discharge date from the first inpatient setting precedes the admission date to a second inpatient setting by 1 calendar day or less.</p> <ul style="list-style-type: none"> <li>• <b>For example:</b> <ul style="list-style-type: none"> <li>– An inpatient discharge on June 1, followed by an admission to another inpatient setting on June 1, <i>is a direct transfer</i>.</li> <li>– An inpatient discharge on June 1, followed by an admission to an inpatient setting on June 2, <i>is a direct transfer</i>.</li> <li>– An inpatient discharge on June 1, followed by an admission to another inpatient setting on June 3, <i>is not a direct transfer</i>; these are two distinct inpatient stays.</li> </ul> </li> </ul>
<b>Episode date</b>	<p>The date of service for any acute inpatient discharge or ED visit during the intake period with a principal diagnosis of COPD.</p> <p><i>For an acute inpatient discharge</i>, the episode date is the date of discharge.</p> <p><i>For direct transfers (to acute or nonacute settings)</i>, the episode date is the discharge date from the transfer admission.</p> <p><i>For an ED visit</i>, the episode date is the date of service.</p>

<b>Intake period</b>	January 1 of the measurement period to November 30 of the measurement period. The intake period captures eligible episodes of treatment.
<b>Initial population</b>	<p><b>Measure item count:</b> Episode.</p> <p><b>Attribution basis:</b> Enrollment.</p> <ul style="list-style-type: none"> <li>• <b>Benefits:</b> Medical and pharmacy.</li> <li>• <b>Continuous enrollment:</b> Episode date through 30 days after the episode date.</li> <li>• <b>Allowable gap:</b> None.</li> </ul> <p><b>Ages:</b> 40 years of age or older as of the first day of the measurement period.</p> <p><b>Event: COPD exacerbation.</b></p> <p><b>Step 1.</b> Identify all persons who had either of the following during the intake period:</p> <ul style="list-style-type: none"> <li>• An ED visit (<a href="#">ED Value Set</a>) with a principal diagnosis of COPD, emphysema or chronic bronchitis (<a href="#">Chronic Obstructive Pulmonary Diseases Value Set</a>).</li> <li>• An acute inpatient discharge with a principal diagnosis of COPD, emphysema or chronic bronchitis (<a href="#">Chronic Obstructive Pulmonary Diseases Value Set</a>) on the discharge claim. To identify acute inpatient discharges:           <ol style="list-style-type: none"> <li>1. Identify all acute and nonacute inpatient stays (<a href="#">Inpatient Stay Value Set</a>).</li> <li>2. Exclude nonacute inpatient stays (<a href="#">Nonacute Inpatient Stay Value Set</a>).</li> <li>3. Identify the discharge date for the stay.</li> </ol> </li> </ul> <p><b>Step 2.</b> Identify all COPD episodes. For each person 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 (<a href="#">Inpatient Stay Value Set</a>).</p> <p><b>Step 3.</b> 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.</p> <p>To identify admissions to and discharges from inpatient settings:</p> <ol style="list-style-type: none"> <li>1. Identify all acute and nonacute inpatient stays (<a href="#">Inpatient Stay Value Set</a>).</li> <li>2. Identify the admission and discharge dates for the stay.</li> </ol> <p><b>Step 4.</b> Calculate continuous enrollment. All episodes that were not excluded remain in the initial population.</p>
<b>Denominator exclusions</b>	<p><b>Persons with a date of death.</b></p> <p>Death in the measurement period, identified using data sources determined by the organization. Method and data sources are subject to review during the HEDIS audit.</p>

	<p><b>Persons in hospice or using hospice services.</b>      Persons who use hospice services (<a href="#">Hospice Encounter Value Set</a>; <a href="#">Hospice Intervention Value Set</a>) or elect to use a hospice benefit any time during the measurement period. Organizations that use the Monthly Membership Detail Data File to identify these persons must use only the run date of the file.</p>																								
<b>Denominator</b>	The initial population minus denominator exclusions.																								
<b>Numerator</b>	<p><b>Numerator 1: Systemic corticosteroid.</b>      Persons who were dispensed a prescription for systemic corticosteroid (<a href="#">Systematic Corticosteroid Medications List</a>) on or 14 days after the episode date. Count systemic corticosteroids that are active on the relevant date.</p> <p><b>Numerator 2: Bronchodilator.</b>      Persons who were dispensed a prescription for a bronchodilator (<a href="#">Bronchodilator Medications List</a>) on or 30 days after the episode date. Count bronchodilators that are active on the relevant date.</p>																								
<b>Summary of changes</b>	<ul style="list-style-type: none"> <li>Moved the definition of “direct transfer” from the initial population to the <i>Definitions</i> section.</li> </ul>																								
<b>Data element tables</b>	<p>Organizations that submit HEDIS data to NCQA must provide the following data elements.</p> <p><b>Table PCE-1/2/3: Data Elements for Pharmacotherapy Management of COPD Exacerbation</b></p> <table border="1"> <thead> <tr> <th>Metric</th> <th>Data Element</th> <th>Reporting Instructions</th> </tr> </thead> <tbody> <tr> <td>SystemicCorticosteroid</td> <td>Benefit</td> <td>Metadata</td> </tr> <tr> <td>Bronchodilator</td> <td>InitialPopulation</td> <td>Repeat per Metric</td> </tr> <tr> <td></td> <td>Exclusions</td> <td>Repeat per Metric</td> </tr> <tr> <td></td> <td>Denominator</td> <td>Repeat per Metric</td> </tr> <tr> <td></td> <td>NumeratorByAdmin</td> <td>For each Metric</td> </tr> <tr> <td></td> <td>NumeratorBySupplemental</td> <td>For each Metric</td> </tr> <tr> <td></td> <td>Rate</td> <td>(Percent)</td> </tr> </tbody> </table>	Metric	Data Element	Reporting Instructions	SystemicCorticosteroid	Benefit	Metadata	Bronchodilator	InitialPopulation	Repeat per Metric		Exclusions	Repeat per Metric		Denominator	Repeat per Metric		NumeratorByAdmin	For each Metric		NumeratorBySupplemental	For each Metric		Rate	(Percent)
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<b>Rules for Allowable Adjustments</b>	<p><b>Copyright and use:</b> The “Rules for Allowable Adjustments of HEDIS” (the “Rules”) describe how NCQA’s HEDIS measure specifications can be adjusted for other populations, if applicable. The Rules, reviewed and approved by NCQA measure experts, provide for expanded use of HEDIS measures without changing their clinical intent.</p> <p><b>Adjusted HEDIS measures may not be used for HEDIS health plan reporting.</b></p> <p><b>ADJUSTMENTS ALLOWED</b></p> <ul style="list-style-type: none"> <li><b>Product lines.</b> Organizations are not required to use product line criteria; product lines may be combined, and all (or no) product line criteria may be used.</li> <li><b>Attribution.</b> Organizations are not required to use enrollment criteria.</li> </ul>																								

- **Benefits.** Organizations are not required to use enrollment criteria.
- **Other.** Organizations may use additional initial population criteria to focus on an area of interest defined by gender, race, ethnicity, socioeconomic or sociodemographic characteristics, geographic region or another characteristic.
- **Exclusions.** The hospice and deceased person exclusions are not required.
- **Telehealth.** Services/events that allow the use of synchronous telehealth visits, telephone visits and asynchronous telehealth (e-visits, virtual check-ins) may be stratified to identify services performed via telehealth. This adjustment is not allowed for events, numerators and exclusions that do not allow the use of telehealth.
- **Supplemental data.** Supplemental data may be used to identify initial population, denominator, exclusion and numerator events.

#### **ADJUSTMENTS ALLOWED WITH LIMITS**

- **Ages.** The age determination dates may be changed (e.g., select "age as of June 30"). The denominator age may be changed if the range is within the specified age range (40 years and older). The denominator age may not be expanded.
- **Initial population:** Event. Organizations may assess at the person level (vs. episode level) by applying measure logic appropriately (i.e., percentage of persons with COPD exacerbations). Value sets, medication lists and logic may not be changed.

#### **ADJUSTMENTS NOT ALLOWED**

- **Numerator.** Medication lists, value sets and logic may not be changed for the Systemic Corticosteroid and Bronchodilator indicators.

# ***Cardiovascular Conditions***

## ***Controlling High Blood Pressure (CBP)***

<b>Measure title</b>	Controlling High Blood Pressure	<b>Measure ID</b>	CBP
<b>Description</b>	The percentage of persons 18–85 years of age who had a diagnosis of hypertension (HTN) and whose blood pressure (BP) was adequately controlled (<140/90 mm Hg) during the measurement period.		
<b>Measurement period</b>	January 1–December 31.		
<b>Copyright and disclaimer notice</b>	<p>Refer to the complete copyright and disclaimer information at the front of this publication.</p> <p>NCQA website: <a href="http://www.ncqa.org">www.ncqa.org</a>.</p> <p>Submit policy clarification support questions via My NCQA (<a href="https://my.ncqa.org">https://my.ncqa.org</a>).</p>		
<b>Clinical recommendation statement/ rationale</b>	<p>The American Academy of Family Physicians (AAFP) strongly recommends clinicians treat adults who have hypertension to a standard blood pressure target (&lt;140/90 mm Hg) to reduce the risk of all-cause and cardiovascular mortality.</p> <p>The Joint National Committee recommends that pharmacologic treatment be initiated in the general population &lt;60 years, to lower systolic BP ≥140 mm Hg (and treat to a goal of systolic BP &lt;140 mm Hg) and to lower diastolic BP ≥90 mm Hg (and treat to a goal of diastolic BP &lt;90 mm Hg).</p>		
<b>Citations</b>	<p>Coles, S., L. Fisher, K. Lin, C. Lyon, A. Vosooney, and M. Bird. “Blood Pressure Targets in Adults With Hypertension: A Clinical Practice Guideline From the AAFP.” November 14, 2022.</p> <p>James, P.A., S. Oparil, B.L. Carter, W.C. Cushman, C. Dennison-Himmelfarb, J. Handler, D.T. Lackland, et al. “2014 Evidence-Based Guideline for the Management of High Blood Pressure in Adults: Report From the Panel Members Appointed to the Eighth Joint National Committee (JNC 8).” <i>JAMA</i> 311, no. 5 (February 5, 2014): 507–20.  <a href="https://doi.org/10.1001/jama.2013.284427">https://doi.org/10.1001/jama.2013.284427</a></p>		
<b>Characteristics</b>			
<b>Scoring</b>	Proportion.		
<b>Type</b>	Outcome.		
<b>Product lines</b>	<ul style="list-style-type: none"> <li>• Commercial.</li> <li>• Medicaid.</li> <li>• Medicare.</li> </ul>		

<b>Stratifications</b>	Race. (Refer to <a href="#">General Guideline: Race and Ethnicity Stratification</a> .) <ul style="list-style-type: none"> <li>• American Indian or Alaska Native.</li> <li>• Asian.</li> <li>• Black or African American.</li> <li>• Middle Eastern or North African.</li> <li>• Native Hawaiian or Pacific Islander.</li> <li>• White.</li> <li>• Some Other Race.</li> <li>• Two or More Races.</li> <li>• Asked But No Answer.</li> <li>• Unknown.</li> </ul> Ethnicity. (Refer to <a href="#">General Guideline: Race and Ethnicity Stratification</a> .) <ul style="list-style-type: none"> <li>• Hispanic or Latino.</li> <li>• Not Hispanic or Latino.</li> <li>• Asked But No Answer.</li> <li>• Unknown.</li> </ul>
<b>Risk adjustment</b>	None.
<b>Improvement notation</b>	Increased score indicates improvement.
<b>Guidance</b>	<b>Data collection methodology:</b> Administrative and hybrid. Refer to <a href="#">General Guideline: Data Collection Methods</a> for additional information. <b>Date specificity:</b> Dates must be specific enough to determine the event occurred in the period being measured. <b>Which services count?</b> When using claims, include all paid, suspended, pending and denied claims.
<b>Definitions</b>	
<b>Adequate control</b>	Both a representative systolic BP <140 mm Hg and a representative diastolic BP of <90 mm Hg.
<b>Representative BP</b>	The most recent BP reading during the measurement period on or after the second diagnosis of hypertension. If multiple BP measurements occur on the same date, or are noted in the chart on the same date, use the lowest systolic and lowest diastolic BP reading. If no BP is recorded during the measurement period, assume the BP is “not controlled.”
<b>Initial population</b>	<b>Measure item count:</b> Person. <b>Attribution basis:</b> Enrollment. <ul style="list-style-type: none"> <li>• <b>Benefits:</b> Medical.</li> <li>• <b>Continuous enrollment:</b> The measurement period.</li> </ul>

	<ul style="list-style-type: none"> <li>• <b>Allowable gap:</b> No more than one gap of ≤45 days during the measurement period. No gaps on the last day of the measurement period.</li> </ul> <p><b>Ages:</b> 18–85 years of age as of the last day of the measurement period.</p> <p><b>Event:</b> <b>Persons with a diagnosis of hypertension.</b></p> <p><b>Step 1.</b> Identify persons who had at least two outpatient visits, telephone visits, e-visits or virtual check-ins (<a href="#">Outpatient and Telehealth Without UBREV Value Set</a>) on different dates of service with a diagnosis of hypertension (<a href="#">Essential Hypertension Value Set</a>) on or between January 1 of the year prior to the measurement period and June 30 of the measurement period.</p> <p><b>Step 2.</b> Remove persons who had a nonacute inpatient admission during the measurement period. To identify nonacute inpatient admissions:</p> <ol style="list-style-type: none"> <li>1. Identify all acute and nonacute inpatient stays (<a href="#">Inpatient Stay Value Set</a>).</li> <li>2. Confirm the stay was for nonacute care based on the presence of a nonacute code (<a href="#">Nonacute Inpatient Stay Value Set</a>) on the claim.</li> <li>3. Identify the admission date for the stay.</li> </ol>
<b>Denominator exclusions</b>	<p><b>Persons with a date of death.</b> Death in the measurement period, identified using data sources determined by the organization. Method and data sources are subject to review during the HEDIS audit.</p> <p><b>Persons in hospice or using hospice services.</b> Persons who use hospice services (<a href="#">Hospice Encounter Value Set</a>; <a href="#">Hospice Intervention Value Set</a>) or elect to use a hospice benefit any time during the measurement period. Organizations that use the Monthly Membership Detail Data File to identify these persons must use only the run date of the file.</p> <p><b>Persons receiving palliative care.</b> Persons receiving palliative care (<a href="#">Palliative Care Assessment Value Set</a>, <a href="#">Palliative Care Encounter Value Set</a>, <a href="#">Palliative Care Intervention Value Set</a>) or who had an encounter for palliative care (ICD-10-CM code Z51.5*) any time during the measurement period.</p> <p><b>Medicare enrollees, 66 years of age and older by the last day of the measurement period, in an institutional SNP (I-SNP) or living long-term in an institution (LTI).</b></p> <ul style="list-style-type: none"> <li>• Enrolled in an Institutional SNP (I-SNP) any time during the measurement period.</li> <li>• Living long-term in an institution any time during the measurement period as identified by the LTI flag in the Monthly Membership Detail Data File. Use the run date of the file to determine if a member had an LTI flag during the measurement period.</li> </ul> <p><b>Persons 66–80 years of age by the last day of the measurement period, with both frailty and advanced illness.</b></p> <ol style="list-style-type: none"> <li>1. <b>Frailty.</b> At least two indications of frailty (<a href="#">Frailty Device Value Set</a>; <a href="#">Frailty Diagnosis Value Set*</a>; <a href="#">Frailty Encounter Value Set</a>; <a href="#">Frailty Symptom Value Set*</a>) with different dates of service during the measurement period.</li> </ol>

	<p>2. <b>Advanced Illness.</b> Either of the following during the measurement period or the year prior to the measurement period:</p> <ul style="list-style-type: none"> <li>– Advanced illness (<a href="#">Advanced Illness Value Set*</a>) on at least two different dates of service.</li> <li>– Dispensed dementia medication (<a href="#">Dementia Medications List</a>).</li> </ul> <p><b>Persons 81 years of age and older as of the last day of the measurement period, with frailty.</b></p> <p>Persons with at least two indications of frailty (<a href="#">Frailty Device Value Set</a>; <a href="#">Frailty Diagnosis Value Set*</a>; <a href="#">Frailty Encounter Value Set</a>; <a href="#">Frailty Symptom Value Set*</a>) with different dates of service during the measurement period.</p> <p><b>End-stage renal disease (ESRD).</b></p> <p>Persons with any of the following during their history on or prior to the last day of the measurement period:</p> <ul style="list-style-type: none"> <li>• Diagnosis that indicates end-stage renal disease (ESRD) (<a href="#">ESRD Diagnosis Value Set*</a>; <a href="#">History of Nephrectomy or Kidney Transplant Value Set*</a>).</li> <li>• Procedure that indicates ESRD: dialysis (<a href="#">Dialysis Procedure Value Set</a>), nephrectomy (<a href="#">Total Nephrectomy Value Set</a>; <a href="#">Partial Nephrectomy Value Set</a>) or kidney transplant (<a href="#">Kidney Transplant Value Set</a>).</li> </ul> <p><b>Diagnosis of pregnancy.</b></p> <p>Persons with a diagnosis of pregnancy (<a href="#">Pregnancy Value Set*</a>) any time during the measurement period.</p> <p><b>Coding Guidance</b> *Do not include laboratory claims (claims with POS code 81).</p>
<b>Denominator</b>	<p><b>ADMINISTRATIVE</b></p> <p>The initial population minus denominator exclusions.</p> <p><b>HYBRID</b></p> <p>A systematic sample drawn from the administrative denominator.</p> <p>The organization may reduce the sample size using the current year's administrative rate or the prior year's audited, product line-specific rate. Refer to the <a href="#">Guidelines for Calculations and Sampling</a> for information on reducing the sample size.</p>
<b>Numerator</b>	<p><b>ADMINISTRATIVE</b></p> <p><b>Both a systolic and diastolic reading &lt;140/90 mm Hg.</b></p> <p>Identify the most recent BP reading (<a href="#">Systolic Blood Pressure Value Set</a>; <a href="#">Diastolic Blood Pressure Value Set</a>) taken during the measurement period. Do not include CPT Category II codes (<a href="#">Systolic and Diastolic Result Value Set</a>) with a modifier (<a href="#">CPT CAT II Modifier Value Set</a>). Do not include BPs taken in an acute inpatient setting (<a href="#">Acute Inpatient Value Set</a>; <a href="#">Acute Inpatient POS Value Set</a>) or during an ED visit (<a href="#">ED Value Set</a>; POS code 23).</p> <p>The BP reading must occur <i>on or after</i> the date of the second diagnosis of hypertension (identified using the initial population criteria).</p> <p>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.</p>

- **Compliant:** BP is <140/90 mm Hg.
- **Non-compliant:** BP is ≥140/90 mm Hg; no BP reading during the measurement period; or if the reading is incomplete (e.g., the systolic or diastolic level is missing).

If the most recent blood pressure was identified based on a CPT Category II code (Systolic and Diastolic Result Value Set) use the following to determine compliance:

- **Systolic Compliant:** Systolic Less Than 140 Value Set.
- **Systolic Not Compliant:** CPT-CAT-II code 3077F.
- **Diastolic Compliant:** Diastolic Less Than 90 Value Set.
- **Diastolic Not Compliant:** CPT-CAT-II code 3080F.

#### **HYBRID**

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

#### ***Identifying the medical record.***

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

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

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

#### **Persons with both a systolic and diastolic reading <140/90 mm Hg.**

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

**Medical record:** Identify the most recent BP reading noted during the measurement period. The BP reading must occur on or after the date when the second diagnosis of hypertension (identified using the event criteria) occurred.

Do not include BP readings:

- Taken during an acute inpatient stay or an ED visit.
- Taken on the same day as a diagnostic test or diagnostic or therapeutic procedure that requires a change in diet or change in medication on or 1 day before the day of the test or procedure, with the exception of fasting blood tests.
- Taken using a non-digital device such as with a manual blood pressure cuff and a stethoscope.

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

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

The person is not compliant if the BP reading is  $\geq 140/90$  mm Hg or is missing, or if there is no BP reading during the measurement period or if the reading is incomplete (e.g., the systolic or diastolic level is missing).

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

#### **Note**

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

<b>Summary of changes</b>	<ul style="list-style-type: none"> <li>Updated the race and ethnicity stratification categories to align with OMB SPD 15 2024.</li> <li>Added instructions on allowable adjustments to the race and ethnicity stratification.</li> </ul>																																																																																																																											
<b>Data element tables</b>	<p>Organizations that submit HEDIS data to NCQA must provide the following data elements.</p> <p><b>Table CBP-A-1/2/3: Data Elements for Controlling High Blood Pressure</b></p> <table border="1"> <thead> <tr> <th>Metric</th> <th>Data Element</th> <th>Reporting Instructions</th> <th>A</th> </tr> </thead> <tbody> <tr> <td>ControlHighBP</td> <td>CollectionMethod</td> <td>Report once</td> <td>✓</td> </tr> <tr> <td></td> <td>InitialPopulation</td> <td>Report once</td> <td>✓</td> </tr> <tr> <td></td> <td>Exclusions</td> <td>Report once</td> <td>✓</td> </tr> <tr> <td></td> <td>Denominator</td> <td>Report once</td> <td>✓</td> </tr> <tr> <td></td> <td>NumeratorByAdminDenom</td> <td>Report once</td> <td></td> </tr> <tr> <td></td> <td>CYAR</td> <td>(Percent)</td> <td></td> </tr> <tr> <td></td> <td>MinReqSampleSize</td> <td>Report once</td> <td></td> </tr> <tr> <td></td> <td>OversampleRate</td> <td>Report once</td> <td></td> </tr> <tr> <td></td> <td>OversampleRecordsNumber</td> <td>(Count)</td> <td></td> </tr> <tr> <td></td> <td>ExclusionValidDataErrors</td> <td>Report once</td> <td></td> </tr> <tr> <td></td> <td>ExclusionEmployeeOrDep</td> <td>Report once</td> <td></td> </tr> <tr> <td></td> <td>OversampleRecsAdded</td> <td>Report once</td> <td></td> </tr> <tr> <td></td> <td>NumeratorByAdmin</td> <td>Report once</td> <td>✓</td> </tr> <tr> <td></td> <td>NumeratorByMedicalRecords</td> <td>Report once</td> <td></td> </tr> <tr> <td></td> <td>NumeratorBySupplemental</td> <td>Report once</td> <td>✓</td> </tr> <tr> <td></td> <td>Rate</td> <td>(Percent)</td> <td>✓</td> </tr> </tbody> </table> <p><b>Table CBP-B-1/2/3: Data Elements for Controlling High Blood Pressure: Stratifications by Race</b></p> <table border="1"> <thead> <tr> <th>Metric</th> <th>Race</th> <th>Data Element</th> <th>Reporting Instructions</th> <th>A</th> </tr> </thead> <tbody> <tr> <td>ControlHighBP</td> <td>AmericanIndianOrAlaskaNative</td> <td>CollectionMethod</td> <td>Repeat per Stratification</td> <td>✓</td> </tr> <tr> <td></td> <td>Asian</td> <td>Denominator</td> <td>For each Stratification</td> <td>✓</td> </tr> <tr> <td></td> <td>BlackOrAfricanAmerican</td> <td>Numerator</td> <td>For each Stratification</td> <td>✓</td> </tr> <tr> <td></td> <td>MiddleEasternOrNorthAfrican</td> <td>Rate</td> <td>(Percent)</td> <td>✓</td> </tr> <tr> <td></td> <td>NativeHawaiianOrPacificIslander</td> <td></td> <td></td> <td></td> </tr> <tr> <td></td> <td>White</td> <td></td> <td></td> <td></td> </tr> <tr> <td></td> <td>SomeOtherRace</td> <td></td> <td></td> <td></td> </tr> <tr> <td></td> <td>TwoOrMoreRaces</td> <td></td> <td></td> <td></td> </tr> <tr> <td></td> <td>AskedButNoAnswer</td> <td></td> <td></td> <td></td> </tr> <tr> <td></td> <td>Unknown</td> <td></td> <td></td> <td></td> </tr> </tbody> </table>	Metric	Data Element	Reporting Instructions	A	ControlHighBP	CollectionMethod	Report once	✓		InitialPopulation	Report once	✓		Exclusions	Report once	✓		Denominator	Report once	✓		NumeratorByAdminDenom	Report once			CYAR	(Percent)			MinReqSampleSize	Report once			OversampleRate	Report once			OversampleRecordsNumber	(Count)			ExclusionValidDataErrors	Report once			ExclusionEmployeeOrDep	Report once			OversampleRecsAdded	Report once			NumeratorByAdmin	Report once	✓		NumeratorByMedicalRecords	Report once			NumeratorBySupplemental	Report once	✓		Rate	(Percent)	✓	Metric	Race	Data Element	Reporting Instructions	A	ControlHighBP	AmericanIndianOrAlaskaNative	CollectionMethod	Repeat per Stratification	✓		Asian	Denominator	For each Stratification	✓		BlackOrAfricanAmerican	Numerator	For each Stratification	✓		MiddleEasternOrNorthAfrican	Rate	(Percent)	✓		NativeHawaiianOrPacificIslander					White					SomeOtherRace					TwoOrMoreRaces					AskedButNoAnswer					Unknown			
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<b>Table CBP-C-1/2/3: Data Elements for Controlling High Blood Pressure: Stratifications by Ethnicity</b>				
Metric	Ethnicity	Data Element	Reporting Instructions	A
ControlHighBP	HispanicOrLatino	CollectionMethod	Repeat per Stratification	✓
	NotHispanicOrLatino	Denominator	For each Stratification	✓
	AskedButNoAnswer	Numerator	For each Stratification	✓
	Unknown	Rate	(Percent)	✓

<b>Rules for Allowable Adjustments</b>	<p><b>Copyright and use:</b> The “Rules for Allowable Adjustments of HEDIS” (the “Rules”) describe how NCQA’s HEDIS measure specifications can be adjusted for other populations, if applicable. The Rules, reviewed and approved by NCQA measure experts, provide for expanded use of HEDIS measures without changing their clinical intent.</p> <p><b>Adjusted HEDIS measures may not be used for HEDIS health plan reporting.</b></p> <p><b>The Rules do not apply to the hybrid portion of the measure; only the administrative sections may be changed.</b></p> <p><b>ADJUSTMENTS ALLOWED</b></p> <ul style="list-style-type: none"> <li>• <b>Product lines.</b> Organizations are not required to use product line criteria; product lines may be combined, and all (or no) product line criteria may be used.</li> <li>• <b>Attribution.</b> Organizations are not required to use enrollment criteria.</li> <li>• <b>Benefits.</b> Organizations are not required to use a benefit.</li> <li>• <b>Other.</b> Organizations may use additional initial population criteria to focus on an area of interest defined by gender, race, ethnicity, socioeconomic or sociodemographic characteristics, geographic region or another characteristic.</li> <li>• <b>Measurement period adjustments.</b> Organizations may adjust the measurement period.</li> <li>• <b>Stratifications:</b> Race and ethnicity stratification. The race and ethnicity stratification is not required. Organizations may adjust this stratification as needed.</li> <li>• <b>Exclusions.</b> The hospice, deceased person, palliative care, I-SNP, LTI, frailty or advanced illness exclusions are not required.</li> <li>• <b>Telehealth.</b> Services/events that allow the use of synchronous telehealth visits, telephone visits and asynchronous telehealth (e-visits, virtual check-ins) may be stratified to identify services performed via telehealth. This adjustment is not allowed for events, numerators and exclusions that do not allow the use of telehealth.</li> </ul>
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- *Supplemental data.* Supplemental data may be used to identify initial population, denominator, exclusion and numerator events.

**ADJUSTMENTS ALLOWED WITH LIMITS**

- *Ages.* Age determination dates may be changed (e.g., select, “age as of June 30”). The denominator age range may be changed if the range is within the specified age range (18–85 years of age).

**ADJUSTMENTS NOT ALLOWED**

- *Initial population:* Event. Only events that contain (or map to) codes in the value sets may be used to identify visits. Value sets and logic may not be changed.
- *Exclusions.* The ESRD and pregnancy exclusions must be applied. The value sets and logic may not be changed.
- *Numerator.* Value sets and logic may not be changed.

## Persistence of Beta-Blocker Treatment After a Heart Attack (PBH)

Measure title	Persistence of Beta-Blocker Treatment After a Heart Attack	Measure ID	PBH
<b>Description</b>	The percentage of persons 18 years of age and older during the measurement period who were hospitalized and discharged from July 1 of the year prior to the measurement period to June 30 of the measurement period with a diagnosis of AMI and who received persistent beta-blocker treatment for 180 days (6 months) after discharge.		
<b>Measurement period</b>	January 1–December 31.		
<b>Copyright and disclaimer notice</b>	<p>Refer to the complete copyright and disclaimer information at the front of this publication.</p> <p>NCQA website: <a href="http://www.ncqa.org">www.ncqa.org</a>.</p> <p>Submit policy clarification support questions via My NCQA (<a href="https://my.ncqa.org">https://my.ncqa.org</a>).</p>		
<b>Clinical recommendation statement/ rationale</b>	<p>American College of Cardiology/American Heart Association (2014)</p> <ul style="list-style-type: none"> <li>• Among patients with non-ST-elevation acute coronary syndrome, initiate oral beta-blockers within the first 24 hours in the absence of heart failure, low-output state, risk for cardiogenic shock, or other contraindications to beta-blockade.</li> </ul> <p>American Heart Association/American College of Cardiology Foundation (2011)</p> <ul style="list-style-type: none"> <li>• Beta-blocker therapy should be started and continued for 3 years in all patients with normal left ventricular function who have had myocardial infarction or acute coronary syndrome.</li> </ul> <p>American College of Cardiology Foundation/ American Heart Association (2013)</p> <ul style="list-style-type: none"> <li>• Oral beta blockers should be initiated in the first 24 hours in patients with ST-Segment Elevation Myocardial Infarction who do not have any of the following: signs of HF, evidence of a low output state, increased risk for cardiogenic shock, or other contraindications to use of oral beta blockers (PR interval more than 0.24 seconds, second- or third-degree heart block, active asthma, or reactive airways disease).</li> <li>• Beta blockers should be continued during and after hospitalization for all patients with ST-Segment Elevation Myocardial Infarction and with no contraindications to their use.</li> </ul>		
<b>Citations</b>	<p>Amsterdam, E.A., N.K. Wenger, R.G. Brindis, D.E. Casey, T.G. Ganiats, D.R. Holmes, A.S. Jaffe, et al. “2014 AHA/ACC Guideline for the Management of Patients With Non-ST-Elevation Acute Coronary Syndromes: A Report of the American College of Cardiology/American Heart Association Task Force on Practice Guidelines.” <i>Circulation</i> 130, no. 25 (December 2014). <a href="https://doi.org/10.1161/CIR.000000000000134">https://doi.org/10.1161/CIR.000000000000134</a></p>		

	<p>Smith, S.C., E.J. Benjamin, R.O. Bonow, L.T. Braun, M.A. Creager, B.A. Franklin, R.J. Gibbons, et al. "AHA/ACCF Secondary Prevention and Risk Reduction Therapy for Patients With Coronary and Other Atherosclerotic Vascular Disease: 2011 Update: A Guideline From the American Heart Association and American College of Cardiology Foundation." <i>Circulation</i> 124, no. 22 (November 29, 2011): 2458–73.  <a href="https://doi.org/10.1161/CIR.0b013e318235eb4d">https://doi.org/10.1161/CIR.0b013e318235eb4d</a></p>
<b>Characteristics</b>	
<b>Scoring</b>	Proportion.
<b>Type</b>	Process.
<b>Product lines</b>	<ul style="list-style-type: none"> <li>• Commercial.</li> <li>• Medicaid.</li> <li>• Medicare.</li> </ul>
<b>Stratifications</b>	None.
<b>Risk adjustment</b>	None.
<b>Improvement notation</b>	Increased score indicates improvement.
<b>Guidance</b>	<p><b>Data collection methodology:</b> Administrative. Refer to <a href="#">General Guideline: Data Collection Methods</a> for additional information.</p> <p><b>Date specificity:</b> Dates must be specific enough to determine the event occurred in the period being measured.</p> <p><b>Which services count?</b> When using claims, include all paid, suspended, pending and denied claims.</p>
<b>Definitions</b>	
<b>180-day measurement interval</b>	The 180-day period that includes the discharge date and the 179 days after discharge.
<b>Direct transfer</b>	<p>When the discharge date from the first inpatient setting precedes the admission date to a second inpatient setting by 1 calendar day or less.</p> <ul style="list-style-type: none"> <li>• <i>For example:</i> <ul style="list-style-type: none"> <li>– An inpatient discharge on June 1, followed by an admission to another inpatient setting on June 1, <i>is a direct transfer</i>.</li> <li>– An inpatient discharge on June 1, followed by an admission to an inpatient setting on June 2, <i>is a direct transfer</i>.</li> <li>– An inpatient discharge on June 1, followed by an admission to another inpatient setting on June 3, <i>is not a direct transfer</i>; these are two distinct inpatient stays.</li> </ul> </li> </ul>

<b>Treatment days (covered days)</b>	The actual number of calendar days covered with prescriptions within the specified 180-day measurement interval (e.g., a prescription of a 90-day supply dispensed on the 100th day will have 81 days counted in the 180-day interval).
<b>Initial population</b>	<p><b>Measure item count:</b> Person.</p> <p><b>Attribution basis:</b> Enrollment.</p> <ul style="list-style-type: none"> <li>• <b>Benefits:</b> Medical and pharmacy.</li> <li>• <b>Continuous enrollment:</b> Discharge date through 179 days after discharge.</li> <li>• <b>Allowable gap:</b> No more than one gap of ≤45 days within the 180 days of the event. No gaps on the discharge date.</li> </ul> <p><b>Ages:</b> 18 years of age and older as of the last day of the measurement period.</p> <p><b>Event: Hospitalization for AMI.</b></p> <p>An acute inpatient discharge from July 1 of the year prior to the measurement period through June 30 of the measurement period with any diagnosis of AMI (<u>AMI Value Set</u>) on the discharge claim.</p> <p>To identify an acute inpatient discharge:</p> <ol style="list-style-type: none"> <li>1. Identify all acute and nonacute inpatient stays (<u>Inpatient Stay Value Set</u>).</li> <li>2. Exclude nonacute inpatient stays (<u>Nonacute Inpatient Stay Value Set</u>).</li> <li>3. Identify the discharge date for the stay.</li> </ol> <p>If a person has more than one eligible episode of AMI from July 1 of the year prior to the measurement period through June 30 of the measurement period, include only the first discharge.</p> <p><b>Direct transfers to an acute inpatient care setting.</b> If there was a direct transfer to an acute inpatient setting (for any diagnosis), use the discharge date from the transfer setting, not the initial discharge. Exclude both the initial discharge and the direct transfer discharge if the transfer discharge occurs after June 30 of the measurement period. Use the instructions below to identify direct transfers and exclude nonacute inpatient stays (<u>Nonacute Inpatient Stay Value Set</u>).</p> <p><b>Direct transfers to a nonacute inpatient care setting.</b> Exclude from the initial population hospitalizations with a direct transfer to a nonacute inpatient care setting for any diagnosis. Use the instructions below to identify direct transfers and confirm the stay was for nonacute inpatient care based on the presence of a nonacute code (<u>Nonacute Inpatient Stay Value Set</u>) on the claim.</p> <p>Use the following method to identify admissions to and discharges from inpatient settings for direct transfers:</p> <ol style="list-style-type: none"> <li>1. Identify all acute and nonacute inpatient stays (<u>Inpatient Stay Value Set</u>).</li> <li>2. If needed, identify nonacute inpatient stays (<u>Nonacute Inpatient Stay Value Set</u>).</li> <li>3. Identify the admission and discharge dates for the stay.</li> </ol>

<p><b>Denominator exclusions</b></p>	<p><b>Persons with a date of death.</b> Death in the measurement period, identified using data sources determined by the organization. Method and data sources are subject to review during the HEDIS audit.</p> <p><b>Persons in hospice or using hospice services.</b> Persons who use hospice services (<u>Hospice Encounter Value Set</u>; <u>Hospice Intervention Value Set</u>) or elect to use a hospice benefit any time during the measurement period. Organizations that use the Monthly Membership Detail Data File to identify these persons must use only the run date of the file.</p> <p><b>Medicare enrollees, 66 years of age and older by the last day of the measurement period, in an institutional SNP (I-SNP) or living long-term in an institution (LTI).</b></p> <ul style="list-style-type: none"> <li>• Enrolled in an Institutional SNP (I-SNP) any time on or between July 1 of the year prior to the measurement period and the last day of the measurement period.</li> <li>• Living long-term in an institution any time on or between July 1 of the year prior to the measurement period and the last day of the measurement period as identified by the LTI flag in the Monthly Membership Detail Data File. Use the run date of the file to determine if a member had an LTI flag any time on or between July 1 of the year prior to the measurement period and the last day of the measurement period.</li> </ul> <p><b>Persons 66–80 years of age by the last day of the measurement period, with both frailty and advanced illness.</b></p> <ol style="list-style-type: none"> <li>1. <b>Frailty.</b> At least two indications of frailty (<u>Frailty Device Value Set</u>; <u>Frailty Diagnosis Value Set*</u>; <u>Frailty Encounter Value Set</u>; <u>Frailty Symptom Value Set*</u>) with different dates of service any time on or between July 1 of the year prior to the measurement period and the last day of the measurement period.</li> <li>2. <b>Advanced illness.</b> Either of the following during the measurement period or the year prior to the measurement period: <ul style="list-style-type: none"> <li>– Advanced illness (<u>Advanced Illness Value Set*</u>) on at least two different dates of service.</li> <li>– Dispensed dementia medication (<u>Dementia Medications List</u>).</li> </ul> </li> </ol> <p><b>Persons 81 years of age and older as of the last day of the measurement period, with frailty.</b> Persons with at least two indications of frailty (<u>Frailty Device Value Set</u>; <u>Frailty Diagnosis Value Set*</u>; <u>Frailty Encounter Value Set</u>; <u>Frailty Symptom Value Set*</u>) with different dates of service any time on or between July 1 of the year prior to the measurement period and the last day of the measurement period.</p> <p><b>Persons with a contraindication to beta-blocker therapy.</b> Persons with a medication dispensing event (<u>Asthma Exclusions Medications List</u>) or a diagnosis (<u>Beta Blocker Contraindications Value Set*</u>) that indicates a contraindication to beta-blocker therapy any time during the person's history through the last day of the continuous enrollment period.</p> <p><b>Coding Guidance</b> *Do not include laboratory claims (claims with POS code 81).</p>
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<b>Denominator</b>	The initial population minus denominator exclusions.																								
<b>Numerator</b>	<p><b>Persistent beta-blocker treatment.</b>            Persons with at least 135 days of treatment with beta-blockers (<a href="#">Beta Blocker Medications List</a>) during the 180-day measurement interval. This allows gaps in medication treatment of up to a total of 45 days during the 180-day measurement interval.</p> <p>Assess for active prescriptions and include days supply that fall within the 180-day measurement interval.</p> <p>For persons who were on beta-blockers prior to admission and those who were dispensed an ambulatory prescription during their inpatient stay, factor those prescriptions into adherence rates if the actual treatment days fall within the 180-day measurement interval.</p>																								
<b>Summary of changes</b>	<ul style="list-style-type: none"> <li>Moved the definition of “direct transfer” from the initial population to the <i>Definitions</i> section.</li> </ul>																								
<b>Data element tables</b>	<p>Organizations that submit HEDIS data to NCQA must provide the following data elements.</p> <p><b>Table PBH-1/2/3: Data Elements for Persistence of Beta-Blocker Treatment After a Heart Attack</b></p> <table border="1"> <thead> <tr> <th>Metric</th> <th>Data Element</th> <th>Reporting Instructions</th> </tr> </thead> <tbody> <tr> <td>BetaBlockerPersistence</td> <td>Benefit</td> <td>Metadata</td> </tr> <tr> <td></td> <td>InitialPopulation</td> <td>Report once</td> </tr> <tr> <td></td> <td>Exclusions</td> <td>Report once</td> </tr> <tr> <td></td> <td>Denominator</td> <td>Report once</td> </tr> <tr> <td></td> <td>NumeratorByAdmin</td> <td>Report once</td> </tr> <tr> <td></td> <td>NumeratorBySupplemental</td> <td>Report once</td> </tr> <tr> <td></td> <td>Rate</td> <td>(Percent)</td> </tr> </tbody> </table>	Metric	Data Element	Reporting Instructions	BetaBlockerPersistence	Benefit	Metadata		InitialPopulation	Report once		Exclusions	Report once		Denominator	Report once		NumeratorByAdmin	Report once		NumeratorBySupplemental	Report once		Rate	(Percent)
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<b>Rules for Allowable Adjustments</b>	<p><b>Copyright and use:</b> The “Rules for Allowable Adjustments of HEDIS” (the “Rules”) describe how NCQA’s HEDIS measure specifications can be adjusted for other populations, if applicable. The Rules, reviewed and approved by NCQA measure experts, provide for expanded use of HEDIS measures without changing their clinical intent.</p> <p><b>Adjusted HEDIS measures may not be used for HEDIS health plan reporting.</b></p> <p><b>ADJUSTMENTS ALLOWED</b></p> <ul style="list-style-type: none"> <li><b>Product lines.</b> Organizations are not required to use product line criteria; product lines may be combined, and all (or no) product line criteria may be used.</li> <li><b>Attribution.</b> Organizations are not required to use enrollment criteria.  <b>Note:</b> Adjusting the discharge date will affect the treatment days and the 180-day measurement interval calculations.</li> <li><b>Benefits.</b> Organizations are not required to use a benefit.</li> </ul>																								

- *Other.* Organizations may use additional initial population criteria to focus on an area of interest defined by gender, race, ethnicity, socioeconomic or sociodemographic characteristics, geographic region or another characteristic.
- *Measurement period adjustments.* Organizations may adjust the measurement period.
- *Exclusions.* The hospice, deceased person, I-SNP, LTI, frailty or advanced illness exclusions are not required.
- *Telehealth.* Services/events that allow the use of synchronous telehealth visits, telephone visits and asynchronous telehealth (e-visits, virtual check-ins) may be stratified to identify services performed via telehealth. This adjustment is not allowed for events, numerators and exclusions that do not allow the use of telehealth.
- *Supplemental data.* Supplemental data may be used to identify initial population, denominator, exclusion and numerator events.

#### **ADJUSTMENTS ALLOWED WITH LIMITS**

- *Ages.* Age determination dates may be changed (e.g., select, "age as of June 30"). The denominator age may be changed if the age is within the specified age range (18 years and older). The denominator age may not be expanded.

#### **ADJUSTMENTS NOT ALLOWED**

- *Initial population:* Event. Only events that contain (or map to) codes in the medication lists and value sets may be used to identify discharges. Medication lists, value sets and logic may not be changed.
- *Exclusions.* The medication dispensing event and diagnosis that indicates a contraindication to beta-blocker therapy exclusions must be applied. The value sets, medication lists and logic may not be changed.
- *Numerator.* Medication lists and logic may not be changed.

## Cardiac Rehabilitation (CRE)

Measure title	Cardiac Rehabilitation	Measure ID	CRE
<b>Description</b>	<p>The percentage of persons 18 years of age and older who attended cardiac rehabilitation following a qualifying cardiac event, including myocardial infarction (MI), percutaneous coronary intervention (PCI), coronary artery bypass grafting (CABG), heart and heart/lung transplantation or heart valve repair/replacement. Four rates are reported:</p> <ul style="list-style-type: none"> <li>• <i>Initiation.</i> The percentage of persons who attended 2 or more sessions of cardiac rehabilitation within 30 days after a qualifying event.</li> <li>• <i>Engagement 1.</i> The percentage of persons who attended 12 or more sessions of cardiac rehabilitation within 90 days after a qualifying event.</li> <li>• <i>Engagement 2.</i> The percentage of persons who attended 24 or more sessions of cardiac rehabilitation within 180 days after a qualifying event.</li> <li>• <i>Achievement.</i> The percentage of persons who attended 36 or more sessions of cardiac rehabilitation within 180 days after a qualifying event.</li> </ul>		
<b>Measurement period</b>	January 1–December 31.		
<b>Copyright and disclaimer notice</b>	<p>Refer to the complete copyright and disclaimer information at the front of this publication.  NCQA website: <a href="http://www.ncqa.org">www.ncqa.org</a>.  Submit policy clarification support questions via My NCQA (<a href="https://my.ncqa.org">https://my.ncqa.org</a>).</p>		
<b>Clinical recommendation statement/ rationale</b>	<p>The American College of Cardiology and the American Heart Association (ACC/AHA) recommend cardiac rehabilitation for patients who have experienced MI, CABG, PCI, coronary revascularization or coronary artery and other atherosclerotic vascular disease.</p>		
<b>Citations</b>	<p>Thomas, R.J., G. Balady, G. Banka, T.M. Beckie, J. Chiu, S. Gokak, P.M. Ho, et al. 2018. “2018 ACC/AHA Clinical Performance and Quality Measures for Cardiac Rehabilitation: A Report of the American College of Cardiology/American Heart Association Task Force on Performance Measures.” <i>Circulation</i> 11 (4): 1–29. <a href="https://doi.org/10.1161/HQQ.0000000000000037">https://doi.org/10.1161/HQQ.0000000000000037</a></p>		
<b>Characteristics</b>			
<b>Scoring</b>	Proportion.		
<b>Type</b>	Process.		
<b>Product lines</b>	<ul style="list-style-type: none"> <li>• Commercial.</li> <li>• Medicaid.</li> <li>• Medicare.</li> </ul>		

<b>Stratifications</b>	Age as of the episode date. <ul style="list-style-type: none"> <li>• 18–64 years of age.</li> <li>• 65 years of age and older.</li> </ul>
<b>Risk adjustment</b>	None.
<b>Improvement notation</b>	Increased score indicates improvement.
<b>Guidance</b>	<p><b>Data collection methodology:</b> Administrative. Refer to <a href="#">General Guideline: Data Collection Methods</a> for additional information.</p> <p><b>Date specificity:</b> Dates must be specific enough to determine the event occurred in the period being measured.</p> <p><b>Which services count?</b> When using claims, include all paid, suspended, pending and denied claims.</p>
<b>Definitions</b>	
<b>Direct transfer</b>	When the discharge date from the first inpatient setting precedes the admission date to a second inpatient setting by 1 calendar day or less. <ul style="list-style-type: none"> <li>• <i>For example:</i> <ul style="list-style-type: none"> <li>– An inpatient discharge on June 1, followed by an admission to another inpatient setting on June 1, <i>is a direct transfer</i>.</li> <li>– An inpatient discharge on June 1, followed by an admission to an inpatient setting on June 2, <i>is a direct transfer</i>.</li> <li>– An inpatient discharge on June 1, followed by an admission to another inpatient setting on June 3, <i>is not a direct transfer</i>; these are two distinct inpatient stays.</li> </ul> </li> </ul>
<b>Episode date</b>	<p>The most recent cardiac event during the intake period, including MI, CABG, PCI, heart or heart/lung transplant or heart valve repair/replacement.</p> <p><i>For MI, CABG, heart or heart/lung transplant or heart valve repair/replacement</i>, the episode date is the date of discharge.</p> <p><i>For PCI</i>, the episode date is the date of service.</p> <p><i>For inpatient claims</i>, the episode date is the date of discharge.</p> <p><i>For direct transfers to an acute or nonacute setting for any diagnosis</i>, the episode date is the discharge date from the last admission.</p>
<b>Intake period</b>	July 1 of the year prior to the measurement period to June 30 of the measurement period.
<b>Initial population</b>	<p><b>Measure item count:</b> Person.</p> <p><b>Attribution basis:</b> Enrollment.</p> <ul style="list-style-type: none"> <li>• <b>Benefits:</b> Medical.</li> <li>• <b>Continuous enrollment:</b> Episode date through the following 180 days.</li> </ul>

	<ul style="list-style-type: none"> <li>• <b>Allowable gap:</b> None.</li> </ul> <p><b>Ages:</b> 18 years of age and older as of the episode date.</p> <p><b>Event: Persons with a cardiac event.</b></p> <p><b>Step 1.</b> Identify all persons who had any of the following cardiac events during the intake period:</p> <ul style="list-style-type: none"> <li>• Persons who had PCI (<a href="#">PCI Value Set</a>; <a href="#">Other PCI Value Set</a>) in any setting.</li> <li>• Persons discharged from an inpatient setting with any of the following on the discharge claim: <ul style="list-style-type: none"> <li>– MI (<a href="#">MI Value Set</a>).</li> <li>– CABG (<a href="#">CABG Value Set</a>; <a href="#">Percutaneous CABG Value Set</a>).</li> <li>– Heart or heart/lung transplant (<a href="#">Heart Transplant Value Set</a>).</li> <li>– Heart valve repair or replacement (<a href="#">Heart Valve Repair or Replacement Value Set</a>).</li> </ul> </li> </ul> <p>To identify discharges:</p> <ol style="list-style-type: none"> <li>1. Identify all acute and nonacute inpatient stays (<a href="#">Inpatient Stay Value Set</a>).</li> <li>2. Identify the discharge date for the stay.</li> </ol> <p><b>Step 2.</b> For persons identified in step 1, the episode is the most recent cardiac event. If more than one cardiac event meets event criteria, include only the most recent during the intake period.</p> <p><b>Step 3.</b> Test for direct transfers. For episodes with a <i>direct transfer</i> to an acute or nonacute setting for any diagnosis the episode date is the <i>discharge date from the last admission</i>.</p> <p>To identify admissions to and discharges from inpatient settings:</p> <ol style="list-style-type: none"> <li>1. Identify all acute and nonacute inpatient stays (<a href="#">Inpatient Stay Value Set</a>).</li> <li>2. Identify the admission and discharge dates for the stay.</li> </ol> <p>Exclude both the initial discharge and the direct transfer discharge if the last discharge occurs after June 30 of the measurement period.</p> <p><b>Note:</b> The direct transfer does not require a cardiac event diagnosis.</p>
<b>Denominator exclusions</b>	<p><b>Persons with a date of death.</b> Death in the measurement period, identified using data sources determined by the organization. Method and data sources are subject to review during the HEDIS audit.</p> <p><b>Persons in hospice or using hospice services.</b> Persons who use hospice services (<a href="#">Hospice Encounter Value Set</a>; <a href="#">Hospice Intervention Value Set</a>) or elect to use a hospice benefit any time during the measurement period. Organizations that use the Monthly Membership Detail Data File to identify these persons must use only the run date of the file.</p>

**Persons receiving palliative care.**

Persons receiving palliative care ([Palliative Care Assessment Value Set](#); [Palliative Care Encounter Value Set](#); [Palliative Care Intervention Value Set](#)) or who had an encounter for palliative care (ICD-10-CM code Z51.5\*) any time during the intake period through the last day of the measurement period.

**Medicare enrollees, 66 years of age and older by the last day of the measurement period, in an institutional SNP (I-SNP) or living long-term in an institution (LTI).**

- Enrolled in an Institutional SNP (I-SNP) any time during the intake period through the last day of the measurement period.
- Living long-term in an institution any time during the measurement period as identified by the LTI flag in the Monthly Membership Detail Data File. Use the run date of the file to determine if a member had an LTI flag during the intake period through the last day of the measurement period.

**Persons 66–80 years of age by the last day of the measurement period, with both frailty and advanced illness.**

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 last day of the measurement period.
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.
  - Dispensed dementia medication ([Dementia Medications List](#)).

**Persons 81 years of age or older by the last day of the measurement period with frailty.**

Persons 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 last day of the measurement period.

**Persons with an additional cardiac event.**

Any of the following cardiac events during the 180 days after the episode date:

- Persons who had PCI ([PCI Value Set](#); [Other PCI Value Set](#)) in any setting.
- Persons discharged from an inpatient setting with any of the following on the discharge claim:
  - MI ([MI Value Set](#)).
  - CABG ([CABG Value Set](#); [Percutaneous CABG Value Set](#)).
  - Heart or heart/lung transplant ([Heart Transplant Value Set](#)).
  - Heart valve repair or replacement ([Heart Valve Repair or Replacement Value Set](#)).

To identify discharges:

1. Identify all acute and nonacute inpatient stays ([Inpatient Stay Value Set](#)).

	<p>2. Identify the discharge date for the stay.</p> <p><b>Coding Guidance</b> *Do not include laboratory claims (claims with POS code 81).</p>																												
<b>Denominator</b>	The initial population minus denominator exclusions.																												
<b>Numerators</b>	<p><b>Numerator 1: Initiation.</b> At least 2 sessions of cardiac rehabilitation (<a href="#">Cardiac Rehabilitation Value Set</a>) on the episode date through 30 days after the episode date (31 total days) (on the same or different dates of service).</p> <p><b>Numerator 2: Engagement 1.</b> At least 12 sessions of cardiac rehabilitation (<a href="#">Cardiac Rehabilitation Value Set</a>) on the episode date through 90 days after the episode date (91 total days) (on the same or different dates of service).</p> <p><b>Numerator 3: Engagement 2.</b> At least 24 sessions of cardiac rehabilitation (<a href="#">Cardiac Rehabilitation Value Set</a>) on the episode date through 180 days after the episode date (181 total days) (on the same or different dates of service).</p> <p><b>Numerator 4: Achievement.</b> At least 36 sessions of cardiac rehabilitation (<a href="#">Cardiac Rehabilitation Value Set</a>) sessions on the episode date through 180 days after the episode date (181 total days) (on the same or different dates of service).</p> <p><b>Note:</b> Count multiple cardiac rehabilitation sessions on the same date of service as multiple sessions. For example, if a person has two different codes for cardiac rehabilitation on the same date of service (or one code billed as two units), count this as two sessions of cardiac rehabilitation.</p>																												
<b>Summary of changes</b>	<ul style="list-style-type: none"> <li>Moved the definition of “direct transfer” from the initial population to the <i>Definitions</i> section.</li> </ul>																												
<b>Data element tables</b>	<p>Organizations that submit HEDIS data to NCQA must provide the following data elements.</p> <p><b>Table CRE-1/2/3: Data Elements for Cardiac Rehabilitation</b></p> <table border="1"> <thead> <tr> <th>Metric</th> <th>Age</th> <th>Data Element</th> <th>Reporting Instructions</th> </tr> </thead> <tbody> <tr> <td>Initiation</td> <td>18-64</td> <td>InitialPopulation</td> <td>For each Stratification, repeat per Metric</td> </tr> <tr> <td>Engagement1</td> <td>65+</td> <td>Exclusions</td> <td>For each Stratification, repeat per Metric</td> </tr> <tr> <td>Engagement2</td> <td>Total</td> <td>Denominator</td> <td>For each Stratification, repeat per Metric</td> </tr> <tr> <td>Achievement</td> <td></td> <td>NumeratorByAdmin</td> <td>For each Metric and Stratification</td> </tr> <tr> <td></td> <td></td> <td>NumeratorBySupplemental</td> <td>For each Metric and Stratification</td> </tr> <tr> <td></td> <td></td> <td>Rate</td> <td>(Percent)</td> </tr> </tbody> </table>	Metric	Age	Data Element	Reporting Instructions	Initiation	18-64	InitialPopulation	For each Stratification, repeat per Metric	Engagement1	65+	Exclusions	For each Stratification, repeat per Metric	Engagement2	Total	Denominator	For each Stratification, repeat per Metric	Achievement		NumeratorByAdmin	For each Metric and Stratification			NumeratorBySupplemental	For each Metric and Stratification			Rate	(Percent)
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		NumeratorBySupplemental	For each Metric and Stratification																										
		Rate	(Percent)																										

<b>Rules for Allowable Adjustments</b>	<p><b>Copyright and use:</b> The “Rules for Allowable Adjustments of HEDIS” (the “Rules”) describe how NCQA’s HEDIS measure specifications can be adjusted for other populations, if applicable. The Rules, reviewed and approved by NCQA measure experts, provide for expanded use of HEDIS measures without changing their clinical intent.</p> <p><b>Adjusted HEDIS measures may not be used for HEDIS health plan reporting.</b></p> <p><b>ADJUSTMENTS ALLOWED</b></p> <ul style="list-style-type: none"> <li>• <i>Product lines.</i> Organizations are not required to use product line criteria; product lines may be combined, and all (or no) product line criteria may be used.</li> <li>• <i>Attribution.</i> Organizations are not required to use enrollment criteria.</li> <li>• <i>Benefits.</i> Organizations are not required to use a benefit.</li> <li>• <i>Other.</i> Organizations may use additional initial population criteria to focus on an area of interest defined by gender, race, ethnicity, socioeconomic or sociodemographic characteristics, geographic region or another characteristic.</li> <li>• <i>Exclusions.</i> The hospice, deceased persons, palliative care, I-SNP, LTI, frailty and advanced illness exclusions are not required.</li> <li>• <i>Measurement period adjustments.</i> Organizations may adjust the measurement period.</li> <li>• <i>Telehealth.</i> Services/events that allow the use of synchronous telehealth visits, telephone visits and asynchronous telehealth (e-visits, virtual check-ins) may be stratified to identify services performed via telehealth. This adjustment is not allowed for events, numerators and exclusions that do not allow the use of telehealth.</li> <li>• <i>Supplemental data.</i> Supplemental data may be used to identify initial population, denominator, exclusion and numerator events.</li> </ul> <p><b>ADJUSTMENTS ALLOWED WITH LIMITS</b></p> <ul style="list-style-type: none"> <li>• <i>Ages.</i> Age determination dates may be changed (e.g., select, “age as of June 30”). The denominator age may be changed if the range is within the specified age range (e.g., 18–30 years of age).</li> </ul> <p><b>ADJUSTMENTS NOT ALLOWED</b></p> <ul style="list-style-type: none"> <li>• <i>Initial population:</i> Event. Only events that contain (or map to) codes in the value sets may be used to identify cardiac events. Value sets and logic may not be changed.</li> <li>• <i>Exclusions.</i> The MI, CABG, heart/lung transplant, heart valve repair/replacement and PCI exclusions must be applied. Value sets and logic may not be changed.</li> <li>• <i>Numerator.</i> Value sets and logic may not be changed.</li> </ul>
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# ***Diabetes***

## Glycemic Status Assessment for Patients With Diabetes (GSD)

Measure title	Glycemic Status Assessment for Patients With Diabetes	Measure ID	GSD
<b>Description</b>	<p>The percentage of persons 18–75 years of age with diabetes (type 1 or type 2) whose most recent glycemic status (hemoglobin A1c [HbA1c] or glucose management indicator [GMI]) was at the following levels during the measurement period:</p> <ul style="list-style-type: none"> <li>• Glycemic Status &lt;8.0%.</li> <li>• Glycemic Status &gt;9.0%.</li> </ul>		
<b>Measurement period</b>	January 1–December 31.		
<b>Copyright and disclaimer notice</b>	<p>Refer to the complete copyright and disclaimer information at the front of this publication.</p> <p>NCQA website: <a href="http://www.ncqa.org">www.ncqa.org</a>.</p> <p>Submit policy clarification support questions via My NCQA (<a href="https://my.ncqa.org">https://my.ncqa.org</a>).</p>		
<b>Clinical recommendation statement/ rationale</b>	<p>American Diabetes Association (2025)</p> <ul style="list-style-type: none"> <li>• Assess glycemic status by A1C (Level of evidence: A) and/or continuous glucose monitoring (CGM) metrics such as time in range, time above range, and time below range (Level of evidence: B). Fructosamine or CGM can be used for glycemic monitoring when an alternative to A1C is required. Level of evidence: B</li> <li>• Assess glycemic status at least two times a year, and more frequently (e.g., every 3 months) for individuals not meeting glycemic goals or with recent treatment changes, frequent or severe hypoglycemia or hyperglycemia, or changes in health status, or during periods of rapid growth and development in youth. Level of evidence: E</li> <li>• An A1C goal of &lt;7% (&lt;53 mmol/mol) is appropriate for many nonpregnant adults without severe hypoglycemia or frequent hypoglycemia affecting health or quality of life. Level of evidence: A</li> <li>• Based on health care professional judgment and the preference of the person with diabetes, achievement of lower A1C levels than the goal of 7% (53 mmol/mol) may be acceptable and even beneficial if it can be achieved safely without frequent or severe hypoglycemia or other adverse effects of treatment. Level of evidence: B</li> <li>• Less stringent glycemic goals may be appropriate for individuals with limited life expectancy or where the harms of treatment are greater than the benefits. Level of evidence: B</li> </ul>		
<b>Citations</b>	<p>American Diabetes Association Professional Practice Committee. 2025. "6. Glycemic Goals and Hypoglycemia: Standards of Care in Diabetes—2025." <i>Diabetes Care</i> 48(Suppl. 1):S128–45.</p>		

Characteristics	
<b>Scoring</b>	Proportion.
<b>Type</b>	Outcome.
<b>Product lines</b>	<ul style="list-style-type: none"> <li>• Commercial.</li> <li>• Medicaid.</li> <li>• Medicare.</li> </ul>
<b>Stratifications</b>	<p>Race. (Refer to <a href="#">General Guideline: Race and Ethnicity Stratification</a>.)</p> <ul style="list-style-type: none"> <li>• American Indian or Alaska Native.</li> <li>• Asian.</li> <li>• Black or African American.</li> <li>• Middle Eastern or North African.</li> <li>• Native Hawaiian or Pacific Islander.</li> <li>• White.</li> <li>• Some Other Race.</li> <li>• Two or More Races.</li> <li>• Asked But No Answer.</li> <li>• Unknown.</li> </ul> <p>Ethnicity. (Refer to <a href="#">General Guideline: Race and Ethnicity Stratification</a>.)</p> <ul style="list-style-type: none"> <li>• Hispanic or Latino.</li> <li>• Not Hispanic or Latino.</li> <li>• Asked But No Answer.</li> <li>• Unknown.</li> </ul>
<b>Risk adjustment</b>	None.
<b>Guidance</b>	<p><b>Data collection methodology:</b> Administrative and hybrid. Refer to <a href="#">General Guideline: Data Collection Methods</a> for additional information. Organizations must use the same data collection method (Administrative or Hybrid) to report these indicators.</p> <p><b>Date specificity:</b> Dates must be specific enough to determine the event occurred in the period being measured.</p> <p><b>Which services count?</b> When using claims, include all paid, suspended, pending and denied claims.</p> <p><b>Other guidance:</b> If a combination of administrative, supplemental or hybrid data are used, the most recent glycemic status assessment must be used, regardless of data source.</p> <p><b>Improvement notation:</b></p> <ul style="list-style-type: none"> <li>• <i>Glycemic status &lt;8.0%</i>. Increased score indicates improvement.</li> <li>• <i>Glycemic status &gt;9.0%</i>. Decreased score indicates improvement.</li> </ul>

<b>Initial population</b>	<p><b>Measure item count:</b> Person.</p> <p><b>Attribution basis:</b> Enrollment.</p> <ul style="list-style-type: none"> <li>• <b>Benefits:</b> Medical.</li> <li>• <b>Continuous enrollment:</b> The measurement period.</li> <li>• <b>Allowable gap:</b> No more than one gap of ≤45 days during the measurement period. No gaps on the last day of the measurement period.</li> </ul> <p><b>Ages:</b> 18–75 years of age as of the last day of the measurement period.</p> <p><b>Event: Identify persons with a diagnosis of diabetes.</b></p> <p>Either of the following meets criteria:</p> <ul style="list-style-type: none"> <li>• <b>Claim/encounter data.</b> At least two diagnoses of diabetes (<a href="#">Diabetes Value Set*</a>) on different dates of service during the measurement period or the year prior to the measurement period.</li> <li>• <b>Pharmacy data.</b> At least one diagnosis of diabetes (<a href="#">Diabetes Value Set*</a>) <b>and</b> at least one diabetes medication dispensing event of insulin or a hypoglycemic/antihyperglycemic medication (<a href="#">Diabetes Medications List</a>) during the measurement period or the year prior to the measurement period.</li> </ul> <p><b>Coding Guidance</b></p> <p>*Do not include laboratory claims (claims with POS code 81).</p>
<b>Denominator exclusions</b>	<p><b>Persons with a date of death.</b> Death in the measurement period, identified using data sources determined by the organization. Method and data sources are subject to review during the HEDIS audit.</p> <p><b>Persons in hospice or using hospice services.</b> Persons who use hospice services (<a href="#">Hospice Encounter Value Set</a>; <a href="#">Hospice Intervention Value Set</a>) or elect to use a hospice benefit any time during the measurement period. Organizations that use the Monthly Membership Detail Data File to identify these persons must use only the run date of the file.</p> <p><b>Persons receiving palliative care.</b> Persons receiving palliative care (<a href="#">Palliative Care Assessment Value Set</a>; <a href="#">Palliative Care Encounter Value Set</a>; <a href="#">Palliative Care Intervention Value Set</a>) or who had an encounter for palliative care (ICD-10-CM code Z51.5*) any time during the measurement period.</p> <p><b>Medicare enrollees, 66 years of age and older by the last day of the measurement period in an institutional SNP (I-SNP) or living long-term in an institution (LTI).</b></p> <ul style="list-style-type: none"> <li>• Enrolled in an Institutional SNP (I-SNP) any time during the measurement period.</li> <li>• Living long-term in an institution any time during the measurement period as identified by the LTI flag in the Monthly Membership Detail Data File. Use the run date of the file to determine if a member had an LTI flag during the measurement period.</li> </ul>

	<p><b>Persons 66 years of age or older by the last day of the measurement period, with both frailty and advanced illness.</b></p> <ol style="list-style-type: none"> <li>1. <b>Frailty.</b> At least two indications of frailty (<a href="#">Frailty Device Value Set</a>; <a href="#">Frailty Diagnosis Value Set*</a>; <a href="#">Frailty Encounter Value Set</a>; <a href="#">Frailty Symptom Value Set*</a>) with different dates of service during the measurement period.</li> <li>2. <b>Advanced illness.</b> Either of the following during the measurement period or the year prior to the measurement period:             <ul style="list-style-type: none"> <li>– Advanced illness (<a href="#">Advanced Illness Value Set*</a>) on at least two different dates of service.</li> <li>– Dispensed dementia medication (<a href="#">Dementia Medications List</a>).</li> </ul> </li> </ol> <p><b>Coding Guidance</b> *Do not include laboratory claims (claims with POS code 81).</p>
<b>Denominator</b>	<p><b>ADMINISTRATIVE</b> The initial population minus denominator exclusions.</p> <p><b>HYBRID</b> A systematic sample drawn from the administrative denominator.</p> <p>Organizations that use the Hybrid Method to report the Glycemic Status Assessment for Patients With Diabetes (GSD) and Blood Pressure Control for Patients With Diabetes (BPD) measures may use the same sample for both measures. If the same sample is used for both measures, the organization must take the inverse of the Glycemic Status &gt;9.0% rate (100 minus the Glycemic Status &gt;9.0% rate) before reducing the sample.</p> <p>Organizations may reduce the sample size based on the current year's administrative rate or the prior year's audited, product line-specific rate for the lowest rate of all GSD indicators and the BPD measure.</p> <p>If separate samples are used for the GSD and BPD measures, organizations may reduce the sample based on the product line-specific current year's administrative rate or the prior year's audited, product line-specific rate for the measure.</p> <p>Refer to the <a href="#">Guidelines for Calculations and Sampling</a> for information on reducing sample size.</p>
<b>Numerator</b>	<p><b>ADMINISTRATIVE</b></p> <p><b>Numerator 1: Glycemic status &lt;8%.</b> Identify the most recent glycemic status assessment (HbA1c or GMI) (<a href="#">HbA1c Lab Test Value Set</a>; <a href="#">HbA1c Test Result or Finding Value Set*†</a>; LOINC code 97506-0) during the measurement period. If there are multiple glycemic status assessments on the same date of service, use the lowest result.</p> <ul style="list-style-type: none"> <li>• <b>Compliant:</b> Most recent glycemic status assessment with a result of &lt;8.0%.</li> <li>• <b>Not compliant:</b> Most recent glycemic status assessment is ≥8.0%; is missing a result; or if a glycemic status assessment was not done during the measurement period.</li> </ul>

If the most recent glycemic status assessment was an HbA1c test identified based on a CPT Category II code (HbA1c Test Result or Finding Value Set), use the following to determine compliance:

- *Compliant:* HbA1c Level Less Than 8.0 Value Set.
- *Not compliant:* HbA1c Level Greater Than or Equal To 8.0 Value Set.

#### **Numerator 2: Glycemic status >9%.**

Identify the most recent glycemic status assessment (HbA1c or GMI) (HbA1c Lab Test Value Set; HbA1c Test Result or Finding Value Set\*†; LOINC code 97506-0) during the measurement period. If there are multiple glycemic status assessments on the same date, use the lowest result.

- *Compliant:* Most recent glycemic status assessment with a result of >9.0% or is missing a result, or if a glycemic status assessment was not done during the measurement period.
- *Not compliant:* Most recent glycemic status assessment during the measurement period is ≤9.0%.

If the most recent glycemic status assessment was an HbA1c test identified based on a CPT Category II code (HbA1c Test Result or Finding Value Set), use the following to determine compliance:

- *Compliant:* CPT Category II code 3046F.
- *Not compliant:* HbA1c Level Less Than or Equal To 9.0 Value Set.

#### **Coding Guidance**

\*Do not include laboratory claims (claims with POS code 81).

†Do not include CPT Category II codes with a modifier (CPT CAT II Modifier Value Set).

#### **HYBRID**

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

#### **Numerator 1: Glycemic status <8.0%.**

The result of the *most recent* glycemic status assessment (HbA1c or GMI) (performed during the measurement period) is <8.0% as documented through laboratory data or medical record review.

*Medical record:* At a minimum, documentation in the medical record must include a note indicating the date when the glycemic status assessment (HbA1c or GMI) was performed, and the result. The person is numerator compliant if the result of the most recent glycemic status assessment during the measurement period is <8.0%.

When identifying the most recent glycemic status assessment (HbA1c or GMI), GMI values must include documentation of the continuous glucose monitoring data date range used to derive the value. Use the terminal date in the range to assign assessment date.

If multiple glycemic status assessments were recorded for a single date, use the lowest result.

	<p>GMI results collected by the person and documented in their medical record are eligible for use in reporting (if the GMI does not meet any exclusion criteria). There is no requirement for evidence that GMI was collected by a PCP or specialist.</p> <p>The person is not numerator compliant if the result of the most recent glycemic status assessment during the measurement period is <math>\geq 8.0\%</math> or is missing, or if a glycemic status assessment was not performed during the measurement period.</p> <p>Ranges and thresholds do not meet criteria for this indicator. A distinct numeric result is required for numerator compliance. "Unknown" is not considered a result/finding.</p> <p><b>Numerator 2: Glycemic status <math>&gt;9.0\%</math>.</b></p> <p>The result of the <i>most recent</i> glycemic status assessment (HbA1c or GMI) (performed during the measurement period) is <math>&gt;9.0\%</math> or is missing, or was not done during the measurement period, as documented through laboratory data or medical record review.</p> <p><i>Medical record:</i> Documentation in the medical record must include a note indicating the date when the glycemic status assessment was performed, and the result. The person is numerator compliant if the result of the most recent glycemic status assessment during the measurement period is <math>&gt;9.0\%</math> or is missing, or if a glycemic status assessment was not done during the measurement period.</p> <p>When identifying the most recent glycemic status assessment (HbA1c or GMI), GMI values must include documentation of the continuous glucose monitoring data date range used to derive the value. Use the terminal date in the range to assign assessment date.</p> <p>If multiple glycemic status assessments were recorded for a single date, use the lowest result.</p> <p>GMI results collected by the person and documented in their medical record are eligible for use in reporting (if the GMI does not meet any exclusion criteria). There is no requirement for evidence the GMI was collected by a PCP or specialist.</p> <p>The person is not numerator compliant if the most recent glycemic status during the measurement year is <math>\leq 9.0\%</math>.</p> <p>Ranges and thresholds do not meet criteria for this indicator. A distinct numeric result is required for numerator compliance. "Unknown" is not considered a result/finding.</p>
<b>Summary of changes</b>	<ul style="list-style-type: none"> <li>Updated the race and ethnicity stratification categories to align with OMB SPD 15 2024.</li> <li>Added instructions on allowable adjustments to the race and ethnicity stratification.</li> </ul>

**Data element tables**

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

**Table GSD-A-1/2/3: Data Elements for Glycemic Status Assessment for Patients With Diabetes**

Metric	Data Element	Reporting Instructions	A
LessThan8	CollectionMethod	Repeat per Metric	✓
GreaterThan9	InitialPopulation*	For each Metric	✓
	Exclusions*	For each Metric	✓
	Denominator*	Repeat per Metric	✓
	NumeratorByAdminDenom	For each Metric	
	CYAR	(Percent)	
	MinReqSampleSize	Repeat per Metric	
	OversampleRate	Repeat per Metric	
	OversampleRecordsNumber	(Count)	
	ExclusionValidDataErrors	Repeat per Metric	
	ExclusionEmployeeOrDep	Repeat per Metric	
	OversampleRecsAdded	Repeat per Metric	
	NumeratorByAdmin	For each Metric	✓
	NumeratorByMedicalRecords	For each Metric	
	NumeratorBySupplemental	For each Metric	✓
	Rate	(Percent)	✓

**Table GSD-B-1/2/3: Data Elements for Glycemic Status Assessment for Patients With Diabetes: Stratifications by Race**

Metric
LessThan8
GreaterThan9

Race	Data Element	Reporting Instructions	A
AmericanIndianOrAlaskaNative	CollectionMethod	Repeat per Metric and Stratification	✓
Asian	Denominator	For each Stratification, repeat per Metric	✓
BlackOrAfricanAmerican	Numerator	For each Metric and Stratification	✓
MiddleEasternOrNorthAfrican	Rate	(Percent)	✓
NativeHawaiianOrPacificIslander			
White			
SomeOtherRace			
TwoOrMoreRaces			
AskedButNoAnswer			
Unknown			

<b>Table GSD-C-1/2/3: Data Elements for Glycemic Status Assessment for Patients With Diabetes: Stratifications by Ethnicity</b>			
Metric			
LessThan8			
GreaterThan9			
Ethnicity	Data Element	Reporting Instructions	A
HispanicOrLatino	CollectionMethod	Repeat per Metric and Stratification	✓
NotHispanicOrLatino	Denominator	For each Stratification, repeat per Metric	✓
AskedButNoAnswer	Numerator	For each Metric and Stratification	✓
Unknown	Rate	(Percent)	✓

\* Repeat the InitialPopulation, Exclusions and Denominator values for metrics using the Administrative Method.

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<b>Rules for Allowable Adjustments</b>	<p><b>Copyright and use:</b> The “Rules for Allowable Adjustments of HEDIS” (the “Rules”) describe how NCQA’s HEDIS measure specifications can be adjusted for other populations, if applicable. The Rules, reviewed and approved by NCQA measure experts, provide for expanded use of HEDIS measures without changing their clinical intent.</p> <p><b>Adjusted HEDIS measures may not be used for HEDIS health plan reporting.</b></p> <p><b>The Rules do not apply to the hybrid portion of the measure; only the administrative sections may be changed.</b></p> <p><b>ADJUSTMENTS ALLOWED</b></p> <ul style="list-style-type: none"> <li>• <b>Product lines.</b> Organizations are not required to use product line criteria; product lines may be combined, and all (or no) product line criteria may be used.</li> <li>• <b>Attribution.</b> Organizations are not required to use enrollment criteria.</li> <li>• <b>Benefits.</b> Organizations are not required to use a benefit.</li> <li>• <b>Other.</b> Organizations may use additional initial population criteria to focus on an area of interest defined by gender, race, ethnicity, socioeconomic or sociodemographic characteristics, geographic region or another characteristic.</li> <li>• <b>Measurement period adjustments.</b> Organizations may adjust the measurement period.</li> <li>• <b>Stratifications:</b> Race and ethnicity stratification. The race and ethnicity stratification is not required. Organizations may adjust this stratification as needed.</li> <li>• <b>Exclusions.</b> The hospice, deceased person, palliative care, I-SNP, LTI, frailty and advanced illness exclusions are not required.</li> </ul>
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- *Telehealth.* Services/events that allow the use of synchronous telehealth visits, telephone visits and asynchronous telehealth (e-visits, virtual check-ins) may be stratified to identify services performed via telehealth. This adjustment is not allowed for events, numerators and exclusions that do not allow the use of telehealth.
- *Supplemental data.* Supplemental data may be used to identify initial population, denominator, exclusion and numerator events.

**ADJUSTMENTS ALLOWED WITH LIMITS**

- *Ages.* Age determination dates may be changed (e.g., select “age as of June 30”). Changing denominator age range is allowed within a specified age range (ages 18–75 years). The denominator age may not be expanded.

**ADJUSTMENTS NOT ALLOWED**

- *Initial population:* Event. Only events or diagnoses that contain (or map to) codes in the medication lists and value sets may be used to identify visits. Medication lists, value sets and logic may not be changed.
- *Numerator.* Value sets and logic may not be changed.

## Blood Pressure Control for Patients With Diabetes (BPD)

Measure title	Blood Pressure Control for Patients With Diabetes		Measure ID	BPD
Description	The percentage of persons 18–75 years of age with diabetes (type 1 or type 2) whose blood pressure (BP) was adequately controlled (<140/90 mm Hg) during the measurement period.			
Measurement period	January 1–December 31.			
Copyright and disclaimer notice	<p>Refer to the complete copyright and disclaimer information at the front of this publication.</p> <p>NCQA website: <a href="http://www.ncqa.org">www.ncqa.org</a>.</p> <p>Submit policy clarification support questions via My NCQA (<a href="https://my.ncqa.org">https://my.ncqa.org</a>).</p>			
Clinical recommendation statement/ rationale	<p>American Diabetes Association (2025)</p> <ul style="list-style-type: none"> <li>The on-treatment target blood pressure goal is &lt;130/80 mmHg, if it can be safely attained. Level of evidence: A</li> <li>The ADA recognizes that there has been no randomized controlled trial to specifically demonstrate a decreased incidence of cardiovascular events in people with diabetes by targeting a blood pressure &lt;130/80 mmHg.</li> </ul> <p>Joslin Diabetes Center (2020)</p> <ul style="list-style-type: none"> <li>Blood pressure goal for each patient aged &gt;18 years is ≤140/90 mmHg. Grade of recommendation: 1B</li> <li>Systolic blood pressure &lt;130 mmHg may be appropriate for individuals without CVD or without multiple risk factors. Grade of recommendation: 1B</li> </ul>			
Citations	<p>American Diabetes Association Professional Practice Committee. 2025. “10. Cardiovascular Disease and Risk Management: Standards of Care in Diabetes—2025. <i>Diabetes Care</i> 48(Suppl. 1):S207–38.</p> <p>Joslin Diabetes Center. 2020. <i>Joslin Diabetes Center Clinical Guidelines for Management of Adults with Diabetes</i>. Joslin Diabetes Center.  <a href="https://www.ajmc.com/view/chapter-1-clinical-guideline-for-adults-with-diabetes">https://www.ajmc.com/view/chapter-1-clinical-guideline-for-adults-with-diabetes</a></p>			
<b>Characteristics</b>				
Scoring	Proportion.			
Type	Outcome.			
Product lines	<ul style="list-style-type: none"> <li>Commercial.</li> <li>Medicaid.</li> <li>Medicare.</li> </ul>			
Stratifications	None.			

<b>Risk adjustment</b>	None.
<b>Improvement notation</b>	Increased score indicates improvement.
<b>Guidance</b>	<p><b>Data collection methodology:</b> Administrative and hybrid. Refer to <a href="#">General Guideline: Data Collection Methods</a> for additional information.</p> <p><b>Date specificity:</b> Dates must be specific enough to determine the event occurred in the period being measured.</p> <p><b>Which services count?</b> When using claims, include all paid, suspended, pending and denied claims.</p> <p><b>Other guidance:</b> If a combination of administrative, supplemental or hybrid data are used, the most recent BP result must be used, regardless of data source.</p>
<b>Initial population</b>	<p>Measure item count: Person.</p> <p>Attribution basis: Enrollment.</p> <ul style="list-style-type: none"> <li>• <b>Benefits:</b> Medical.</li> <li>• <b>Continuous enrollment:</b> The measurement period.</li> <li>• <b>Allowable gap:</b> No more than one gap of ≤45 days during the measurement period. No gaps on the last day of the measurement period.</li> </ul> <p>Ages: 18–75 years of age as of the last day of the measurement period.</p> <p><b>Event: Identify persons with a diagnosis of diabetes.</b> Either of the following meets criteria:</p> <ul style="list-style-type: none"> <li>• <b>Claim/encounter data.</b> At least two diagnoses of diabetes (<a href="#">Diabetes Value Set*</a>) on different dates of service during the measurement period or the year prior to the measurement period.</li> <li>• <b>Pharmacy data.</b> At least one diagnosis of diabetes (<a href="#">Diabetes Value Set*</a>) <b>and</b> at least one diabetes medication dispensing event of insulin or a hypoglycemic/antihyperglycemic medication (<a href="#">Diabetes Medications List</a>) during the measurement period or the year prior to the measurement period.</li> </ul> <p><b>Coding Guidance</b> *Do not include laboratory claims (claims with POS code 81).</p>
<b>Denominator exclusions</b>	<p><b>Persons with a date of death.</b> Death in the measurement period, identified using data sources determined by the organization. Method and data sources are subject to review during the HEDIS audit.</p> <p><b>Persons in hospice or using hospice services.</b> Persons who use hospice services (<a href="#">Hospice Encounter Value Set</a>; <a href="#">Hospice Intervention Value Set</a>) or elect to use a hospice benefit any time during the measurement period. Organizations that use the Monthly Membership Detail Data File to identify these persons must use only the run date of the file.</p>

	<p><b>Persons receiving palliative care.</b> Persons receiving palliative care (<a href="#">Palliative Care Assessment Value Set</a>; <a href="#">Palliative Care Encounter Value Set</a>; <a href="#">Palliative Care Intervention Value Set</a>) or who had an encounter for palliative care (ICD-10-CM code Z51.5*) any time during the measurement period.</p> <p><b>Medicare enrollees, 66 years of age and older by the last day of the measurement period, in an institutional SNP (I-SNP) or living long-term in an institution (LTI).</b></p> <ul style="list-style-type: none"> <li>• Enrolled in an Institutional SNP (I-SNP) any time during the measurement period.</li> <li>• Living long-term in an institution any time during the measurement period as identified by the LTI flag in the Monthly Membership Detail Data File. Use the run date of the file to determine if a member had an LTI flag during the measurement period.</li> </ul> <p><b>Persons 66 years of age or older by the last day of the measurement period, with both frailty and advanced illness.</b></p> <ol style="list-style-type: none"> <li>1. <b>Frailty.</b> At least two indications of frailty (<a href="#">Frailty Device Value Set</a>; <a href="#">Frailty Diagnosis Value Set*</a>; <a href="#">Frailty Encounter Value Set</a>; <a href="#">Frailty Symptom Value Set*</a>) with different dates of service during the measurement period.</li> <li>2. <b>Advanced illness.</b> Either of the following during the measurement period or the year prior to the measurement period:       <ul style="list-style-type: none"> <li>– Advanced illness (<a href="#">Advanced Illness Value Set*</a>) on at least two different dates of service.</li> <li>– Dispensed dementia medication (<a href="#">Dementia Medications List</a>).</li> </ul> </li> </ol> <p><b>Coding Guidance</b> *Do not include laboratory claims (claims with POS code 81).</p>
<b>Denominator</b>	<p><b>ADMINISTRATIVE</b> The initial population minus denominator exclusions.</p> <p><b>HYBRID</b> A systematic sample drawn from the administrative denominator. Organizations that use the Hybrid Method to report the Glycemic Status Assessment for Patients With Diabetes (GSD) and Blood Pressure Control for Patients With Diabetes (BPD) measures may use the same sample for both measures. If the same sample is used for both measures, the organization must take the inverse of the Glycemic Status &gt;9.0% rate (100 minus the Glycemic Status &gt;9.0% rate) before reducing the sample. Organizations may reduce the sample size based on the current year's administrative rate or the prior year's audited, product line-specific rate for the lowest rate of all GSD indicators and the BPD measure. If separate samples are used for the GSD and BPD measures, organizations may reduce the sample based on the product line-specific current measurement year's administrative rate or the prior year's audited, product line-specific rate for the measure.</p>

	Refer to the <a href="#">Guidelines for Calculations and Sampling</a> for information on reducing sample size.
Numerator	<p><b>ADMINISTRATIVE</b></p> <p><b>Both a systolic and diastolic reading &lt;140/90 mm Hg.</b></p> <p>Identify the most recent BP reading (<u>Systolic Blood Pressure Value Set</u>; <u>Diastolic Blood Pressure Value Set</u>) taken during the measurement period. Do not include CPT Category II codes (<u>Systolic and Diastolic Result Value Set</u>) with a modifier (<u>CPT CAT II Modifier Value Set</u>). Do not include BPs taken in an acute inpatient setting (<u>Acute Inpatient Value Set</u>; <u>Acute Inpatient POS Value Set</u>) or during an ED visit (<u>ED Value Set</u>; POS code 23).</p> <ul style="list-style-type: none"> <li>• <i>Compliant:</i> BP is &lt;140/90 mm Hg.</li> <li>• <i>Non-compliant:</i> BP is ≥140/90 mm Hg; no BP reading during the measurement period; or if the reading is incomplete (e.g., the systolic or diastolic level is missing).</li> </ul> <p>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.</p> <p>If the most recent BP was identified based on a CPT Category II code (<u>Systolic and Diastolic Result Value Set</u>), use the following to determine compliance:</p> <ul style="list-style-type: none"> <li>• <i>Systolic Compliant:</i> <u>Systolic Less Than 140 Value Set</u>.</li> <li>• <i>Systolic Not Compliant:</i> CPT-CAT-II code 3077F.</li> <li>• <i>Diastolic Compliant:</i> <u>Diastolic Less Than 90 Value Set</u>.</li> <li>• <i>Diastolic Not Compliant:</i> CPT-CAT-II code 3080F.</li> </ul> <p><b>HYBRID</b></p> <p><i>Administrative:</i> Refer to administrative specifications to identify positive numerator hits from administrative data.</p> <p><b>Both a systolic and diastolic reading &lt;140/90 mm Hg.</b></p> <p>The most recent BP level (taken during the measurement period) is &lt;140/90 mm Hg as documented through administrative data or medical record review.</p> <p><i>Medical record:</i> Organizations that use the same sample for the GSD and BPD measures may use the medical record from which it abstracts data for the GSD and BPD measures. If the organization uses separate samples for the GSD and BPD measures, it should use the medical record of the provider that manages the person's diabetes. If that medical record does not contain a BP, the organization may use the medical record of another PCP or specialist from whom the person receives care.</p> <p>Identify the most recent BP reading noted during the measurement period.</p> <p>Do not include BP readings:</p> <ul style="list-style-type: none"> <li>• Taken during an acute inpatient stay or an ED visit.</li> <li>• Taken on the same day as a diagnostic test or diagnostic or therapeutic procedure that requires a change in diet or change in medication on or one day before the day of the test or procedure, with the exception of fasting blood tests.</li> </ul>

	<ul style="list-style-type: none"> <li>• Taken by the person using a non-digital device such as with a manual blood pressure cuff and a stethoscope.</li> </ul> <p>Identify the lowest systolic and lowest diastolic BP reading from the most recent BP notation in the medical record. If multiple readings were recorded for a single date, use the lowest systolic and lowest diastolic BP on that date as the representative BP. The systolic and diastolic results do not need to be from the same reading.</p> <p>BP readings taken by the person and documented in the medical record are eligible for use in reporting (provided the BP does not meet any exclusion criteria). There is no requirement that there be evidence the BP was collected by a PCP or specialist.</p> <p>The person is not compliant if the BP reading is <math>\geq 140/90</math> mm Hg or is missing, if there is no BP reading during the measurement period or if the reading is incomplete (i.e., the systolic or diastolic level is missing). "Unknown" is not considered a result/finding.</p> <p>Ranges and thresholds do not meet criteria for this measure. A distinct numeric result for both the systolic and diastolic BP reading is required for numerator compliance. A BP documented as an "average BP" (e.g., "average BP: 139/70") is eligible for use.</p> <p><b>Note</b></p> <ul style="list-style-type: none"> <li>• When excluding BP readings from the numerator, the intent is to identify diagnostic or therapeutic procedures that require a medication regimen, a change in diet or a change in medication. For example (this list is for reference only and is not exhaustive): <ul style="list-style-type: none"> <li>– A colonoscopy requires a change in diet (NPO on the day of procedure) and a medication change (a medication is taken to prep the colon).</li> <li>– Dialysis, infusions and chemotherapy (including oral chemotherapy) are all therapeutic procedures that require a medication regimen.</li> <li>– A nebulizer treatment with albuterol is considered a therapeutic procedure that requires a medication regimen (the albuterol).</li> <li>– A patient forgetting to take regular medications on the day of the procedure is not considered a required change in medication, and therefore the BP reading is eligible.</li> </ul> </li> <li>• BP readings taken on the same day that the patient receives a common low-intensity or preventive procedure are eligible for use. For example, the following procedures are considered common low-intensity or preventive procedures (this list is for reference only and is not exhaustive): <ul style="list-style-type: none"> <li>– Vaccinations.</li> <li>– Injections (e.g., allergy, vitamin B-12, insulin, steroid, Toradol, Depo-Provera, testosterone, lidocaine).</li> <li>– TB test.</li> <li>– IUD insertion.</li> <li>– Eye exam with dilating agents.</li> <li>– Wart or mole removal.</li> </ul> </li> </ul>
<b>Summary of changes</b>	<ul style="list-style-type: none"> <li>• No changes to this measure.</li> </ul>

<b>Data element tables</b>	<p>Organizations that submit HEDIS data to NCQA must provide the following data elements.</p> <p><b>Table BPD-1/2/3: Data Elements for Blood Pressure Control for Patients With Diabetes</b></p> <table border="1" data-bbox="463 333 1445 1220"> <thead> <tr> <th>Metric</th><th>Data Element</th><th>Reporting Instructions</th><th>A</th></tr> </thead> <tbody> <tr> <td>BPUnder140Over90</td><td>CollectionMethod</td><td>Report once</td><td>✓</td></tr> <tr> <td></td><td>InitialPopulation</td><td>Report once</td><td>✓</td></tr> <tr> <td></td><td>Exclusions</td><td>Report once</td><td>✓</td></tr> <tr> <td></td><td>Denominator</td><td>Report once</td><td>✓</td></tr> <tr> <td></td><td>NumeratorByAdminDenom</td><td>Report once</td><td></td></tr> <tr> <td></td><td>CYAR</td><td>(Percent)</td><td></td></tr> <tr> <td></td><td>MinReqSampleSize</td><td>Report once</td><td></td></tr> <tr> <td></td><td>OversampleRate</td><td>Report once</td><td></td></tr> <tr> <td></td><td>OversampleRecordsNumber</td><td>(Count)</td><td></td></tr> <tr> <td></td><td>ExclusionValidDataErrors</td><td>Report once</td><td></td></tr> <tr> <td></td><td>ExclusionEmployeeOrDep</td><td>Report once</td><td></td></tr> <tr> <td></td><td>OversampleRecsAdded</td><td>Report once</td><td></td></tr> <tr> <td></td><td>NumeratorByAdmin</td><td>Report once</td><td>✓</td></tr> <tr> <td></td><td>NumeratorByMedicalRecords</td><td>Report once</td><td></td></tr> <tr> <td></td><td>NumeratorBySupplemental</td><td>Report once</td><td>✓</td></tr> <tr> <td></td><td>Rate</td><td>(Percent)</td><td>✓</td></tr> </tbody> </table>	Metric	Data Element	Reporting Instructions	A	BPUnder140Over90	CollectionMethod	Report once	✓		InitialPopulation	Report once	✓		Exclusions	Report once	✓		Denominator	Report once	✓		NumeratorByAdminDenom	Report once			CYAR	(Percent)			MinReqSampleSize	Report once			OversampleRate	Report once			OversampleRecordsNumber	(Count)			ExclusionValidDataErrors	Report once			ExclusionEmployeeOrDep	Report once			OversampleRecsAdded	Report once			NumeratorByAdmin	Report once	✓		NumeratorByMedicalRecords	Report once			NumeratorBySupplemental	Report once	✓		Rate	(Percent)	✓
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<b>Rules for Allowable Adjustments</b>	<p><b>Copyright and use:</b> The “Rules for Allowable Adjustments of HEDIS” (the “Rules”) describe how NCQA’s HEDIS measure specifications can be adjusted for other populations, if applicable. The Rules, reviewed and approved by NCQA measure experts, provide for expanded use of HEDIS measures without changing their clinical intent.</p> <p><b>Adjusted HEDIS measures may not be used for HEDIS health plan reporting.</b></p> <p><b>The Rules do not apply to the hybrid portion of the measure; only the administrative sections may be changed.</b></p> <p><b>ADJUSTMENTS ALLOWED</b></p> <ul style="list-style-type: none"> <li>• <b>Product lines.</b> Organizations are not required to use product line criteria; product lines may be combined, and all (or no) product line criteria may be used.</li> <li>• <b>Attribution.</b> Organizations are not required to use enrollment criteria.</li> <li>• <b>Benefits.</b> Organizations are not required to use a benefit.</li> </ul>																																																																				

- *Other.* Organizations may use additional initial population criteria to focus on an area of interest defined by gender, race, ethnicity, socioeconomic or sociodemographic characteristics, geographic region or another characteristic.
- *Measurement period adjustments.* Organizations may adjust the measurement period.
- *Exclusions.* The hospice, deceased persons, palliative care, I-SNP, LTI, frailty and advanced illness exclusions are not required.
- *Telehealth.* Services/events that allow the use of synchronous telehealth visits, telephone visits and asynchronous telehealth (e-visits, virtual check-ins) may be stratified to identify services performed via telehealth. This adjustment is not allowed for events/diagnoses, numerators and exclusions that do not allow the use of telehealth.
- *Supplemental data.* Supplemental data may be used to identify initial population, denominator, exclusion and numerator events.

#### **ADJUSTMENTS ALLOWED WITH LIMITS**

- *Ages.* Age determination dates may be changed (e.g., select, “age as of June 30”). Changing the denominator age range is allowed within a specified age range (ages 18–75 years). The denominator age may not be expanded.

#### **ADJUSTMENTS NOT ALLOWED**

- *Initial population:* Event. Only events or diagnoses that contain (or map to) codes in the medication lists and value sets may be used to identify visits. Medication lists, value sets and logic may not be changed.
- *Numerator.* Value sets and logic may not be changed.

## ***Eye Exam for Patients With Diabetes (EED)***

<b>Measure title</b>	Eye Exam for Patients With Diabetes	<b>Measure ID</b>	EED
<b>Description</b>	The percentage of persons 18–75 years of age with diabetes (type 1 or type 2) who had a retinal eye exam.		
<b>Measurement period</b>	January 1–December 31.		
<b>Copyright and disclaimer notice</b>	<p>Refer to the complete copyright and disclaimer information at the front of this publication.</p> <p>NCQA website: <a href="http://www.ncqa.org">www.ncqa.org</a>.</p> <p>Submit policy clarification support questions via My NCQA (<a href="https://my.ncqa.org">https://my.ncqa.org</a>).</p>		
<b>Clinical recommendation statement/rationale</b>	<p>American Diabetes Association (2025)</p> <ul style="list-style-type: none"> <li>• Adults with type 1 diabetes should have an initial dilated and comprehensive eye examination by an ophthalmologist or optometrist within 5 years after the onset of diabetes. Level of evidence: B</li> <li>• Patients with type 2 diabetes should have an initial dilated and comprehensive eye examination by an ophthalmologist or optometrist at the time of the diabetes diagnosis. Level of evidence: B</li> <li>• If there is no evidence of retinopathy for one or more annual eye exams and glycemic indicators are within the goal range, then screening every 1–2 years may be considered. If any level of diabetic retinopathy is present, subsequent dilated retinal examinations should be repeated at least annually by an ophthalmologist or optometrist. If retinopathy is progressing or sight-threatening, then examinations will be required more frequently. Level of evidence: B</li> <li>• Programs that use retinal photography with remote reading or the use of U.S. Food and Drug Administration–approved artificial intelligence algorithms to improve access to diabetic retinopathy screening are appropriate screening strategies for diabetic retinopathy. Such programs need to provide pathways for timely referral for a comprehensive eye examination when indicated. Level of evidence: B</li> </ul>		
<b>Citations</b>	American Diabetes Association Professional Practice Committee. 2025. 12. “Retinopathy, Neuropathy, and Foot Care: Standards of Care in Diabetes—2025.” <i>Diabetes Care</i> 48(Suppl. 1):S252–65.		
<b>Characteristics</b>			
<b>Scoring</b>	Proportion.		
<b>Type</b>	Process.		

<b>Product lines</b>	<ul style="list-style-type: none"> <li>• Commercial.</li> <li>• Medicaid.</li> <li>• Medicare.</li> </ul>
<b>Stratifications</b>	<p>Race. (Refer to <a href="#">General Guideline: Race and Ethnicity Stratification</a>.)</p> <ul style="list-style-type: none"> <li>• American Indian or Alaska Native.</li> <li>• Asian.</li> <li>• Black or African American.</li> <li>• Middle Eastern or North African.</li> <li>• Native Hawaiian or Pacific Islander.</li> <li>• White.</li> <li>• Some Other Race.</li> <li>• Two or More Races.</li> <li>• Asked But No Answer.</li> <li>• Unknown.</li> </ul> <p>Ethnicity. (Refer to <a href="#">General Guideline: Race and Ethnicity Stratification</a>.)</p> <ul style="list-style-type: none"> <li>• Hispanic or Latino.</li> <li>• Not Hispanic or Latino.</li> <li>• Asked But No Answer.</li> <li>• Unknown.</li> </ul> <p>SES (Medicare only). (Refer to <a href="#">General Guideline: Medicare Socioeconomic Status Stratification</a>.)</p> <ul style="list-style-type: none"> <li>• Non-LIS/DE, Nondisability.</li> <li>• LIS/DE.</li> <li>• Disability.</li> <li>• LIS/DE and Disability.</li> <li>• Other.</li> <li>• Unknown.</li> </ul>
<b>Risk adjustment</b>	None.
<b>Improvement notation</b>	Increased score indicates improvement.
<b>Guidance</b>	<p><b>Data collection methodology:</b> Administrative. Refer to <a href="#">General Guideline: Data Collection Methods</a> for additional information.</p> <p><b>Date specificity:</b> Dates must be specific enough to determine the event occurred in the period being measured.</p> <p><b>Which services count?</b> When using claims, include all paid, suspended, pending and denied claims.</p>

<b>Initial population</b>	<p><b>Measure item count:</b> Person.</p> <p><b>Attribution basis:</b> Enrollment.</p> <ul style="list-style-type: none"> <li>• <b>Benefits:</b> Medical.</li> <li>• <b>Continuous enrollment:</b> The measurement period.</li> <li>• <b>Allowable gap:</b> No more than one gap of ≤45 days during the measurement period. No gaps on the last day of the measurement period.</li> </ul> <p><b>Ages:</b> 18–75 years of age as of the last day of the measurement period.</p> <p><b>Event: Identify persons with a diagnosis of diabetes.</b></p> <p>Either of the following meets criteria:</p> <ul style="list-style-type: none"> <li>• <b>Claim/encounter data.</b> At least two diagnoses of diabetes (<a href="#">Diabetes Value Set*</a>) on different dates of service during the measurement period or the year prior to the measurement period.</li> <li>• <b>Pharmacy data.</b> At least one diagnosis of diabetes (<a href="#">Diabetes Value Set*</a>) <b>and</b> at least one diabetes medication dispensing event of insulin or a hypoglycemic/antihyperglycemic medication (<a href="#">Diabetes Medications List</a>) during the measurement period or the year prior to the measurement period.</li> </ul> <p><b>Coding Guidance</b></p> <p>*Do not include laboratory claims (claims with POS code 81).</p>
<b>Denominator exclusions</b>	<p><b>Persons with a date of death.</b> Death in the measurement period, identified using data sources determined by the organization. Method and data sources are subject to review during the HEDIS audit.</p> <p><b>Persons in hospice or using hospice services.</b> Persons who use hospice services (<a href="#">Hospice Encounter Value Set</a>; <a href="#">Hospice Intervention Value Set</a>) or elect to use a hospice benefit any time during the measurement period. Organizations that use the Monthly Membership Detail Data File to identify these persons must use only the run date of the file.</p> <p><b>Persons receiving palliative care.</b> Persons receiving palliative care (<a href="#">Palliative Care Assessment Value Set</a>; <a href="#">Palliative Care Encounter Value Set</a>; <a href="#">Palliative Care Intervention Value Set</a>) or who had an encounter for palliative care (ICD-10-CM code Z51.5*) any time during the measurement period.</p> <p><b>Medicare enrollees, 66 years of age and older by the last day of the measurement period, in an institutional SNP (I-SNP) or living long-term in an institution (LTI).</b></p> <ul style="list-style-type: none"> <li>• Enrolled in an Institutional SNP (I-SNP) any time during the measurement period.</li> <li>• Living long-term in an institution any time during the measurement period as identified by the LTI flag in the Monthly Membership Detail Data File. Use the run date of the file to determine if a member had an LTI flag during the measurement period.</li> </ul>

	<p><b>Persons 66 years of age or older by the last day of the measurement period, with both frailty and advanced illness.</b></p> <ol style="list-style-type: none"> <li>1. <b>Frailty.</b> At least two indications of frailty (<a href="#">Frailty Device Value Set</a>; <a href="#">Frailty Diagnosis Value Set*</a>; <a href="#">Frailty Encounter Value Set</a>; <a href="#">Frailty Symptom Value Set*</a>) with different dates of service during the measurement period.</li> <li>2. <b>Advanced illness.</b> Either of the following during the measurement period or the year prior to the measurement period:             <ul style="list-style-type: none"> <li>– Advanced illness (<a href="#">Advanced Illness Value Set*</a>) on at least two different dates of service.</li> <li>– Dispensed dementia medication (<a href="#">Dementia Medications List</a>).</li> </ul> </li> </ol> <p><b>Persons with bilateral absence of eyes or eye enucleation.</b></p> <ul style="list-style-type: none"> <li>• Bilateral absence of eyes (SNOMED CT code 15665641000119103) any time during the person's history through the last day of the measurement period.</li> <li>• Bilateral eye enucleation any time during the person's history through the last day of the measurement period:             <ul style="list-style-type: none"> <li>– Unilateral eye enucleation (<a href="#">Unilateral Eye Enucleation Value Set</a>) with a bilateral modifier (CPT Modifier code 50).</li> <li>– Two unilateral eye enucleations (<a href="#">Unilateral Eye Enucleation Value Set</a>) with service dates 14 days or more apart.</li> <li>– 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.</li> <li>– A unilateral eye enucleation (<a href="#">Unilateral Eye Enucleation Value Set</a>) and a left unilateral eye enucleation (ICD-10-PCS code 08T1XZZ) with service dates 14 days or more apart.</li> <li>– A unilateral eye enucleation (<a href="#">Unilateral Eye Enucleation Value Set</a>) and a right unilateral eye enucleation (ICD-10-PCS code 08T0XZZ) with service dates 14 days or more apart.</li> </ul> </li> </ul> <p><b>Coding Guidance</b> *Do not include laboratory claims (claims with POS code 81).</p>
<b>Denominator</b>	The initial population minus denominator exclusions.
<b>Numerator</b>	<p><b>Retinal eye exam.</b> Screening or monitoring for diabetic retinal disease. This includes persons with diabetes who had one of the following:</p> <ul style="list-style-type: none"> <li>• A retinal or dilated eye exam by an eye care professional (optometrist or ophthalmologist) in the measurement period.</li> <li>• A negative retinal or dilated eye exam (negative for retinopathy) by an eye care professional in the year prior to the measurement period.</li> </ul> <p>Any of the following meet criteria:</p> <ul style="list-style-type: none"> <li>• Any code in the <a href="#">Retinal Eye Exams Value Set</a> billed by an eye care professional (optometrist or ophthalmologist) during the measurement period.</li> </ul>

	<ul style="list-style-type: none"> <li>• Any code in the <u>Retinal Eye Exams Value Set</u> billed by an eye care professional (optometrist or ophthalmologist) during the year prior to the measurement period, with a diagnosis of diabetes without complications (<u>Diabetes Mellitus Without Complications Value Set</u>).</li> <li>• Any code in the <u>Eye Exam With Evidence of Retinopathy Value Set†</u>, <u>Eye Exam Without Evidence of Retinopathy Value Set†</u> billed by any provider type during the measurement period.</li> <li>• Retinal imaging with interpretation and reporting by a qualified reading center (<u>Retinal Imaging Value Set</u>) billed by any provider type during the measurement period.</li> <li>• Autonomous eye exam billed by any provider type during the measurement period. Either of the following meets criteria: <ul style="list-style-type: none"> <li>– CPT code 92229.</li> <li>– LOINC code 105914-6 <b>with</b> a result (<u>Autonomous Eye Exam Result or Finding Value Set</u>).</li> </ul> </li> <li>• Any code in the <u>Eye Exam Without Evidence of Retinopathy Value Set†</u> billed by any provider type during the year prior to the measurement period.</li> <li>• Diabetic retinal screening negative in prior year (CPT-CAT-II code 3072F†) billed by any provider type during the measurement period.</li> <li>• Any combination that indicates findings from a retinal exam for diabetic retinopathy performed in <b>both</b> the <b>left and right eye</b> by any provider, or a combination that indicates one eye is enucleated and the other was examined. <ul style="list-style-type: none"> <li>– <b>Left eye:</b> <ul style="list-style-type: none"> <li>▪ Retinal exam finding: Any level of retinopathy (LOINC code 71490-7 <b>with</b> <u>Diabetic Retinopathy Severity Level Value Set</u>) during the measurement period.</li> <li>▪ Retinal exam finding: No retinopathy (LOINC code 71490-7 <b>with</b> LOINC code LA18643-9) in the year prior to the measurement period.</li> <li>▪ Enucleation: ICD-10-PCS code 08T1XZZ any time during the person's history through the last day of the measurement period.</li> </ul> </li> <li>– <b>Right eye:</b> <ul style="list-style-type: none"> <li>▪ Retinal exam finding: Any level of retinopathy (LOINC code 71491-5 <b>with</b> <u>Diabetic Retinopathy Severity Level Value Set</u>) during the measurement period.</li> <li>▪ Retinal exam finding: No retinopathy (LOINC code 71491-5 <b>with</b> LOINC code LA18643-9) in the year prior to the measurement period.</li> <li>▪ Enucleation: ICD-10-PCS code 08T0XZZ any time during the person's history through the last day of the measurement period.</li> </ul> </li> </ul> </li> </ul>
<b>Coding Guidance</b>	†Do not include codes with a modifier ( <u>CPT CAT II Modifier Value Set</u> ).
<b>Summary of changes</b>	<ul style="list-style-type: none"> <li>• Updated the race and ethnicity stratification categories to align with OMB SPD 15 2024.</li> </ul>

	<ul style="list-style-type: none"> <li>Added instructions on allowable adjustments to the race and ethnicity and SES stratification.</li> </ul>																																																																																													
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<b>Table EED-C-1/2/3: Data Elements for Eye Exam for Patients With Diabetes: Stratifications by Ethnicity</b>			
Metric	Ethnicity	Data Element	Reporting Instructions
EyeExams	HispanicOrLatino	Denominator	For each Stratification
	NotHispanicOrLatino	Numerator	For each Stratification
	AskedButNoAnswer	Rate	(Percent)
	Unknown		
<b>Rules for Allowable Adjustments</b>	<p><b>Copyright and use:</b> The “Rules for Allowable Adjustments of HEDIS” (the “Rules”) describe how NCQA’s HEDIS measure specifications can be adjusted for other populations, if applicable. The Rules, reviewed and approved by NCQA measure experts, provide for expanded use of HEDIS measures without changing their clinical intent.</p> <p><b>Adjusted HEDIS measures may not be used for HEDIS health plan reporting.</b></p> <p><b>ADJUSTMENTS ALLOWED</b></p> <ul style="list-style-type: none"> <li>• <b>Product lines.</b> Organizations are not required to use product line criteria; product lines may be combined, and all (or no) product line criteria may be used.</li> <li>• <b>Attribution.</b> Organizations are not required to use enrollment criteria.</li> <li>• <b>Benefits.</b> Organizations are not required to use a benefit.</li> <li>• <b>Other.</b> Organizations may use additional initial population criteria to focus on an area of interest defined by gender, race, ethnicity, socioeconomic or sociodemographic characteristics, geographic region, or another characteristic.</li> <li>• <b>Measurement period adjustments.</b> Organizations may adjust the measurement period.</li> <li>• <b>Stratifications:</b> Race and ethnicity stratification. The race and ethnicity stratification is not required. Organizations may adjust this stratification as needed.</li> <li>• <b>Exclusions.</b> The hospice, deceased person, palliative care, I-SNP, LTI, frailty and advanced illness exclusions are not required.</li> <li>• <b>Telehealth.</b> Services/events that allow the use of synchronous telehealth visits, telephone visits and asynchronous telehealth (e-visits, virtual check-ins) may be stratified to identify services performed via telehealth. This adjustment is not allowed for events, numerators and exclusions that do not allow the use of telehealth.</li> <li>• <b>Supplemental data.</b> Supplemental data may be used to identify initial population, denominator, exclusion and numerator events.</li> </ul> <p><b>ADJUSTMENTS ALLOWED WITH LIMITS</b></p> <ul style="list-style-type: none"> <li>• <b>Ages.</b> Age determination dates may be changed (e.g., select, “age as of June 30”). Changing denominator age range is allowed within a specified age range (ages 18–75 years).</li> </ul>		

- *Stratifications:* SES stratification. The SES stratification is not required, but if it is applied, no adjustments may be made.

**ADJUSTMENTS NOT ALLOWED**

- *Initial population:* Event. Only events or diagnoses that contain (or map to) codes in the medication lists and value sets may be used to identify visits. Medication lists, value sets and logic may not be changed.
- *Exclusions.* The bilateral absence of eyes or eye enucleation exclusions must be applied. The value sets, medication lists and logic may not be changed.
- *Numerator.* Value sets and logic may not be changed.

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

Measure title	Kidney Health Evaluation for Patients With Diabetes*	Measure ID	KED
<b>Description</b>	The percentage of persons 18–85 years of age with diabetes (type 1 or type 2) who received a kidney health evaluation, defined by an estimated glomerular filtration rate (eGFR) <b>and</b> a urine albumin-creatinine ratio (uACR), during the measurement period.		
<b>Measurement period</b>	January 1–December 31.		
<b>Copyright and disclaimer notice</b>	<p>*This measure was developed by NCQA with input from the National Kidney Foundation.</p> <p>Refer to the complete copyright and disclaimer information at the front of this publication.</p> <p>NCQA website: <a href="http://www.ncqa.org">www.ncqa.org</a>.</p> <p>Submit policy clarification support questions via My NCQA (<a href="https://my.ncqa.org">https://my.ncqa.org</a>).</p>		
<b>Clinical recommendation statement/ rationale</b>	<p>American Diabetes Association (2025)</p> <ul style="list-style-type: none"> <li>• Assess kidney function (i.e., spot urine albumin-to-creatinine ratio [UACR]) and estimated glomerular filtration rate [eGFR] in people with type 1 diabetes with duration of ≥5 years and in all people with type 2 diabetes regardless of treatment. Level of evidence: B</li> </ul> <p>National Kidney Foundation (2007, updated 2012)</p> <ul style="list-style-type: none"> <li>• Patients with diabetes should be screened annually for diabetic kidney disease. Initial screening should commence: <ul style="list-style-type: none"> <li>– 5 years after the diagnosis of Type 1 diabetes. Grade of evidence: A; <b>or</b></li> <li>– From diagnosis of Type 2 diabetes. Grade of evidence: B</li> </ul> </li> <li>• Screening should include: <ul style="list-style-type: none"> <li>– Measurement of urinary albumin-creatinine ratio (ACR) in a spot urine sample. Grade of evidence: B</li> <li>– Measurement of serum creatinine and estimation of GFR. Grade of evidence: B</li> </ul> </li> </ul> <p>For adults with diabetes, guidelines recommend measuring both albumin and creatinine simultaneously from a random spot urine sample to assess albumin-to-creatinine ratio (uACR). The intent of the measure is to align with this recommendation even if separate billing codes are used for urine albumin and urine creatinine.</p>		
<b>Citations</b>	American Diabetes Association Professional Practice Committee. 2025. “11. Chronic Kidney Disease and Risk Management: Standards of Care in Diabetes—2025.” <i>Diabetes Care</i> 48(Suppl. 1):S239–51.		

	National Kidney Foundation. 2012. "KDOQI Clinical Practice Guideline for Diabetes and CKD: 2012 Update." <i>Am J Kidney Dis</i> 60(5):850–86. <a href="http://dx.doi.org/10.1053/j.ajkd.2012.07.005">http://dx.doi.org/10.1053/j.ajkd.2012.07.005</a>
<b>Characteristics</b>	
<b>Scoring</b>	Proportion.
<b>Type</b>	Process.
<b>Product lines</b>	<ul style="list-style-type: none"> <li>• Commercial.</li> <li>• Medicaid.</li> <li>• Medicare.</li> </ul>
<b>Stratifications</b>	<p>Age as of the last day of the measurement period.</p> <ul style="list-style-type: none"> <li>• 18–64 years.</li> <li>• 65–75 years.</li> <li>• 76–85 years.</li> </ul> <p>Race. (Refer to <a href="#">General Guideline: Race and Ethnicity Stratification</a>.)</p> <ul style="list-style-type: none"> <li>• American Indian or Alaska Native.</li> <li>• Asian.</li> <li>• Black or African American.</li> <li>• Middle Eastern or North African.</li> <li>• Native Hawaiian or Pacific Islander.</li> <li>• White.</li> <li>• Some Other Race.</li> <li>• Two or More Races.</li> <li>• Asked But No Answer.</li> <li>• Unknown.</li> </ul> <p>Ethnicity. (Refer to <a href="#">General Guideline: Race and Ethnicity Stratification</a>.)</p> <ul style="list-style-type: none"> <li>• Hispanic or Latino.</li> <li>• Not Hispanic or Latino.</li> <li>• Asked But No Answer.</li> <li>• Unknown.</li> </ul>
<b>Risk adjustment</b>	None.
<b>Improvement notation</b>	Increased score indicates improvement.
<b>Guidance</b>	<p><b>Data collection methodology:</b> Administrative. Refer to <a href="#">General Guideline: Data Collection Methods</a> for additional information.</p> <p><b>Date specificity:</b> Dates must be specific enough to determine the event occurred in the period being measured.</p>

	<b>What services count?</b> When using claims, include all paid, suspended, pending and denied claims.
<b>Initial population</b>	<p><b>Measure item count:</b> Person.</p> <p><b>Attribution basis:</b> Enrollment.</p> <ul style="list-style-type: none"> <li>• <b>Benefits:</b> Medical.</li> <li>• <b>Continuous enrollment:</b> The measurement period.</li> <li>• <b>Allowable gap:</b> No more than one gap of ≤45 days during the measurement period. No gaps on the last day of the measurement period.</li> </ul> <p><b>Ages:</b> 18–85 years of age as of the last day of the measurement period.</p> <p><b>Event: Identify persons with a diagnosis of diabetes.</b></p> <p>Either of the following meets criteria:</p> <ul style="list-style-type: none"> <li>• <b>Claim/encounter data.</b> At least two diagnoses of diabetes (<a href="#">Diabetes Value Set*</a>) on different dates of service during the measurement period or the year prior to the measurement period.</li> <li>• <b>Pharmacy data.</b> At least one diagnosis of diabetes (<a href="#">Diabetes Value Set*</a>) <b>and</b> at least one diabetes medication dispensing event of insulin or a hypoglycemic/antihyperglycemic medication (<a href="#">Diabetes Medications List</a>) during the measurement period or the year prior to the measurement period.</li> </ul> <p><b>Coding Guidance</b></p> <p>*Do not include laboratory claims (claims with POS code 81).</p>
<b>Denominator exclusions</b>	<p><b>Persons with a date of death.</b></p> <p>Death in the measurement period, identified using data sources determined by the organization. Method and data sources are subject to review during the HEDIS audit.</p> <p><b>Persons in hospice or using hospice services.</b></p> <p>Persons who use hospice services (<a href="#">Hospice Encounter Value Set</a>; <a href="#">Hospice Intervention Value Set</a>) or elect to use a hospice benefit any time during the measurement period. Organizations that use the Monthly Membership Detail Data File to identify these persons must use only the run date of the file.</p> <p><b>Persons receiving palliative care.</b></p> <p>Persons receiving palliative care (<a href="#">Palliative Care Assessment Value Set</a>; <a href="#">Palliative Care Encounter Value Set</a>; <a href="#">Palliative Care Intervention Value Set</a>) or who had an encounter for palliative care (ICD-10-CM code Z51.5*) any time during the measurement period.</p> <p><b>Medicare enrollees, 66 years of age and older by the last day of the measurement period, in an institutional SNP (I-SNP) or living long-term in an institution (LTI).</b></p> <ul style="list-style-type: none"> <li>• Enrolled in an Institutional SNP (I-SNP) any time during the measurement period.</li> </ul>

	<ul style="list-style-type: none"> <li>Living long-term in an institution any time during the measurement period as identified by the LTI flag in the Monthly Membership Detail Data File. Use the run date of the file to determine if a member had an LTI flag during the measurement period.</li> </ul> <p><b>Persons 66–80 years of age by the last day of the measurement period, with both frailty and advanced illness.</b></p> <ol style="list-style-type: none"> <li><b>Frailty.</b> At least two indications of frailty (<u>Frailty Device Value Set</u>; <u>Frailty Diagnosis Value Set*</u>; <u>Frailty Encounter Value Set</u>; <u>Frailty Symptom Value Set*</u>) with different dates of service during the measurement period.</li> <li><b>Advanced illness.</b> Either of the following during the measurement period or the year prior to the measurement period: <ul style="list-style-type: none"> <li>Advanced illness (<u>Advanced Illness Value Set*</u>) on at least two different dates of service.</li> <li>Dispensed dementia medication (<u>Dementia Medications List</u>).</li> </ul> </li> </ol> <p><b>Persons 81 years of age and older as of the last day of the measurement period, with frailty.</b></p> <p>Persons with at least two indications of frailty (<u>Frailty Device Value Set</u>; <u>Frailty Diagnosis Value Set*</u>; <u>Frailty Encounter Value Set</u>; <u>Frailty Symptom Value Set*</u>) with different dates of service during the measurement period.</p> <p><b>ESRD or dialysis.</b></p> <p>Persons with a diagnosis of ESRD (<u>ESRD Diagnosis Value Set*</u>) or who had dialysis (<u>Dialysis Procedure Value Set</u>) any time during the person's history on or prior to the last day of the measurement period.</p> <p><b>Coding Guidance</b>  *Do not include laboratory claims (claims with POS code 81).</p>
<b>Denominator</b>	The initial population minus denominator exclusions.
<b>Numerator</b>	<p><b>Kidney health evaluation.</b></p> <p>Persons who received <b>both</b> an eGFR and a uACR during the measurement period on the same or different dates of service:</p> <ul style="list-style-type: none"> <li>At least one eGFR (<u>Estimated Glomerular Filtration Rate Lab Test Value Set</u>).</li> <li>At least one uACR identified by either of the following: <ul style="list-style-type: none"> <li>Both a quantitative urine albumin test (<u>Quantitative Urine Albumin Lab Test Value Set</u>) <b>and</b> a urine creatinine test (<u>Urine Creatinine Lab Test Value Set</u>) <b>with</b> service dates four days or less apart. <ul style="list-style-type: none"> <li><i>For example</i>, if the service date for the quantitative urine albumin test was December 1 of the measurement period, then the urine creatinine test must have a service date on or between November 27 and December 5 of the measurement period.</li> </ul> </li> <li>A uACR (<u>Urine Albumin Creatinine Ratio Lab Test Value Set</u>).</li> </ul> </li> </ul>
<b>Summary of changes</b>	<ul style="list-style-type: none"> <li>Updated the race and ethnicity stratification categories to align with OMB SPD 15 2024.</li> <li>Added instructions on allowable adjustments to the race and ethnicity stratifications.</li> </ul>

**Data element tables**

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

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

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

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

Metric	Race	Data Element	Reporting Instructions
KidneyHealthEvaluation	AmericanIndianOrAlaskaNative	Denominator	For each Stratification
	Asian	Numerator	For each Stratification
	BlackOrAfricanAmerican	Rate	(Percent)
	MiddleEasternOrNorthAfrican		
	NativeHawaiianOrPacificIslander		
	White		
	SomeOtherRace		
	TwoOrMoreRaces		
	AskedButNoAnswer		
	Unknown		

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

Metric	Ethnicity	Data Element	Reporting Instructions
KidneyHealthEvaluation	HispanicOrLatino	Denominator	For each Stratification
	NotHispanicOrLatino	Numerator	For each Stratification
	AskedButNoAnswer	Rate	(Percent)
	Unknown		

## Rules for Allowable Adjustments

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

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

### ADJUSTMENTS ALLOWED

- *Product lines.* Organizations are not required to use product line criteria; product lines may be combined, and all (or no) product line criteria may be used.
- *Attribution.* Organizations are not required to use enrollment criteria.
- *Benefits.* Organizations are not required to use a benefit.
- *Other.* Organizations may use additional initial population criteria to focus on an area of interest as defined by gender, race, ethnicity, socioeconomic or sociodemographic characteristics, geographic region or another characteristic.
- *Measurement period adjustments.* Organizations may adjust the measurement period.
- *Stratifications: Race and ethnicity stratification.* The race and ethnicity stratification is not required. Organizations may adjust this stratification as needed.
- *Exclusions.* The hospice, deceased persons, palliative care, I-SNP, LTI, frailty or advanced illness exclusions are not required.
- *Telehealth.* Services/events that allow the use of synchronous telehealth visits, telephone visits and asynchronous telehealth (e-visits, virtual check-ins) may be stratified to identify services performed via telehealth. This adjustment is not allowed for events, numerators and exclusions that do not allow the use of telehealth.
- *Supplemental data.* Supplemental data may be used to identify initial population, denominator, exclusion and numerator events.

### ADJUSTMENTS ALLOWED WITH LIMITS

- *Ages.* Age determination dates may be changed (e.g., select, “age as of June 30”). The denominator age may be changed if the range is within the specified age range (18–85 years).

### ADJUSTMENTS NOT ALLOWED

- *Initial population:* Event. Only events or diagnoses that contain (or map to) codes in the medication lists and value sets may be used to identify visits. Medication lists, value sets and logic may not be changed.
- *Exclusions.* The ESRD and dialysis exclusions must be applied. Value sets and logic may not be changed.
- *Numerator.* Value sets and logic may not be changed.

# ***Musculoskeletal Conditions***

## Osteoporosis Management in Women Who Had a Fracture (OMW)

Measure title	Osteoporosis Management in Women Who Had a Fracture	Measure ID	OMW
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 (6 months) after the fracture.		
Measurement period	January 1–December 31.		
Copyright and disclaimer notice	<p>Refer to the complete copyright and disclaimer information at the front of this publication.</p> <p>NCQA website: <a href="http://www.ncqa.org">www.ncqa.org</a>.</p> <p>Submit policy clarification support questions via My NCQA (<a href="https://my.ncqa.org">https://my.ncqa.org</a>).</p>		
Clinical recommendation statement/ rationale	<p>Osteoporosis is the most common metabolic bone disease and is characterized by low bone mineral density and structural deterioration of bone tissue, causing bone fragility and increasing the risk of fractures. An estimated 12.3 million people 50 and older have osteoporosis. Osteoporosis affects about 25% of women 65 years and older and about 5% of men 65 and older. Osteoporosis or low bone mass at the femur neck or lumbar spine increases with age.</p> <p>The U.S. Preventive Services Task Force (USPSTF) recommends screening for osteoporosis with bone measurement testing to prevent osteoporotic fractures in women 65 years and older. This is a B recommendation, meaning that the USPSTF recommends the service and there is moderate certainty for the net benefit of screening for osteoporosis.</p> <p>The USPSTF also recommends screening for osteoporosis with bone measurement testing to prevent osteoporotic fractures in postmenopausal women younger than 65 who are at increased risk of osteoporosis, as determined by a formal clinical risk assessment tool.</p> <p>The North American Menopause Society recommends osteoporosis drug therapy for postmenopausal women who have had an osteoporotic vertebral or hip fracture and postmenopausal women who have bone mineral density values consistent with osteoporosis. The American Association of Clinical Endocrinologists also recommends pharmacological therapy for all patients who have a history of spine or hip fractures.</p> <p>Osteoporosis-related fractures cost patients, their families and the health care system an estimated \$19 billion annually. By 2025, experts predict osteoporosis will be responsible for 3 million fractures, resulting in \$25.3 billion in costs.</p>		

<b>Citations</b>	<p>Camacho, P.M., S.M. Petak, N. Binkley, et al. 2020. "American Association of Clinical Endocrinologists/American College of Endocrinology Clinical Practice Guidelines for the Diagnosis and Treatment of Postmenopausal Osteoporosis—2020 Update." <i>Endocrine Practice</i> 26:1–46. doi:10.4158/GL-2020-0524SUPPL</p> <p>Looker, A.C., N.S. Isfahani, B. Fan, and J.A. Shepherd. 2017. "Trends in Osteoporosis and Low Bone Mass in Older US Adults, 2005–2006 Through 2013–2014." <i>Osteoporosis International</i> 28(6), 1979–88.</p> <p>"Management of Osteoporosis in Postmenopausal Women: The 2021 Position Statement of The North American Menopause Society." 2021. <i>Menopause</i> 28(9):973–97. doi:10.1097/GME.0000000000001831</p> <p>National Institutes of Health. 2017. <i>Osteoporosis: Overview</i>. National Institute of Arthritis and Musculoskeletal and Skin Disorders (NIH NIAMS). <a href="https://www.bones.nih.gov/health-info/bone/osteoporosis/overview">https://www.bones.nih.gov/health-info/bone/osteoporosis/overview</a></p> <p>National Osteoporosis Foundation. 2015. <i>Osteoporosis Fast Facts</i>. <a href="https://cdn.nof.org/wp-content/uploads/2015/12/Osteoporosis-Fast-Facts.pdf">https://cdn.nof.org/wp-content/uploads/2015/12/Osteoporosis-Fast-Facts.pdf</a></p> <p>U.S. Preventive Services Task Force (USPSTF). 2025. <i>Final Recommendation Statement: Osteoporosis to Prevent Fractures: Screening</i>. <a href="https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/osteoporosis-screening">https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/osteoporosis-screening</a></p> <p>Wright, N.C., A.C. Looker, K.G. Saag, J.R. Curtis, E.S. Delzell, S. Randall, and B. Dawson-Hughes. 2014. "The Recent Prevalence of Osteoporosis and Low Bone Mass in the United States Based on Bone Mineral Density at the Femoral Neck or Lumbar Spine." <i>Journal of Bone and Mineral Research</i> 29(11), 2520–6.</p>
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<b>Characteristics</b>	
<b>Scoring</b>	Proportion.
<b>Type</b>	Process.
<b>Product lines</b>	Medicare.
<b>Stratifications</b>	None.
<b>Risk adjustment</b>	None.
<b>Improvement notation</b>	Increased score indicates improvement.
<b>Guidance</b>	<p><b>Data collection methodology:</b> Administrative. Refer to <a href="#">General Guideline: Data Collection Methods</a> for additional information.</p> <p><b>Date specificity:</b> Dates must be specific enough to determine the event occurred in the time period being measured.</p> <p><b>Which services count?</b> When using claims, include all paid, suspended, pending and denied claims.</p> <p><b>Other guidance:</b> Fractures of finger, toe, face and skull are not included in this measure.</p>

<b>Definitions</b>	
<b>Active prescription</b>	A prescription is considered active if the “days supply” indicated on the date when the person was dispensed the prescription is the number of days or more between that date and the relevant service date.
<b>Direct transfer</b>	<p><b>A direct transfer</b> 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.</p> <ul style="list-style-type: none"> <li>• <i>For example:</i> <ul style="list-style-type: none"> <li>– An inpatient discharge on June 1, followed by an admission to another inpatient setting on June 1, <i>is a direct transfer</i>.</li> <li>– An inpatient discharge on June 1, followed by an admission to an inpatient setting on June 2, <i>is a direct transfer</i>.</li> <li>– An inpatient discharge on June 1, followed by an admission to another inpatient setting on June 3, <i>is not a direct transfer</i>; these are two distinct inpatient stays.</li> </ul> </li> </ul> <p>Use the following method to identify admissions to and discharges from inpatient settings.</p> <ol style="list-style-type: none"> <li>1. Identify all acute and nonacute inpatient stays (<u>Inpatient Stay Value Set</u>).</li> <li>2. Identify the admission and discharge dates for the stay.</li> </ol> <p><b>Note:</b> <i>The direct transfer does not require a fracture diagnosis.</i></p>
<b>Episode date</b>	<p>The date of service for an eligible encounter during the intake period with a diagnosis of fracture.</p> <p><i>For an outpatient or ED visit</i>, the episode date is the date of service.</p> <p><i>For an inpatient stay</i>, the episode date is the date of discharge.</p> <p><i>For direct transfers</i>, the episode date is the discharge date from the last admission.</p>
<b>IESD</b>	Index episode start date. The earliest episode date during the intake period that meets all initial population criteria.
<b>Intake period</b>	July 1 of the year prior to the measurement period to June 30 of the measurement period. The intake period is used to capture the first fracture.
<b>Initial population</b>	<p><b>Measure item count:</b> Person.</p> <p><b>Attribution basis:</b> Enrollment.</p> <ul style="list-style-type: none"> <li>• <b>Benefits:</b> Medical and pharmacy.</li> <li>• <b>Continuous enrollment:</b> 365 days prior to the episode date through 180 days after the episode date.</li> <li>• <b>Allowable gap:</b> No more than one gap of ≤45 days during the continuous enrollment period. No gaps on the episode date.</li> </ul> <p><b>Ages:</b> 67–85 years of age as of the last day of the measurement period.</p>

	<p><b>Gender/sex criteria:</b></p> <ul style="list-style-type: none"> <li>• Administrative Gender of Female (AdministrativeGender code female) any time in the person's history.</li> </ul> <p><b>Event: Persons who have suffered a fracture.</b></p> <p><b>Step 1.</b> Identify all persons who had either of the following during the intake period.</p> <ul style="list-style-type: none"> <li>• An outpatient visit or ED visit (<u>Outpatient and ED Value Set</u>) for a fracture (<u>Fractures Value Set</u>).       <ul style="list-style-type: none"> <li>– Do not include visits that result in an inpatient stay (<u>Inpatient Stay Value Set</u>).</li> </ul> </li> <li>• An acute or nonacute inpatient discharge with a fracture (<u>Fractures Value Set</u>) on the discharge claim. To identify acute and nonacute inpatient discharges:       <ol style="list-style-type: none"> <li>1. Identify all acute and nonacute inpatient stays (<u>Inpatient Stay Value Set</u>).</li> <li>2. Identify the discharge date for the stay.</li> </ol> </li> </ul> <p>If the person had more than one fracture, identify all fractures and assess eligibility in steps 2–4.</p> <p><b>Step 2.</b> Test for negative diagnosis history. Remove episodes where either of the following occurred during the 60-day period prior to the episode date:</p> <ul style="list-style-type: none"> <li>• An outpatient visit, ED visit, telephone visit, e-visit or virtual check-in (<u>Outpatient, ED and Telehealth Value Set</u>) for a fracture (<u>Fractures Value Set</u>).       <ul style="list-style-type: none"> <li>– Do not include visits that result in an inpatient stay (<u>Inpatient Stay Value Set</u>).</li> </ul> </li> <li>• An acute or nonacute inpatient discharge with a fracture (<u>Fractures Value Set</u>) on the discharge claim. To identify acute and nonacute inpatient discharges:       <ol style="list-style-type: none"> <li>1. Identify all acute and nonacute inpatient stays (<u>Inpatient Stay Value Set</u>).</li> <li>2. Identify the discharge date for the stay.</li> </ol> </li> </ul> <p><i>For an acute or nonacute inpatient episode</i>, use the date of admission to determine the 60-day period.</p> <p><i>For episodes that were direct transfers</i>, use the first admission to determine the negative diagnosis history.</p> <p><i>For inpatient stay episodes that were a result of an outpatient or ED visit</i>, use the date of the outpatient or ED visit to determine negative diagnosis history.</p> <p><b>Step 3.</b> Calculate continuous enrollment.</p> <p><b>Step 4.</b> Remove episode dates where any of the following are met:</p> <ul style="list-style-type: none"> <li>• A BMD test (<u>Bone Mineral Density Tests Value Set</u>; <u>Bone Mineral Density Test Result or Finding Value Set</u>) during the 730 days prior to the episode date.</li> </ul>
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	<ul style="list-style-type: none"> <li>• A claim/encounter for osteoporosis therapy (<a href="#">Osteoporosis Medication Therapy Value Set</a>) during the 365 days prior to the episode date.</li> <li>• A prescription dispensed or an active prescription to treat osteoporosis (<a href="#">Osteoporosis Medications List</a>) during the 365 days prior to the episode date.</li> </ul> <p><i>For an acute or nonacute inpatient event</i>, use the date of admission to identify the days prior to the episode date.</p> <p><i>For direct transfers</i>, use the first admission date to identify the days prior to the episode date.</p> <p><i>For outpatient and ED visits that result in an inpatient stay</i>, use the date of the outpatient or ED visit to identify the days prior to the episode date.</p> <p><b>Step 5.</b> Select the IESD. The measure examines the earliest eligible episode per person that meets the criteria above.</p>
<b>Denominator exclusions</b>	<p><b>Persons with a date of death.</b> Death in the measurement period, identified using data sources determined by the organization. Method and data sources are subject to review during the HEDIS audit.</p> <p><b>Persons in hospice or using hospice services.</b> Persons who use hospice services (<a href="#">Hospice Encounter Value Set</a>; <a href="#">Hospice Intervention Value Set</a>) or elect to use a hospice benefit any time during the measurement period. Organizations that use the Monthly Membership Detail Data File to identify these persons must use only the run date of the file.</p> <p><b>Persons receiving palliative care.</b> Persons receiving palliative care (<a href="#">Palliative Care Assessment Value Set</a>; <a href="#">Palliative Care Encounter Value Set</a>; <a href="#">Palliative Care Intervention Value Set</a>) or who had an encounter for palliative care (ICD-10-CM code Z51.5*) any time during the intake period through last day of the measurement period.</p> <p><b>Medicare enrollees, 67 years of age and older as of the last day of the measurement period, in an institutional SNP (I-SNP) or living long-term in an institution (LTI).</b></p> <ul style="list-style-type: none"> <li>• Enrolled in an Institutional SNP (I-SNP) any time during the intake period through the last day of the measurement period.</li> <li>• Living long-term in an institution any time during the measurement period as identified by the LTI flag in the Monthly Membership Detail Data File. Use the run date of the file to determine if a member had an LTI flag during the intake period through the last day of the measurement period.</li> </ul> <p><b>Persons 67–80 years of age as of the last day of the measurement period, with both frailty and advanced illness.</b></p> <ol style="list-style-type: none"> <li>1. <b>Frailty.</b> At least two indications of frailty (<a href="#">Frailty Device Value Set</a>; <a href="#">Frailty Diagnosis Value Set*</a>; <a href="#">Frailty Encounter Value Set</a>; <a href="#">Frailty Symptom Value Set*</a>) with different dates of service during the intake period through the last day of the measurement period.</li> <li>2. <b>Advanced illness.</b> Either of the following during the measurement period or the year prior to the measurement period:</li> </ol>

	<ul style="list-style-type: none"> <li>– Advanced illness (<a href="#">Advanced Illness Value Set*</a>) on at least two different dates of service.</li> <li>– Dispensed dementia medication (<a href="#">Dementia Medications List</a>).</li> </ul> <p><b>Persons 81 years of age and older as of the last day of the measurement period, with frailty.</b></p> <p>Persons with at least two indications of frailty (<a href="#">Frailty Device Value Set</a>; <a href="#">Frailty Diagnosis Value Set*</a>; <a href="#">Frailty Encounter Value Set</a>; <a href="#">Frailty Symptom Value Set*</a>) with different dates of service during the measurement period.</p> <p><b>Coding Guidance</b></p> <p>*Do not include laboratory claims (claims with POS code 81).</p>																								
<b>Denominator</b>	The initial population minus denominator exclusions.																								
<b>Numerator</b>	<p><b>Persons with appropriate testing or treatment for osteoporosis in the specified time frames.</b></p> <p>Identify any of the following criteria:</p> <ul style="list-style-type: none"> <li>• A BMD test (<a href="#">Bone Mineral Density Tests Value Set</a>; <a href="#">Bone Mineral Density Test Result or Finding Value Set</a>), in any setting, on the IESD or in the 180-day period after the IESD.</li> <li>• If the IESD was an inpatient stay, a BMD test (<a href="#">Bone Mineral Density Tests Value Set</a>; <a href="#">Bone Mineral Density Test Result or Finding Value Set</a>) during the inpatient stay.</li> <li>• Osteoporosis therapy (<a href="#">Osteoporosis Medication Therapy Value Set</a>) on the IESD or in the 180-day period after the IESD.</li> <li>• If the IESD was an inpatient stay, long-acting osteoporosis therapy (<a href="#">Long Acting Osteoporosis Medications Value Set</a>) during the inpatient stay.</li> <li>• A dispensed prescription to treat osteoporosis (<a href="#">Osteoporosis Medications List</a>) on the IESD or in the 180-day period after the IESD.</li> </ul>																								
<b>Summary of changes</b>	<ul style="list-style-type: none"> <li>• Added an administrative gender code to the initial population.</li> </ul>																								
<b>Data element tables</b>	<p>Organizations that submit HEDIS data to NCQA must provide the following data elements.</p> <p><b>Table OMW-3: Data Elements for Osteoporosis Management in Women Who Had a Fracture</b></p> <table border="1"> <thead> <tr> <th>Metric</th> <th>Data Element</th> <th>Reporting Instructions</th> </tr> </thead> <tbody> <tr> <td>OsteoporosisManagementWomen</td> <td>Benefit</td> <td>Metadata</td> </tr> <tr> <td></td> <td>InitialPopulation</td> <td>Report once</td> </tr> <tr> <td></td> <td>Exclusions</td> <td>Report once</td> </tr> <tr> <td></td> <td>Denominator</td> <td>Report once</td> </tr> <tr> <td></td> <td>NumeratorByAdmin</td> <td>Report once</td> </tr> <tr> <td></td> <td>NumeratorBySupplemental</td> <td>Report once</td> </tr> <tr> <td></td> <td>Rate</td> <td>(Percent)</td> </tr> </tbody> </table>	Metric	Data Element	Reporting Instructions	OsteoporosisManagementWomen	Benefit	Metadata		InitialPopulation	Report once		Exclusions	Report once		Denominator	Report once		NumeratorByAdmin	Report once		NumeratorBySupplemental	Report once		Rate	(Percent)
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<b>Rules for Allowable Adjustments</b>	<p><b>Copyright and use:</b> The “Rules for Allowable Adjustments of HEDIS” (the “Rules”) describe how NCQA’s HEDIS measure specifications can be adjusted for other populations, if applicable. The Rules, reviewed and approved by NCQA measure experts, provide for expanded use of HEDIS measures without changing their clinical intent.</p> <p><b>Adjusted HEDIS measures may not be used for HEDIS health plan reporting.</b></p> <p><b>ADJUSTMENTS ALLOWED</b></p> <ul style="list-style-type: none"> <li>• <i>Product lines.</i> Organizations are not required to use product line criteria; product lines may be combined, and all (or no) product line criteria may be used.</li> <li>• <i>Attribution.</i> Organizations are not required to use enrollment criteria.</li> <li>• <i>Benefits.</i> Organizations are not required to use a benefit.</li> <li>• <i>Other.</i> Organizations may use additional initial population criteria to focus on an area of interest defined by gender, race, ethnicity, socioeconomic or sociodemographic characteristics, geographic region or another characteristic.</li> <li>• <i>Measurement period adjustments.</i> Organizations may adjust the measurement period. Changes to these criteria can affect how the event will be calculated using the intake period, IESD and negative diagnosis history.</li> <li>• <i>Exclusions.</i> The hospice, deceased person, palliative care, I-SNP, LTI, frailty and advanced illness exclusions are not required.</li> <li>• <i>Telehealth.</i> Services/events that allow the use of synchronous telehealth visits, telephone visits and asynchronous telehealth (e-visits, virtual check-ins) may be stratified to identify services performed via telehealth. This adjustment is not allowed for events, numerators and exclusions that do not allow the use of telehealth.</li> <li>• <i>Supplemental data.</i> Supplemental data may be used to identify initial population, denominator, exclusion and numerator events.</li> </ul> <p><b>ADJUSTMENTS ALLOWED WITH LIMITS</b></p> <ul style="list-style-type: none"> <li>• <i>Ages.</i> Age determination dates may be changed (e.g., select, “age as of June 30”). Changing the denominator age range is allowed between 50 and 85 years of age.</li> </ul> <p><b>ADJUSTMENTS NOT ALLOWED</b></p> <ul style="list-style-type: none"> <li>• <i>Initial population:</i> Event. Only events or diagnoses that contain (or map to) codes in the value sets may be used to identify visits. Medication lists, value sets and logic may not be changed.</li> <li>• <i>Numerator.</i> Medication lists, value sets and logic may not be changed.</li> </ul>
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## Osteoporosis Screening in Older Women (OSW)

<b>Measure title</b>	Osteoporosis Screening in Older Women	<b>Measure ID</b>	OSW
<b>Description</b>	The percentage of women 65–75 years of age who received osteoporosis screening.		
<b>Measurement period</b>	January 1–December 31.		
<b>Copyright and disclaimer notice</b>	<p>Refer to the complete copyright and disclaimer information at the front of this publication.</p> <p>NCQA website: <a href="http://www.ncqa.org">www.ncqa.org</a>.</p> <p>Submit policy clarification support questions via My NCQA (<a href="https://my.ncqa.org">https://my.ncqa.org</a>).</p>		
<b>Clinical recommendation statement/ rationale</b>	<p>The U.S. Preventive Services Task Force (USPSTF) recommends screening for osteoporosis with bone measurement testing to prevent osteoporotic fractures in women 65 years and older. This is a B recommendation, meaning that the USPSTF recommends the service and there is moderate certainty for the net benefit of screening for osteoporosis.</p> <p>The USPSTF also recommends screening for osteoporosis with bone measurement testing to prevent osteoporotic fractures in postmenopausal women younger than 65 who are at increased risk of osteoporosis, as determined by a formal clinical risk assessment tool.</p>		
<b>Citations</b>	<p>U.S. Preventive Services Task Force (USPSTF). 2025. <i>Final Recommendation Statement: Osteoporosis to Prevent Fractures: Screening</i> <a href="https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/osteoporosis-screening">https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/osteoporosis-screening</a></p>		
<b>Characteristics</b>			
<b>Scoring</b>	Proportion.		
<b>Type</b>	Process.		
<b>Product lines</b>	Medicare.		
<b>Stratifications</b>	None.		
<b>Risk adjustment</b>	None.		
<b>Improvement notation</b>	Increased score indicates improvement.		
<b>Guidance</b>	<p><b>Data collection methodology:</b> Administrative. Refer to <a href="#">General Guideline: Data Collection Methods</a> for additional information.</p> <p><b>Date specificity:</b> Dates must be specific enough to determine the event occurred in the period being measured.</p>		

	<b>Which services count?</b> When using claims, include all paid, suspended, pending and denied claims.
<b>Initial population</b>	<p><b>Measure item count:</b> Person.</p> <p><b>Attribution basis:</b> Enrollment.</p> <ul style="list-style-type: none"> <li>• <b>Benefits:</b> Medical and pharmacy.</li> <li>• <b>Continuous enrollment:</b> The measurement period and the year prior to the measurement period.</li> <li>• <b>Allowable gap:</b> No more than one gap of ≤45 days during each year of the continuous enrollment period. No gaps on the last day of the measurement period.</li> </ul> <p><b>Ages:</b> 66–75 years of age as of the last day of the measurement period.</p> <p><b>Gender/sex criteria:</b></p> <ul style="list-style-type: none"> <li>• Administrative Gender of Female (AdministrativeGender code female) any time in the person's history.</li> </ul> <p><b>Event:</b> None.</p>
<b>Denominator exclusions</b>	<p><b>Persons with a date of death.</b> Death in the measurement period, identified using data sources determined by the organization. Method and data sources are subject to review during the HEDIS audit.</p> <p><b>Persons in hospice or using hospice services.</b> Persons who use hospice services (<u>Hospice Encounter Value Set</u>; <u>Hospice Intervention Value Set</u>) or elect to use a hospice benefit any time during the measurement period. Organizations that use the Monthly Membership Detail Data File to identify these persons must use only the run date of the file.</p> <p><b>Persons receiving palliative care.</b> Persons receiving palliative care (<u>Palliative Care Assessment Value Set</u>; <u>Palliative Care Encounter Value Set</u>; <u>Palliative Care Intervention Value Set</u>) or who had an encounter for palliative care (ICD-10-CM code Z51.5*) any time during the measurement period.</p> <p><b>Persons 66 years of age or older by the last day of the measurement period, with both frailty and advanced illness.</b></p> <ol style="list-style-type: none"> <li>1. <b>Frailty.</b> At least two indications of frailty (<u>Frailty Device Value Set</u>; <u>Frailty Diagnosis Value Set*</u>; <u>Frailty Encounter Value Set</u>; <u>Frailty Symptom Value Set*</u>) with different dates of service during the measurement period.</li> <li>2. <b>Advanced illness.</b> Either of the following during the measurement period or the year prior to the measurement period: <ul style="list-style-type: none"> <li>– Advanced illness (<u>Advanced Illness Value Set*</u>) on at least two different dates of service.</li> <li>– Dispensed dementia medication (<u>Dementia Medications List</u>).</li> </ul> </li> </ol>

	<p><b>Osteoporosis therapy.</b> A claim/encounter for osteoporosis therapy (<a href="#">Osteoporosis Medication Therapy Value Set</a>; <a href="#">Long Acting Osteoporosis Medications Value Set</a>) any time in the person's history through the last day of the year prior to the measurement period.</p> <p><b>Osteoporosis medications.</b> Dispensed prescription to treat osteoporosis (<a href="#">Osteoporosis Medications List</a>) any time on or between January 1 three years prior to the measurement period through the last day of the year prior to the measurement period.</p> <p><b>Coding Guidance</b> *Do not include laboratory claims (claims with POS code 81).</p>																								
<b>Denominator</b>	The initial population minus denominator exclusions.																								
<b>Numerator</b>	<p><b>Osteoporosis screening</b> One or more osteoporosis screening tests (<a href="#">Osteoporosis Screening Tests Value Set</a>) on or between the person's 65th birthday and the last day of the measurement period.</p>																								
<b>Summary of changes</b>	<ul style="list-style-type: none"> <li>Added an administrative gender code to the initial population.</li> </ul>																								
<b>Data element tables</b>	<p>Organizations that submit HEDIS data to NCQA must provide the following data elements.</p> <p><b>Table OSW-3: Data Elements for Osteoporosis Screening in Women</b></p> <table border="1"> <thead> <tr> <th>Metric</th><th>Data Element</th><th>Reporting Instructions</th></tr> </thead> <tbody> <tr> <td>OsteoporosisScreeningWomen</td><td>Benefit</td><td>Metadata</td></tr> <tr> <td></td><td>InitialPopulation</td><td>Report once</td></tr> <tr> <td></td><td>Exclusions</td><td>Report once</td></tr> <tr> <td></td><td>Denominator</td><td>Report once</td></tr> <tr> <td></td><td>NumeratorByAdmin</td><td>Report once</td></tr> <tr> <td></td><td>NumeratorBySupplemental</td><td>Report once</td></tr> <tr> <td></td><td>Rate</td><td>(Percent)</td></tr> </tbody> </table>	Metric	Data Element	Reporting Instructions	OsteoporosisScreeningWomen	Benefit	Metadata		InitialPopulation	Report once		Exclusions	Report once		Denominator	Report once		NumeratorByAdmin	Report once		NumeratorBySupplemental	Report once		Rate	(Percent)
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- *Attribution.* Organizations are not required to use enrollment criteria.
- *Benefits.* Organizations are not required to use a benefit.
- *Other.* Organizations may use additional initial population criteria to focus on an area of interest defined by gender, race, ethnicity, socioeconomic or sociodemographic characteristics, geographic region or another characteristic.
- *Exclusions.* The hospice, deceased persons, palliative care, frailty and advanced illness exclusions are not required.
- *Telehealth.* Services/events that allow the use of synchronous telehealth visits, telephone visits and asynchronous telehealth (e-visits, virtual check-ins) may be stratified to identify services performed via telehealth. This adjustment is not allowed for events, numerators and exclusions that do not allow the use of telehealth.
- *Supplemental data.* Supplemental data may be used to identify initial population, denominator, exclusion and numerator events.

#### **ADJUSTMENTS ALLOWED WITH LIMITS**

- *Ages.* The age determination dates may be changed (e.g., select, "age as of June 30"). The denominator age may be changed if the range is within the specified age range (66–75 years).

#### **ADJUSTMENTS NOT ALLOWED**

- *Exclusions.* The osteoporosis therapy and osteoporosis prescription exclusions must be applied. Value sets, medication lists and logic may not be changed.
- *Numerator.* Value sets and logic may not be changed.

## ***Behavioral Health***

## ***Diagnosed Mental Health Disorders (DMH)***

<b>Measure title</b>	Diagnosed Mental Health Disorders	<b>Measure ID</b>	DMH
<b>Description</b>	The percentage of persons 1 year of age and older who were diagnosed with a mental health disorder during the measurement period.		
<b>Measurement period</b>	January 1–December 31.		
<b>Copyright and disclaimer notice</b>	<p>Refer to the complete copyright and disclaimer information at the front of this publication.</p> <p>NCQA website: <a href="http://www.ncqa.org">www.ncqa.org</a>.</p> <p>Submit policy clarification support questions via My NCQA (<a href="https://my.ncqa.org">https://my.ncqa.org</a>).</p>		
<b>Clinical recommendation statement/ rationale</b>	<p>According to the National Survey on Drug Use and Health (NSDUH), 22.8% (58.7 million) of U.S. adults lived with a mental illness in 2023, and only 53.9% (31.6 million) of those adults received mental health treatment. In the same year, 31.9% (8.3 million people) of adolescents reported receipt of mental health treatment.</p> <p>This measure provides data on the diagnosed prevalence of mental health disorders to allow health plans to understand the population size affected, and support the provision of case management services and coordination of mental health treatment, as appropriate.</p>		
<b>Citations</b>	<p>Substance Abuse and Mental Health Services Administration (SAMHSA). 2024. <i>Key Substance Use and Mental Health Indicators in the United States: Results from the 2023 National Survey on Drug Use and Health (HHS Publication No. PEP24-07-021, NSDUH Series H-59)</i>. Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration. <a href="https://www.samhsa.gov/data/report/2023-nsduh-annual-national-report">https://www.samhsa.gov/data/report/2023-nsduh-annual-national-report</a></p>		
<b>Characteristics</b>			
<b>Scoring</b>	Proportion.		
<b>Type</b>	Process.		
<b>Product lines</b>	<ul style="list-style-type: none"> <li>• Commercial.</li> <li>• Medicaid.</li> <li>• Medicare.</li> </ul>		
<b>Stratifications</b>	<p>Age as of the last day of the measurement period.</p> <ul style="list-style-type: none"> <li>• 1–17 years.</li> <li>• 18–64 years.</li> <li>• 65 years and older.</li> </ul>		
<b>Risk adjustment</b>	None.		

<b>Guidance</b>	<p><b>Data collection methodology:</b> Administrative. Refer to <a href="#">General Guideline: Data Collection Methods</a> for additional information.</p> <p><b>Date specificity:</b> Dates must be specific enough to determine the event occurred in the period being measured.</p> <p><b>Which services count?</b> Use all paid, suspended, pending and denied claims.</p> <p><b>Improvement notation:</b> Neither a higher nor a lower rate indicates better performance. This measure provides information on the prevalence of diagnosed mental health disorders.</p>
<b>Initial population</b>	<p><b>Measure item count:</b> Person.</p> <p><b>Attribution basis:</b> Enrollment.</p> <ul style="list-style-type: none"> <li>• <b>Benefits:</b> Medical.</li> <li>• <b>Continuous enrollment:</b> The measurement period.</li> <li>• <b>Allowable gap:</b> No more than one gap of ≤45 days during the measurement period.</li> </ul> <p><b>Ages:</b> At least 1 year of age as of the last day of the measurement period.</p> <p><b>Event:</b> None.</p>
<b>Denominator exclusions</b>	<p><b>Persons with a date of death.</b> Death in the measurement period, identified using data sources determined by the organization. Method and data sources are subject to review during the HEDIS audit.</p> <p><b>Persons in hospice or using hospice services.</b> Persons who use hospice services (<a href="#">Hospice Encounter Value Set</a>; <a href="#">Hospice Intervention Value Set</a>) or elect to use a hospice benefit any time during the measurement period. Organizations that use the Monthly Membership Detail Data File to identify these persons must use only the run date of the file.</p>
<b>Denominator</b>	The initial population minus denominator exclusions.
<b>Numerator</b>	<p><b>Mental health disorder diagnosis.</b> Persons who had a mental health disorder diagnosis (<a href="#">Mental Health Diagnosis Value Set*</a>) during the measurement period.</p> <p><b>Coding Guidance</b> *Do not include laboratory claims (claims with POS code 81).</p>
<b>Summary of changes</b>	<ul style="list-style-type: none"> <li>• No changes to this measure.</li> </ul>

<b>Data element tables</b>	<p>Organizations that submit HEDIS data to NCQA must provide the following data elements.</p> <p><b>Table DMH-1/2/3: Data Elements for Diagnosed Mental Health Disorders</b></p> <table border="1" data-bbox="491 333 1470 635"> <thead> <tr> <th>Metric</th><th>Age</th><th>Data Element</th><th>Reporting Instructions</th></tr> </thead> <tbody> <tr> <td rowspan="6">MentalHealthDisorders</td><td>1-17</td><td>InitialPopulation</td><td>For each Stratification</td></tr> <tr> <td>18-64</td><td>Exclusions</td><td>For each Stratification</td></tr> <tr> <td>65+</td><td>Denominator</td><td>For each Stratification</td></tr> <tr> <td>Total</td><td>NumeratorByAdmin</td><td>For each Stratification</td></tr> <tr> <td></td><td>NumeratorBySupplemental</td><td>For each Stratification</td></tr> <tr> <td></td><td>Rate</td><td>(Percent)</td></tr> </tbody> </table>	Metric	Age	Data Element	Reporting Instructions	MentalHealthDisorders	1-17	InitialPopulation	For each Stratification	18-64	Exclusions	For each Stratification	65+	Denominator	For each Stratification	Total	NumeratorByAdmin	For each Stratification		NumeratorBySupplemental	For each Stratification		Rate	(Percent)
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		NumeratorBySupplemental	For each Stratification																					
		Rate	(Percent)																					
<b>Rules for Allowable Adjustments</b>	<p><b>Copyright and use:</b> The “Rules for Allowable Adjustments of HEDIS” (the “Rules”) describe how NCQA’s HEDIS measure specifications can be adjusted for other populations, if applicable. The Rules, reviewed and approved by NCQA measure experts, provide for expanded use of HEDIS measures without changing their clinical intent.</p> <p><b>Adjusted HEDIS measures may not be used for HEDIS health plan reporting.</b></p> <p><b>ADJUSTMENTS ALLOWED</b></p> <ul style="list-style-type: none"> <li><i>Product lines.</i> Organizations are not required to use product line criteria; product lines may be combined, and all (or no) product line criteria may be used.</li> <li><i>Attribution.</i> Organizations are not required to use enrollment criteria.</li> <li><i>Benefits.</i> Organizations are not required to use a benefit.</li> <li><i>Other.</i> Organizations may use additional initial population criteria to focus on an area of interest defined by gender, race, ethnicity, socioeconomic or sociodemographic characteristics, geographic region or another characteristic.</li> <li><i>Measurement period adjustments.</i> Organizations may adjust the measurement period.</li> <li><i>Exclusions.</i> The hospice and deceased person exclusions are not required.</li> <li><i>Telehealth.</i> Services/events that allow the use of synchronous telehealth visits, telephone visits and asynchronous telehealth (e-visits, virtual check-ins) may be stratified to identify services performed via telehealth. This adjustment is not allowed for events, numerators and exclusions that do not allow the use of telehealth.</li> <li><i>Supplemental data.</i> Supplemental data may be used to identify initial population, denominator, exclusion and numerator events.</li> </ul> <p><b>ADJUSTMENTS ALLOWED WITH LIMITS</b></p> <ul style="list-style-type: none"> <li><i>Ages.</i> Age determination dates may be changed (e.g., select, “age as of June 30”). The denominator age may not be expanded.</li> </ul> <p><b>ADJUSTMENTS NOT ALLOWED</b></p> <ul style="list-style-type: none"> <li><i>Numerator.</i> Value sets and logic may not be changed.</li> </ul>																							

## ***Follow-Up After Hospitalization for Mental Illness (FUH)***

Measure title	Follow-Up After Hospitalization for Mental Illness	Measure ID	FUH
<b>Description</b>	<p>The percentage of discharges for persons 6 years of age and older who were hospitalized for a principal diagnosis of mental illness, or any diagnosis of intentional self-harm, and had a mental health follow-up service. Two rates are reported:</p> <ol style="list-style-type: none"> <li>1. The percentage of discharges for which the person received follow-up within 30 days after discharge.</li> <li>2. The percentage of discharges for which the person received follow-up within 7 days after discharge.</li> </ol>		
<b>Measurement period</b>	January 1–December 31.		
<b>Copyright and disclaimer notice</b>	<p>Refer to the complete copyright and disclaimer information at the front of this publication.  NCQA website: <a href="http://www.ncqa.org">www.ncqa.org</a>.  Submit policy clarification support questions via My NCQA (<a href="https://my.ncqa.org">https://my.ncqa.org</a>).</p>		
<b>Clinical recommendation statement/ rationale</b>	<p>Ensuring coordination of care for individuals leaving the inpatient setting is critical. Individuals discharged from these settings may face health risks, including potential medication non-compliance, social isolation, substance use, suicidal ideation or self-harm, as well as financial or practical challenges, such as stable housing.</p> <p>Follow-up services can act as a critical link between the inpatient setting and transition into the community, ensuring coordination of care and ongoing support. During follow-up, providers have the opportunity to evaluate progress, address emerging symptoms and concerns, and adjust the treatment plan as needed. Early interventions and proactive management of potential challenges can reduce risk of readmission and promote sustained well-being. Additionally, studies have shown that timely follow-up after psychiatric hospitalization can increase the likelihood of adherence to medication and outpatient treatment, and reduce risk of suicide.</p>		
<b>Citations</b>	<p>Fontanella, C.A., L.A. Warner, J.D. Steelesmith, G. Brock, J.A. Bridge, &amp; J.V. Campo. 2020. “Association of Timely Outpatient Mental Health Services for Youths after Psychiatric Hospitalization with Risk of Death by Suicide.” <i>JAMA Network Open</i> 3(8), E2012887.</p> <p>Chung, D.T. C.J. Ryan, D. Hadzi-Pavlovic, S.P. Singh, C. Stanton, &amp; M.M. Large. 2017. “Suicide Rates After Discharge From Psychiatric Facilities: A Systematic Review and Meta-Analysis.” <i>JAMA Psychiatry</i> 74(7), 694–702.</p> <p>Fontanella, C.A., J.A. Bridge, S.C. Marcus, &amp; Campo, J.V. 2011. “Factors Associated with Antidepressant Adherence for Medicaid-Enrolled Children and Adolescents. <i>Annals of Pharmacotherapy</i> 45(7-8), 898–909.</p>		

	Beadles, C.A., A.R. Ellis, J.C. Lichstein, J.F. Farley, C.T. Jackson, J.P. Morrissey, & M.E. Domino. 2015. "First Outpatient Follow-Up After Psychiatric Hospitalization: Does One Size Fit All?" <i>Psychiatric Services</i> 66(4), 364–72. <a href="https://doi.org/10.1176/appi.ps.201400081">https://doi.org/10.1176/appi.ps.201400081</a>
<b>Characteristics</b>	
<b>Scoring</b>	Proportion.
<b>Type</b>	Process.
<b>Product lines</b>	<ul style="list-style-type: none"> <li>• Commercial.</li> <li>• Medicaid.</li> <li>• Medicare.</li> </ul>
<b>Stratifications</b>	<p>Age as of the date of discharge.</p> <ul style="list-style-type: none"> <li>• 6–17 years.</li> <li>• 18–64 years.</li> <li>• 65 years and older.</li> </ul> <p>Race. (Refer to <a href="#">General Guideline: Race and Ethnicity Stratification</a>.)</p> <ul style="list-style-type: none"> <li>• American Indian or Alaska Native.</li> <li>• Asian.</li> <li>• Black or African American.</li> <li>• Middle Eastern or North African.</li> <li>• Native Hawaiian or Pacific Islander.</li> <li>• White.</li> <li>• Some Other Race.</li> <li>• Two or More Races.</li> <li>• Asked But No Answer.</li> <li>• Unknown.</li> </ul> <p>Ethnicity. (Refer to <a href="#">General Guideline: Race and Ethnicity Stratification</a>.)</p> <ul style="list-style-type: none"> <li>• Hispanic or Latino.</li> <li>• Not Hispanic or Latino.</li> <li>• Asked But No Answer.</li> <li>• Unknown.</li> </ul>
<b>Risk adjustment</b>	None.
<b>Improvement notation</b>	Increased score indicates improvement.
<b>Guidance</b>	<p><b>Data collection methodology:</b> Administrative. Refer to the <a href="#">General Guideline: Data Collection Methods</a> for additional information.</p> <p><b>Date specificity:</b> Dates must be specific enough to determine the event occurred in the period being measured.</p>

	<p><b>Which services count?</b></p> <ul style="list-style-type: none"> <li>When using claims, include all paid, suspended, pending and denied claims.</li> <li>Organizations may have different methods for billing intensive outpatient visits and partial hospitalizations. Some may be comparable to outpatient billing, with separate claims for each date of service; others may be comparable to inpatient billing, with an admission date, a discharge date and units of service. Organizations whose billing methods are comparable to inpatient billing may count each unit of service as an individual visit. The unit of service must have occurred during the required period for the rate (e.g., within 30 days after discharge or within 7 days after discharge).</li> </ul> <p><b>Other guidance:</b></p> <ul style="list-style-type: none"> <li>Refer to <a href="#">Appendix 1</a> for the definition of <i>mental health provider</i>. Organizations must develop their own methods to identify mental health providers. Methods are subject to review by the HEDIS auditor.</li> <li>The measure is based on episodes; therefore, it is possible for the denominator to include multiple events for the same person.</li> </ul>
<b>Initial population</b>	<p><b>Measure item count:</b> Episode.</p> <p><b>Attribution basis:</b> Enrollment.</p> <ul style="list-style-type: none"> <li><b>Benefits:</b> Medical and mental health (inpatient and outpatient).</li> <li><b>Continuous enrollment:</b> Date of discharge through 30 days after discharge.</li> <li><b>Allowable gap:</b> None.</li> </ul> <p><b>Ages:</b> 6 years of age and older as of the date of discharge.</p> <p><b>Event: Hospitalization for mental illness.</b></p> <p>An acute inpatient discharge with a principal diagnosis of mental illness (<a href="#">Mental Illness Value Set</a>), or any diagnosis of intentional self-harm (<a href="#">Intentional Self Harm Value Set</a>), on the discharge claim on or between January 1 and December 1 of the measurement period. To identify acute inpatient discharges:</p> <ol style="list-style-type: none"> <li>Identify all acute and nonacute inpatient stays (<a href="#">Inpatient Stay Value Set</a>).</li> <li>Exclude nonacute inpatient stays (<a href="#">Nonacute Inpatient Stay Value Set</a>).</li> <li>Identify the discharge date for the stay.</li> </ol> <p><b>Acute readmission or direct transfer.</b></p> <p>Identify readmissions and direct transfers to an acute inpatient care setting during the 30-day follow-up period:</p> <ol style="list-style-type: none"> <li>Identify all acute and nonacute inpatient stays (<a href="#">Inpatient Stay Value Set</a>).</li> <li>Exclude nonacute inpatient stays (<a href="#">Nonacute Inpatient Stay Value Set</a>).</li> <li>Identify the admission date for the stay (the admission date must occur during the 30-day follow-up period).</li> <li>Identify the discharge date for the stay.</li> </ol> <p>Exclude both the initial discharge and the readmission/direct transfer discharge if the last discharge occurs after December 1 of the measurement period.</p>

	<p>If the readmission/direct transfer to the acute inpatient care setting was for a principal diagnosis of mental health disorder, or any diagnosis of intentional self-harm (<a href="#">Mental Health Diagnosis Value Set</a>; <a href="#">Intentional Self Harm Value Set</a>), count only the last discharge (use only the discharge claim).</p> <p>If the readmission/direct transfer to the acute inpatient care setting was for any other principal diagnosis, and intentional self-harm was not on the claim in any diagnosis position, exclude both the original and the readmission/direct transfer discharge (use only the discharge claim).</p> <p><b>Nonacute readmission or direct transfer.</b></p> <p>Exclude discharges followed by readmission or direct transfer to a nonacute inpatient care setting (except for psychiatric residential treatment) within the 30-day follow-up period, regardless of the diagnosis for the readmission. To identify readmissions and direct transfers to a nonacute inpatient care setting:</p> <ol style="list-style-type: none"> <li>1. Identify all acute and nonacute inpatient stays except for residential psychiatric treatment (<a href="#">Inpatient Stay Except Psychiatric Residential Value Set</a>).</li> <li>2. Confirm the stay was for nonacute care based on the presence of a nonacute code (<a href="#">Nonacute Inpatient Stay Value Set</a>) on the claim.</li> <li>3. Identify the admission date for the stay.</li> </ol> <p>These discharges are excluded from the measure because rehospitalization or direct transfer may prevent an outpatient follow-up visit from taking place.</p>
<b>Denominator exclusions</b>	<p><b>Persons with a date of death.</b> Death in the measurement period, identified using data sources determined by the organization. Method and data sources are subject to review during the HEDIS audit.</p> <p><b>Persons in hospice or using hospice services.</b> Persons who use hospice services (<a href="#">Hospice Encounter Value Set</a>; <a href="#">Hospice Intervention Value Set</a>) or elect to use a hospice benefit any time during the measurement period. Organizations that use the Monthly Membership Detail Data File to identify these persons must use only the run date of the file.</p>
<b>Denominator</b>	The initial population minus denominator exclusions.
<b>Numerator</b>	<p><b>Numerator 1: 30-day follow-up.</b> A follow-up visit with a mental health provider, or with any practitioner for any diagnosis of a mental health disorder, within 30 days after discharge. Do not include visits that occur on the date of discharge.</p> <p><b>Numerator 2: 7-day follow-up.</b> A follow-up visit with a mental health provider, or with any practitioner for any diagnosis of a mental health disorder, within 7 days after discharge. Do not include visits that occur on the date of discharge.</p> <p>For both indicators, any of the following meet criteria for a follow-up visit:</p> <ul style="list-style-type: none"> <li>• An outpatient visit (<a href="#">Visit Setting Unspecified Value Set</a>) <b>with</b> (<a href="#">Outpatient POS Value Set</a>) <b>with</b> a mental health provider.</li> </ul>

	<ul style="list-style-type: none"> <li>• An outpatient visit (<u>Visit Setting Unspecified Value Set</u>) <b>with</b> (<u>Outpatient POS Value Set</u>) <b>with</b> any diagnosis of mental health disorder (<u>Mental Health Diagnosis Value Set</u>).</li> <li>• An outpatient visit (<u>BH Outpatient Value Set</u>) <b>with</b> a mental health provider.</li> <li>• An outpatient visit (<u>BH Outpatient Value Set</u>) <b>with</b> any diagnosis of mental health disorder (<u>Mental Health Diagnosis Value Set</u>).</li> <li>• An intensive outpatient encounter or partial hospitalization (<u>Visit Setting Unspecified Value Set</u> <b>with</b> POS code 52).</li> <li>• An intensive outpatient encounter or partial hospitalization (<u>Partial Hospitalization or Intensive Outpatient Value Set</u>).</li> <li>• A community mental health center visit (<u>Visit Setting Unspecified Value Set; BH Outpatient Value Set; Transitional Care Management Services Value Set</u>) <b>with</b> POS code 53.</li> <li>• Electroconvulsive therapy (<u>Electroconvulsive Therapy Value Set</u>) <b>with</b> (<u>Outpatient POS Value Set</u>; POS code 24; POS code 52; POS code 53).</li> <li>• A telehealth visit (<u>Visit Setting Unspecified Value Set</u>) <b>with</b> (<u>Telehealth POS Value Set</u>) <b>with</b> a mental health provider.</li> <li>• A telehealth visit (<u>Visit Setting Unspecified Value Set</u>) <b>with</b> (<u>Telehealth POS Value Set</u>) <b>with</b> any diagnosis of mental health disorder (<u>Mental Health Diagnosis Value Set</u>).</li> <li>• Transitional care management services (<u>Transitional Care Management Services Value Set</u>) <b>with</b> a mental health provider.</li> <li>• Transitional care management services (<u>Transitional Care Management Services Value Set</u>) <b>with</b> any diagnosis of mental health disorder (<u>Mental Health Diagnosis Value Set</u>).</li> <li>• A visit in a behavioral healthcare setting (<u>Behavioral Healthcare Setting Value Set</u>).</li> <li>• A telephone visit (<u>Telephone Visits Value Set</u>) <b>with</b> a mental health provider.</li> <li>• A telephone visit (<u>Telephone Visits Value Set</u>) <b>with</b> any diagnosis of mental health disorder (<u>Mental Health Diagnosis Value Set</u>).</li> <li>• Psychiatric collaborative care management (<u>Psychiatric Collaborative Care Management Value Set</u>).</li> <li>• Peer support services (<u>Peer Support Services Value Set</u>) <b>with</b> any diagnosis of mental health disorder (<u>Mental Health Diagnosis Value Set</u>).</li> <li>• Psychiatric residential treatment (<u>Residential Behavioral Health Treatment Value Set</u>).</li> <li>• Psychiatric residential treatment (<u>Visit Setting Unspecified Value Set</u> <b>with</b> POS code 56).</li> </ul>
<b>Summary of changes</b>	<ul style="list-style-type: none"> <li>• Updated the race and ethnicity stratification categories to align with OMB SPD 15 2024.</li> <li>• Added instructions on allowable adjustments to the race and ethnicity stratification.</li> </ul>

<b>Data element tables</b>	Organizations that submit HEDIS data to NCQA must provide the following data elements.			
<b>Table FUH-A-1/2/3: Data Elements for Follow-Up After Hospitalization for Mental Illness</b>				
	<b>Metric</b>	<b>Age</b>	<b>Data Element</b>	<b>Reporting Instructions</b>
	FollowUp30Day	6-17	Benefit	Metadata
	FollowUp7Day	18-64	InitialPopulation	For each Stratification, repeat per Metric
		65+	Exclusions	For each Stratification, repeat per Metric
		Total	Denominator	For each Stratification, repeat per Metric
			NumeratorByAdmin	For each Metric and Stratification
			NumeratorBySupplemental	For each Metric and Stratification
			Rate	(Percent)
<b>Table FUH-B-1/2/3: Data Elements for Follow-Up After Hospitalization for Mental Illness: Stratifications by Race</b>				
	<b>Metric</b>	<b>Race</b>	<b>Data Element</b>	<b>Reporting Instructions</b>
	FollowUp30Day	AmericanIndianOrAlaskaNative	Denominator	For each Stratification, repeat per Metric
	FollowUp7Day	Asian	Numerator	For each Metric and Stratification
		BlackOrAfricanAmerican	Rate	(Percent)
		MiddleEasternOrNorthAfrican		
		NativeHawaiianOrPacificIslander		
		White		
		SomeOtherRace		
		TwoOrMoreRaces		
		AskedButNoAnswer		
		Unknown		
<b>Table FUH-C-1/2/3: Data Elements for Follow-Up After Hospitalization for Mental Illness: Stratifications by Ethnicity</b>				
	<b>Metric</b>	<b>Ethnicity</b>	<b>Data Element</b>	<b>Reporting Instructions</b>
	FollowUp30Day	HispanicOrLatino	Denominator	For each Stratification, repeat per Metric
	FollowUp7Day	NotHispanicOrLatino	Numerator	For each Metric and Stratification
		AskedButNoAnswer	Rate	(Percent)
		Unknown		

## Rules for Allowable Adjustments

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

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

### ADJUSTMENTS ALLOWED

- *Product lines.* Organizations are not required to use product line criteria; product lines may be combined, and all (or no) product line criteria may be used.
- *Benefits.* Organizations are not required to use a benefit.
- *Attribution.* Organizations are not required to use enrollment criteria.
- *Ages.* The denominator age range may be expanded. Age determination dates may be changed (6 years as of the date of the ED visit).
- *Other.* Organizations may use additional initial population criteria to focus on an area of interest defined by gender, race, ethnicity, socioeconomic or sociodemographic characteristics, geographic region or another characteristic.
- *Measurement period adjustments.* Organizations may adjust the measurement period.
- *Stratifications:* Race and ethnicity stratification. The race and ethnicity stratification is not required. Organizations may adjust this stratification as needed.
- *Exclusions.* The hospice and deceased persons exclusions are not required.
- *Telehealth.* Services/events that allow the use of synchronous telehealth visits, telephone visits and asynchronous telehealth (e-visits, virtual check-ins) may be stratified to identify services performed via telehealth. This adjustment is not allowed for events, numerators and exclusions that do not allow the use of telehealth.
- *Supplemental data.* Supplemental data may be used to identify initial population, denominator, exclusion and numerator events.

### ADJUSTMENTS ALLOWED WITH LIMITS

- *Initial population:* Event. Only events or diagnoses that contain (or map to) codes in the value sets may be used to identify visits with a diagnosis. Value sets and logic may not be changed. Organizations may assess at the person level by applying measure logic appropriately (i.e., percentage of persons with documentation of an ED visit with a principal diagnosis of mental illness or intentional self-harm, who had a follow-up visit for mental illness).

### ADJUSTMENTS NOT ALLOWED

- *Numerator.* Value sets and logic may not be changed for both the 30-day and 7-day follow-up rates.

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

<b>Measure title</b>	Follow-Up After Emergency Department Visit for Mental Illness*	<b>Measure ID</b>	FUM
<b>Description</b>	<p>The percentage of emergency department (ED) visits for persons 6 years of age and older with a principal diagnosis of mental illness, or any diagnosis of intentional self-harm, and had a mental health follow-up service. Two rates are reported:</p> <ol style="list-style-type: none"> <li>1. The percentage of ED visits for which the person received follow-up within 30 days of the ED visit (31 total days).</li> <li>2. The percentage of ED visits for which the person received follow-up within 7 days of the ED visit (8 total days).</li> </ol>		
<b>Measurement period</b>	January 1–December 31.		
<b>Copyright and disclaimer notice</b>	<p><i>*Adapted from an NCQA measure with financial support from the Office of the Assistant Secretary for Planning and Evaluation (ASPE) under Prime Contract No. HHSP23320100019WI/HHSP23337001T, in which NCQA was a subcontractor to Mathematica. Additional financial support was provided by the Substance Abuse and Mental Health Services Administration (SAMHSA).</i></p> <p>Refer to the complete copyright and disclaimer information at the front of this publication.</p> <p>NCQA website: <a href="http://www.ncqa.org">www.ncqa.org</a>.</p> <p>Submit policy clarification support questions via My NCQA (<a href="https://my.ncqa.org">https://my.ncqa.org</a>).</p>		
<b>Clinical recommendation statement/ rationale</b>	<p>A substantial number of ED visits are related to mental health crises, including psychiatric emergencies, suicidal ideation, self-harm and acute exacerbations of mental health disorders. Between 2017 and 2019, 52.9 of every 1,000 ED visits were due to mental illness. The ED is an initial point of contact for individuals experiencing a mental health crisis, especially when other resources, such as outpatient mental health services, may not be readily accessible or available outside regular office hours.</p> <p>Timely follow-up care is associated with remaining in the community for a longer period of time and avoiding future emergency visits. Evidence suggests that patients who fail to receive aftercare following their emergency psychiatric visit have 6 times higher odds of returning to the ED within 2 months, compared with patients who received aftercare. Follow-up visits not only provide the opportunity for coordination of care, but also allow opportunities for providers to identify changing or emerging issues, address treatment barriers and intervene promptly.</p>		
<b>Citations</b>	<p>Santo, L., J.Z. Peters, &amp; J.C. DeFrances. 2021. “Emergency Department Visits Among Adults With Mental Health Disorders: United States, 2017–2019.” Centers for Disease Control and Prevention, NCHS Data Brief No. 426. <a href="https://www.cdc.gov/nchs/products/databriefs/db426.htm#Key_finding">https://www.cdc.gov/nchs/products/databriefs/db426.htm#Key_finding</a></p>		

	<p>McCullumsmith, C., B. Clark, C. Blair, K. Cropsey, &amp; R. Shelton. 2015. "Rapid Follow-Up for Patients After Psychiatric Crisis." <i>Community Mental Health Journal</i> 51(2), 139–44. <a href="https://doi.org/10.1007/s10597-014-9782-z">https://doi.org/10.1007/s10597-014-9782-z</a></p> <p>Bruffaerts, R., M. Sabbe, &amp; K. Demyttenaere. 2005. "Predicting Aftercare in Psychiatric Emergencies." <i>Social Psychiatry and Psychiatric Epidemiology</i> 40(10), 829–34. <a href="https://doi.org/10.1007/s00127-005-0959-x">https://doi.org/10.1007/s00127-005-0959-x</a></p>
<b>Characteristics</b>	
<b>Scoring</b>	Proportion.
<b>Type</b>	Process.
<b>Product lines</b>	<ul style="list-style-type: none"> <li>• Commercial.</li> <li>• Medicaid.</li> <li>• Medicare.</li> </ul>
<b>Stratifications</b>	<p>Age as of the ED visit.</p> <ul style="list-style-type: none"> <li>• 6–17 years.</li> <li>• 18–64 years.</li> <li>• 65 years and older.</li> </ul> <p>Race. (Refer to <a href="#">General Guideline: Race and Ethnicity Stratification</a>.)</p> <ul style="list-style-type: none"> <li>• American Indian or Alaska Native.</li> <li>• Asian.</li> <li>• Black or African American.</li> <li>• Middle Eastern or North African.</li> <li>• Native Hawaiian or Pacific Islander.</li> <li>• White.</li> <li>• Some Other Race.</li> <li>• Two or More Races.</li> <li>• Asked But No Answer.</li> <li>• Unknown.</li> </ul> <p>Ethnicity. (Refer to <a href="#">General Guideline: Race and Ethnicity Stratification</a>.)</p> <ul style="list-style-type: none"> <li>• Hispanic or Latino.</li> <li>• Not Hispanic or Latino.</li> <li>• Asked But No Answer.</li> <li>• Unknown.</li> </ul>
<b>Risk adjustment</b>	None.
<b>Improvement notation</b>	Increased score indicates improvement.

<b>Guidance</b>	<p><b>Data collection methodology:</b> Administrative. Refer to <a href="#">General Guideline: Data Collection Methods</a> for additional information.</p> <p><b>Date specificity:</b> Dates must be specific enough to determine the event occurred in the period being measured.</p> <p><b>Which services count?</b> When using claims, include all paid, suspended, pending and denied claims.</p> <p><b>Other guidance:</b> The measure is based on episodes; therefore, it is possible for the denominator to include multiple events for the same person.</p>
<b>Initial population</b>	<p><b>Measure item count:</b> Episode.</p> <p><b>Attribution basis:</b> Enrollment.</p> <ul style="list-style-type: none"> <li>• <b>Benefits:</b> Medical and mental health.</li> <li>• <b>Continuous enrollment:</b> Date of the ED visit through 30 days after the ED visit (31 total days).</li> <li>• <b>Allowable gap:</b> None.</li> </ul> <p><b>Ages:</b> 6 years of age and older as of the ED visit.</p> <p><b>Event: Emergency department visit for mental illness.</b></p> <p>An ED visit (<a href="#">ED Value Set</a>) with a principal diagnosis of mental illness (<a href="#">Mental Illness Value Set</a>), or any diagnosis of intentional self-harm (<a href="#">Intentional Self Harm Value Set</a>), on or between January 1 and December 1 of the measurement period.</p> <p>If a person has more than one ED visit, identify all eligible ED visits between January 1 and December 1 of the measurement period and do not include more than one visit per 31-day period as described below.</p> <p><b>Multiple visits in a 31-day period.</b></p> <p>If a person has more than one ED visit in a 31-day period, include only the first eligible ED visit.</p> <ul style="list-style-type: none"> <li>• <i>For example</i>, if a person has an ED visit on January 1, include the January 1 visit and do not include ED visits that occur on or between January 2 and January 31; then, if applicable, include the next ED visit that occurs on or after February 1. Identify visits chronologically, including only one per 31-day period.</li> </ul> <p><b>Note:</b> Removal of multiple visits in a 31-day period is based on <b>eligible</b> visits. Assess each ED visit for exclusions before removing multiple visits in a 31-day period.</p> <p><b>ED visits followed by inpatient admission.</b></p> <p>Exclude ED visits that result in an inpatient stay. Exclude ED visits followed by admission to an acute or nonacute inpatient care setting on the date of the ED visit or within the 30 days after the ED visit (31 total days), regardless of the principal diagnosis for the admission. To identify admissions to an acute or nonacute inpatient care setting:</p> <ol style="list-style-type: none"> <li>1. Identify all acute and nonacute inpatient stays except for residential psychiatric treatment (<a href="#">Inpatient Stay Except Psychiatric Residential Value Set</a>).</li> </ol>

	<p>2. Identify the admission date for the stay.</p> <p>These events are excluded from the measure because admission to an acute or nonacute inpatient setting may prevent an outpatient follow-up visit from taking place.</p>
<b>Denominator exclusions</b>	<p><b>Persons with a date of death.</b> Death in the measurement period, identified using data sources determined by the organization. Method and data sources are subject to review during the HEDIS audit.</p> <p><b>Persons in hospice or using hospice services.</b> Persons who use hospice services (<u>Hospice Encounter Value Set</u>; <u>Hospice Intervention Value Set</u>) or elect to use a hospice benefit any time during the measurement period. Organizations that use the Monthly Membership Detail Data File to identify these persons must use only the run date of the file.</p>
<b>Denominator</b>	The initial population minus denominator exclusions.
<b>Numerator</b>	<p><b>Numerator 1: 30-day follow-up.</b> Follow-up visit for any diagnosis of a mental health disorder within 30 days after the ED visit (31 total days). Include visits that occur on the date of the ED visit.</p> <p><b>Numerator 2: 7-day follow-up.</b> Follow-up visit for any diagnosis of a mental health disorder within 7 days after the ED visit (8 total days). Include visits that occur on the date of the ED visit.</p> <p>For both indicators, any of the following meet criteria for a follow-up visit:</p> <ul style="list-style-type: none"> <li>• An outpatient visit (<u>Visit Setting Unspecified Value Set</u> <b>with</b> <u>Outpatient POS Value Set</u>) <b>with</b> any diagnosis of a mental health disorder (<u>Mental Health Diagnosis Value Set</u>).</li> <li>• An outpatient visit (<u>BH Outpatient Value Set</u>) <b>with</b> any diagnosis of a mental health disorder (<u>Mental Health Diagnosis Value Set</u>).</li> <li>• An intensive outpatient encounter or partial hospitalization (<u>Visit Setting Unspecified Value Set</u>) <b>with</b> POS code 52.</li> <li>• An intensive outpatient encounter or partial hospitalization (<u>Partial Hospitalization or Intensive Outpatient Value Set</u>) <b>with</b> any diagnosis of a mental health disorder (<u>Mental Health Diagnosis Value Set</u>).</li> <li>• A community mental health center visit (<u>Visit Setting Unspecified Value Set</u>) <b>with</b> POS code 53.</li> <li>• Electroconvulsive therapy (<u>Electroconvulsive Therapy Value Set</u>) <b>with</b> (<u>Outpatient POS Value Set</u>; POS code 24; POS code 52; POS code 53).</li> <li>• A telehealth visit (<u>Visit Setting Unspecified Value Set</u> <b>with</b> <u>Telehealth POS Value Set</u>) <b>with</b> any diagnosis of a mental health disorder (<u>Mental Health Diagnosis Value Set</u>).</li> <li>• A telephone visit (<u>Telephone Visits Value Set</u>) <b>with</b> any diagnosis of a mental health disorder (<u>Mental Health Diagnosis Value Set</u>).</li> <li>• An e-visit or virtual check-in (<u>Online Assessments Value Set</u>) <b>with</b> any diagnosis of a mental health disorder (<u>Mental Health Diagnosis Value Set</u>).</li> </ul>

	<ul style="list-style-type: none"> <li>• Psychiatric collaborative care management (<a href="#">Psychiatric Collaborative Care Management Value Set</a>).</li> <li>• Peer support services (<a href="#">Peer Support Services Value Set</a>) <b>with</b> any diagnosis of mental health disorder (<a href="#">Mental Health Diagnosis Value Set</a>).</li> <li>• Psychiatric residential treatment (<a href="#">Residential Behavioral Health Treatment Value Set</a>).</li> <li>• Psychiatric residential treatment (<a href="#">Visit Setting Unspecified Value Set</a> <b>with</b> POS code 56).</li> <li>• A visit in a behavioral healthcare setting (<a href="#">Behavioral Healthcare Setting Value Set</a>).</li> </ul> <p><b>Note:</b> Events that meet both initial population and numerator criteria should not be included in the numerator.</p>																																																
<b>Summary of changes</b>	<ul style="list-style-type: none"> <li>• Updated the race and ethnicity stratification categories to align with OMB SPD 15 2024.</li> <li>• Added instructions on allowable adjustments to the race and ethnicity stratification.</li> </ul>																																																
<b>Data element table</b>	<p>Organizations that submit HEDIS data to NCQA must provide the following data elements.</p> <p><b>Table FUM-A-1/2/3: Data Elements for Follow-Up After Emergency Department Visit for Mental Illness</b></p> <table border="1"> <thead> <tr> <th>Metric</th> <th>Age</th> <th>Data Element</th> <th>Reporting Instructions</th> </tr> </thead> <tbody> <tr> <td>FollowUp30Day</td> <td>6-17</td> <td>Benefit</td> <td>Metadata</td> </tr> <tr> <td>FollowUp7Day</td> <td>18-64</td> <td>InitialPopulation</td> <td>For each Stratification, repeat per Metric</td> </tr> <tr> <td></td> <td>65+</td> <td>Exclusions</td> <td>For each Stratification, repeat per Metric</td> </tr> <tr> <td></td> <td>Total</td> <td>Denominator</td> <td>For each Stratification, repeat per Metric</td> </tr> <tr> <td></td> <td></td> <td>NumeratorByAdmin</td> <td>For each Metric and Stratification</td> </tr> <tr> <td></td> <td></td> <td>NumeratorBySupplemental</td> <td>For each Metric and Stratification</td> </tr> <tr> <td></td> <td></td> <td>Rate</td> <td>(Percent)</td> </tr> </tbody> </table> <p><b>Table FUM-B-1/2/3: Data Elements for Follow-Up After Emergency Department Visit for Mental Illness: Stratifications by Race</b></p> <table border="1"> <thead> <tr> <th>Metric</th> <th>Race</th> <th>Data Element</th> <th>Reporting Instructions</th> </tr> </thead> <tbody> <tr> <td>FollowUp30Day</td> <td>AmericanIndianOrAlaskaNative</td> <td>Denominator</td> <td>For each Stratification, repeat per Metric</td> </tr> <tr> <td>FollowUp7Day</td> <td>Asian</td> <td>Numerator</td> <td>For each Metric and Stratification</td> </tr> <tr> <td></td> <td>BlackOrAfricanAmerican</td> <td>Rate</td> <td>(Percent)</td> </tr> </tbody> </table>	Metric	Age	Data Element	Reporting Instructions	FollowUp30Day	6-17	Benefit	Metadata	FollowUp7Day	18-64	InitialPopulation	For each Stratification, repeat per Metric		65+	Exclusions	For each Stratification, repeat per Metric		Total	Denominator	For each Stratification, repeat per Metric			NumeratorByAdmin	For each Metric and Stratification			NumeratorBySupplemental	For each Metric and Stratification			Rate	(Percent)	Metric	Race	Data Element	Reporting Instructions	FollowUp30Day	AmericanIndianOrAlaskaNative	Denominator	For each Stratification, repeat per Metric	FollowUp7Day	Asian	Numerator	For each Metric and Stratification		BlackOrAfricanAmerican	Rate	(Percent)
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Metric	Race	Data Element	Reporting Instructions
	MiddleEasternOrNorthAfrican		
	NativeHawaiianOrPacificIslander		
	White		
	SomeOtherRace		
	TwoOrMoreRaces		
	AskedButNoAnswer		
	Unknown		

Metric	Ethnicity	Data Element	Reporting Instructions
FollowUp30Day	HispanicOrLatino	Denominator	For each Stratification, repeat per Metric
FollowUp7Day	NotHispanicOrLatino	Numerator	For each Metric and Stratification
	AskedButNoAnswer	Rate	(Percent)
	Unknown		

Rules for Allowable Adjustments	<p><b>Copyright and use:</b> The “Rules for Allowable Adjustments of HEDIS” (the “Rules”) describe how NCQA’s HEDIS measure specifications can be adjusted for other populations, if applicable. The Rules, reviewed and approved by NCQA measure experts, provide for expanded use of HEDIS measures without changing their clinical intent.</p> <p><b>Adjusted HEDIS measures may not be used for HEDIS health plan reporting.</b></p> <p><b>ADJUSTMENTS ALLOWED</b></p> <ul style="list-style-type: none"> <li><b>Product lines.</b> Organizations are not required to use product line criteria; product lines may be combined, and all (or no) product line criteria may be used.</li> <li><b>Ages.</b> The denominator age range may be expanded. Age determination dates may be changed (6 years as of the date of the ED visit).</li> <li><b>Attribution.</b> Organizations are not required to use enrollment criteria.</li> <li><b>Benefits.</b> Organizations are not required to use a benefit.</li> <li><b>Other.</b> Organizations may use additional initial population criteria to focus on an area of interest defined by gender, race, ethnicity, socioeconomic or sociodemographic characteristics, geographic region or another characteristic.</li> <li><b>Measurement period adjustments.</b> Organizations may adjust the measurement period.</li> </ul>
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- *Stratifications:* Race and ethnicity stratification. The race and ethnicity stratification is not required. Organizations may adjust this stratification as needed.
- *Exclusions.* The hospice and deceased persons exclusions are not required.
- *Telehealth.* Services/events that allow the use of synchronous telehealth visits, telephone visits and asynchronous telehealth (e-visits, virtual check-ins) may be stratified to identify services performed via telehealth. This adjustment is not allowed for events, numerators and exclusions that do not allow the use of telehealth.
- *Supplemental data.* Supplemental data may be used to identify initial population, denominator, exclusion and numerator events.

**ADJUSTMENTS ALLOWED WITH LIMITS**

- *Initial population:* Event. Only events or diagnoses that contain (or map to) codes in the value sets may be used to identify visits with a diagnosis. Value sets and logic may not be changed. Organizations may assess at the person level by applying measure logic appropriately (i.e., percentage of persons with documentation of an ED visit with a principal diagnosis of mental illness or intentional self-harm, who had a follow-up visit for mental illness).

**ADJUSTMENTS NOT ALLOWED**

- *Numerator.* Value sets and logic may not be changed for both the 30-day follow-up and 7-day follow-up rates.

## ***Diagnosed Substance Use Disorders (DSU)***

Measure title	Diagnosed Substance Use Disorders	Measure ID	DSU
<b>Description</b>	<p>The percentage of persons 13 years of age and older who were diagnosed with a substance use disorder during the measurement period. Four rates are reported:</p> <ol style="list-style-type: none"> <li>1. The percentage of persons diagnosed with an alcohol disorder.</li> <li>2. The percentage of persons diagnosed with an opioid disorder.</li> <li>3. The percentage of persons diagnosed with a disorder for other or unspecified drugs.</li> <li>4. The percentage of persons diagnosed with any substance use disorder.</li> </ol>		
<b>Measurement period</b>	January 1–December 31.		
<b>Copyright and disclaimer notice</b>	<p>Refer to the complete copyright and disclaimer information at the front of this publication.  NCQA website: <a href="http://www.ncqa.org">www.ncqa.org</a>.  Submit policy clarification support questions via My NCQA (<a href="https://my.ncqa.org">https://my.ncqa.org</a>).</p>		
<b>Clinical recommendation statement/ rationale</b>	<p>In 2018, 20.3 million individuals in the U.S. age 12 or older (approximately 7.4% of the population) were classified as having an SUD within the past year. Individuals with SUDs are at increased risk of overdose, injury, soft tissue infections and mortality. Of the 20.3 million individuals with an SUD in 2018, only 3.7 million received any substance use treatment in the past year; 2.4 million of these received treatment in a specialty SUD program.</p> <p>By providing data on the diagnosed prevalence of SUD, this measure allows plans to understand the size of the population affected by substance use disorders and may encourage the provision of case management services and coordination of treatment, as appropriate.</p>		
<b>Citations</b>	<p>Substance Abuse and Mental Health Services Administration. 2019. <i>Key substance use and mental health indicators in the United States: Results from the 2018 National Survey on Drug Use and Health</i> (HHS Publication No. PEP19-5068, NSDUH Series H-54). Rockville, MD: Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration. <a href="https://www.samhsa.gov/data/sites/default/files/cbhsq-reports/NSDUHNationalFindingsReport2018/NSDUHNationalFindingsReport2018.htm#mhisud">https://www.samhsa.gov/data/sites/default/files/cbhsq-reports/NSDUHNationalFindingsReport2018/NSDUHNationalFindingsReport2018.htm#mhisud</a></p> <p>Bahorik, A.L., D.D. Satre, A.H. Kline-Simon, C.M. Weisner, C.L. Campbell. 2017. "Alcohol, Cannabis, and Opioid Use Disorders, and Disease Burden in an Integrated Health Care System." <i>J Addiction Medicine</i> 11(1), 3–9.</p>		

Characteristics	
<b>Scoring</b>	Proportion.
<b>Type</b>	Process.
<b>Product lines</b>	<ul style="list-style-type: none"> <li>• Commercial.</li> <li>• Medicaid.</li> <li>• Medicare.</li> </ul>
<b>Stratifications</b>	<p>Age as of the last day of the measurement period.</p> <ul style="list-style-type: none"> <li>• 13–17 years.</li> <li>• 18–64 years.</li> <li>• 65 years and older.</li> </ul>
<b>Risk adjustment</b>	None.
<b>Guidance</b>	<p><b>Data collection methodology:</b> Administrative. Refer to <a href="#">General Guideline: Data Collection Methods</a> for additional information.</p> <p><b>Date specificity:</b> Dates must be specific enough to determine the event occurred in the period being measured.</p> <p><b>Which services count?</b> Use all paid, suspended, pending and denied claims.</p> <p><b>Improvement notation:</b> Neither a higher nor a lower rate indicates better performance. This measure provides information on the diagnosed prevalence of substance use disorders.</p>
<b>Initial population</b>	<p><b>Measure item count:</b> Person.</p> <p><b>Attribution basis:</b> Enrollment.</p> <ul style="list-style-type: none"> <li>• <b>Benefits:</b> Medical.</li> <li>• <b>Continuous enrollment:</b> The measurement period.</li> <li>• <b>Allowable gap:</b> No more than one gap of ≤45 days during the measurement period.</li> </ul> <p><b>Ages:</b> 13 years of age and older as of the last day of the measurement period.</p> <p><b>Event:</b> None.</p>
<b>Denominator exclusions</b>	<p><b>Persons with a date of death.</b> Death in the measurement period, identified using data sources determined by the organization. Method and data sources are subject to review during the HEDIS audit.</p> <p><b>Persons in hospice or using hospice services.</b> Persons who use hospice services (<a href="#">Hospice Encounter Value Set</a>; <a href="#">Hospice Intervention Value Set</a>) or elect to use a hospice benefit any time during the measurement period. Organizations that use the Monthly Membership Detail Data File to identify these persons must use only the run date of the file.</p>
<b>Denominator</b>	The initial population minus denominator exclusions.

<b>Numerator</b>	<p><b>Numerator 1: Alcohol use disorder.</b> Persons who had an alcohol use disorder diagnosis (<u>Alcohol Abuse and Dependence Value Set*</u>) during the measurement period.</p> <p><b>Numerator 2: Opioid use disorder.</b> Persons who had an opioid use disorder diagnosis (<u>Opioid Abuse and Dependence Value Set*</u>) during the measurement period.</p> <p><b>Numerator 3: Other substance use disorder.</b> Persons who had a diagnosis of SUD that was neither for opioid or alcohol (<u>Other Drug Abuse and Dependence Value Set*</u>) during the measurement period.</p> <p><b>Numerator 4: Any substance use disorder.</b> Persons who had any substance use disorder during the measure period. Any of the following meet criteria.</p> <ul style="list-style-type: none"> <li>• <u>Alcohol Abuse and Dependence Value Set*</u>.</li> <li>• <u>Opioid Abuse and Dependence Value Set*</u>.</li> <li>• <u>Other Drug Abuse and Dependence Value Set*</u>.</li> </ul> <p><b>Coding Guidance</b> *Do not include laboratory claims (claims with POS code 81).</p>																												
<b>Summary of changes</b>	<ul style="list-style-type: none"> <li>• No changes to this measure.</li> </ul>																												
<b>Data element tables</b>	<p>Organizations that submit HEDIS data to NCQA must provide the following data elements.</p> <p><i>Table DSU-1/2/3: Data Elements for Diagnosed Substance Use Disorders</i></p> <table border="1"> <thead> <tr> <th>Metric</th> <th>Age</th> <th>Data Element</th> <th>Reporting Instructions</th> </tr> </thead> <tbody> <tr> <td>Alcohol</td> <td>13-17</td> <td>InitialPopulation</td> <td>For each Stratification, repeat per Metric</td> </tr> <tr> <td>Opioid</td> <td>18-64</td> <td>Exclusions</td> <td>For each Stratification, repeat per Metric</td> </tr> <tr> <td>Other</td> <td>65+</td> <td>Denominator</td> <td>For each Stratification, repeat per Metric</td> </tr> <tr> <td>Any</td> <td>Total</td> <td>NumeratorByAdmin</td> <td>For each Metric and Stratification</td> </tr> <tr> <td></td> <td></td> <td>NumeratorBySupplemental</td> <td>For each Metric and Stratification</td> </tr> <tr> <td></td> <td></td> <td>Rate</td> <td>(Percent)</td> </tr> </tbody> </table>	Metric	Age	Data Element	Reporting Instructions	Alcohol	13-17	InitialPopulation	For each Stratification, repeat per Metric	Opioid	18-64	Exclusions	For each Stratification, repeat per Metric	Other	65+	Denominator	For each Stratification, repeat per Metric	Any	Total	NumeratorByAdmin	For each Metric and Stratification			NumeratorBySupplemental	For each Metric and Stratification			Rate	(Percent)
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<b>Rules for Allowable Adjustments</b>	<p><b>Copyright and use:</b> The “Rules for Allowable Adjustments of HEDIS” (the “Rules”) describe how NCQA’s HEDIS measure specifications can be adjusted for other populations, if applicable. The Rules, reviewed and approved by NCQA measure experts, provide for expanded use of HEDIS measures without changing their clinical intent.</p> <p><b>Adjusted HEDIS measures may not be used for HEDIS health plan reporting.</b></p>																												

	<p><b>ADJUSTMENTS ALLOWED</b></p> <ul style="list-style-type: none"><li>• <i>Product lines.</i> Organizations are not required to use product line criteria; product lines may be combined, and all (or no) product line criteria may be used.</li><li>• <i>Attribution.</i> Organizations are not required to use enrollment criteria.</li><li>• <i>Benefits.</i> Organizations are not required to use a benefit.</li><li>• <i>Other.</i> Organizations may use additional initial population criteria to focus on an area of interest defined by gender, race, ethnicity, socioeconomic or sociodemographic characteristics, geographic region or another characteristic.</li><li>• <i>Measurement period adjustments.</i> Organizations may adjust the measurement period.</li><li>• <i>Exclusions.</i> The hospice and deceased person exclusions are not required.</li><li>• <i>Telehealth.</i> Services/events that allow the use of synchronous telehealth visits, telephone visits and asynchronous telehealth (e-visits, virtual check-ins) may be stratified to identify services performed via telehealth. This adjustment is not allowed for events, numerators and exclusions that do not allow the use of telehealth.</li><li>• <i>Supplemental data.</i> Supplemental data may be used to identify initial population, denominator, exclusion and numerator events.</li></ul> <p><b>ADJUSTMENTS ALLOWED WITH LIMITS</b></p> <ul style="list-style-type: none"><li>• <i>Ages.</i> Age determination dates may be changed (e.g., select, “age as of June 30”). The denominator age may not be expanded.</li></ul> <p><b>ADJUSTMENTS NOT ALLOWED</b></p> <ul style="list-style-type: none"><li>• <i>Numerator.</i> Value sets and logic may not be changed for the Alcohol Use Disorder, Opioid Use Disorder, Other Substance Use Disorder and Any Substance Use Disorder indicators.</li></ul>
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## **Follow-Up After High-Intensity Care for Substance Use Disorder (FUI)**

<b>Measure title</b>	Follow-Up After High-Intensity Care for Substance Use Disorder	<b>Measure ID</b>	FUI
<b>Description</b>	<p>The percentage of acute inpatient hospitalizations, residential treatment or withdrawal management visits for a diagnosis of substance use disorder among persons 13 years of age and older that result in a follow-up visit or service for substance use disorder. Two rates are reported:</p> <ol style="list-style-type: none"> <li>1. The percentage of visits or discharges for which the person received follow-up for substance use disorder within the 30 days after the visit or discharge.</li> <li>2. The percentage of visits or discharges for which the person received follow-up for substance use disorder within the 7 days after the visit or discharge.</li> </ol>		
<b>Measurement period</b>	January 1–December 31.		
<b>Copyright and disclaimer notice</b>	<p>Refer to the complete copyright and disclaimer information at the front of this publication.  NCQA website: <a href="http://www.ncqa.org">www.ncqa.org</a>.  Submit policy clarification support questions via My NCQA (<a href="https://my.ncqa.org">https://my.ncqa.org</a>).</p>		
<b>Clinical recommendation statement/ rationale</b>	<p>Timely follow-up and continuity of care following a high-intensity event for a diagnosis of SUD are critical, as individuals receiving SUD care in these settings are vulnerable to losing contact with the health care system. Lack of timely follow-up can result in negative outcomes, such as continued substance use, relapse, high utilization of intensive care services and mortality. Although clinical practice guidelines and expert consensus do not define the ideal timing for follow-up, guidelines recommend that individuals with SUD receive patient-centered, timely follow-up care in an appropriate care setting, to ensure ongoing treatment and management.</p>		
<b>Citations</b>	<p>National Institute on Drug Abuse (NIDA). 2017. <i>Trends &amp; Statistics</i>. National Institute on Drug Abuse, April 2017. <a href="https://www.drugabuse.gov/related-topics/trends-statistics#supplemental-references-for-economic-costs">https://www.drugabuse.gov/related-topics/trends-statistics#supplemental-references-for-economic-costs</a></p> <p>National Institute on Drug Abuse (NIDA). 2018. <i>Principles of Drug Addiction Treatment: A Research-Based Guide (Third Edition)</i>. National Institute on Drug Abuse, 17 Jan. 2018. <a href="https://www.drugabuse.gov/publications/principles-drug-addiction-treatment-research-based-guide-third-edition">https://www.drugabuse.gov/publications/principles-drug-addiction-treatment-research-based-guide-third-edition</a></p> <p>Work Group on Substance Use Disorders. 2006. <i>Practice Guideline for the Treatment of Patients With Substance Use Disorders Second Edition</i>. American Psychiatric Association (APA); Aug. 276 pg. [1789 references]. <a href="https://psychiatryonline.org/pb/assets/raw/sitewide/practice_guidelines/guidelines/substanceuse.pdf">https://psychiatryonline.org/pb/assets/raw/sitewide/practice_guidelines/guidelines/substanceuse.pdf</a></p>		

Characteristics	
<b>Scoring</b>	Proportion.
<b>Type</b>	Process.
<b>Product lines</b>	<ul style="list-style-type: none"> <li>• Commercial.</li> <li>• Medicaid.</li> <li>• Medicare.</li> </ul>
<b>Stratifications</b>	<p>Age as of date of the discharge, stay or event.</p> <ul style="list-style-type: none"> <li>• 13–17 years.</li> <li>• 18–64 years.</li> <li>• 65 years and older.</li> </ul>
<b>Risk adjustment</b>	None.
<b>Improvement notation</b>	Increased score indicates improvement.
<b>Guidance</b>	<p><b>Data collection methodology:</b> Administrative. Refer to <a href="#">General Guideline: Data Collection Methods</a> for additional information.</p> <p><b>Date specificity:</b> Dates must be specific enough to determine the event occurred in the period being measured.</p> <p><b>Which services count?</b> When using claims, include all paid, suspended, pending and denied claims.</p> <p><b>Other guidance:</b></p> <ul style="list-style-type: none"> <li>• Methadone is not included on the medication lists for this measure. Methadone for opioid use disorder is only administered or dispensed by federally certified opioid treatment programs and does not show up in pharmacy claims data. A pharmacy claim for methadone would be more indicative of treatment for pain than for an opioid use disorder and therefore is not included on medication lists. The <a href="#">AOD Medication Treatment Value Set</a> and <a href="#">OUD Weekly Drug Treatment Service Value Set</a> include codes that identify methadone treatment for opioid use disorder because these codes are used on medical claims, not on pharmacy claims.</li> <li>• The measure is based on episodes; therefore, it is possible for the denominator to include multiple events for the same person.</li> </ul>
Definitions	
<b>Direct transfer</b>	<p>When the discharge date from the first acute inpatient or residential care setting precedes the admission date to a second acute inpatient or residential care setting by 1 calendar day or less.</p> <ul style="list-style-type: none"> <li>• <i>For example:</i> <ul style="list-style-type: none"> <li>– An inpatient discharge on June 1, followed by an admission to another inpatient setting on June 1, is a direct transfer.</li> </ul> </li> </ul>

	<ul style="list-style-type: none"> <li>– An inpatient discharge on June 1, followed by an admission to an inpatient setting on June 2, <i>is a direct transfer</i>.</li> <li>– An inpatient discharge on June 1, followed by an admission to another inpatient setting on June 3, <i>is not a direct transfer</i>; these are two distinct inpatient stays.</li> </ul> <p><b>Episode date</b></p> <p>The date of service for any acute inpatient discharge, residential treatment discharge or withdrawal management visit with a principal diagnosis of SUD.</p> <p>For an acute inpatient discharge or residential treatment discharge or for withdrawal management that occurred during an acute inpatient stay or residential treatment stay, the episode date is the discharge date.</p> <p>For direct transfers, the episode date is the discharge date from the transfer admission.</p> <p>For withdrawal management (other than withdrawal management that occurred during an acute inpatient stay or residential treatment stay), the episode date is the date of service.</p>
<b>Initial population</b>	<p><b>Measure item count:</b> Episode.</p> <p><b>Attribution basis:</b> Enrollment.</p> <ul style="list-style-type: none"> <li>• <b>Benefits:</b> Medical, chemical dependency and pharmacy.</li> <li>• <b>Note:</b> A withdrawal management/detoxification-only chemical dependency benefit does not meet these criteria.</li> <li>• <b>Continuous enrollment:</b> Episode date through 30 days after the episode date (31 total days).</li> <li>• <b>Allowable gap:</b> None.</li> </ul> <p><b>Ages:</b> 13 years of age or older as of date of the discharge, stay or event.</p> <p><b>Event: High-intensity care for substance use disorder.</b></p> <p>Acute inpatient discharge, residential treatment or withdrawal management event for a principal diagnosis of substance use disorder on or between January 1 and December 1 of the measurement period.</p> <p>Either of the following meets criteria:</p> <ul style="list-style-type: none"> <li>• An acute inpatient discharge or a residential behavioral health stay <b>with</b> a principal diagnosis of substance use disorder (<u>AOD Abuse and Dependence Value Set</u>) on the discharge claim. To identify acute inpatient discharges: <ol style="list-style-type: none"> <li>1. Identify all acute and nonacute inpatient stays (<u>Inpatient Stay Value Set</u>).</li> <li>2. Exclude nonacute inpatient stays other than behavioral health (<u>Nonacute Inpatient Stay Other Than Behavioral Health Accommodations Value Set</u>).</li> <li>3. Identify the discharge date for the stay.</li> </ol> </li> <li>• A withdrawal management visit (<u>Detoxification Value Set</u>) <b>with</b> a principal diagnosis of substance use disorder (<u>AOD Abuse and Dependence Value Set</u>).</li> </ul>

	<p><b>Direct transfer.</b></p> <p>Identify direct transfers to an acute inpatient care or residential setting. If the direct transfer to the acute inpatient or residential care setting was for a principal diagnosis of substance use disorder (<a href="#">AOD Abuse and Dependence Value Set</a>), use the date of last discharge.</p> <p>To identify direct transfers:</p> <ol style="list-style-type: none"> <li>1. Identify all acute and nonacute inpatient stays (<a href="#">Inpatient Stay Value Set</a>).</li> <li>2. Exclude nonacute inpatient stays other than behavioral health (<a href="#">Nonacute Inpatient Stay Other Than Behavioral Health Accommodations Value Set</a>).</li> <li>3. Identify the admission date for the stay.</li> </ol> <p>Exclude both the initial discharge and the direct transfer discharge if the last discharge occurs after December 1 of the measurement period.</p> <p>If the direct transfer to the acute inpatient or residential behavioral health care setting was for any other principal diagnosis, exclude both the original and the direct transfer discharge.</p> <p><b>Multiple discharges, visits or events in a 31-day period.</b></p> <p>After evaluating for direct transfers, if a person has more than one episode in a 31-day period, include only the first eligible episode.</p> <ul style="list-style-type: none"> <li>• <i>For example</i>, if a person is discharged from a residential treatment stay on January 1, include that discharge and do not include subsequent episodes that occur on or between January 2 and January 31; then, if applicable, include the next episode that occurs on or after February 1. Identify episodes chronologically, including only the first episode per 31-day period.</li> </ul> <p><b>Note:</b> Removal of multiple episodes in a 31-day period is based on eligibility. Assess each episode for eligibility before removing multiple episodes in a 31-day period.</p>
<b>Denominator exclusions</b>	<p><b>Persons with a date of death.</b></p> <p>Death in the measurement period, identified using data sources determined by the organization. Method and data sources are subject to review during the HEDIS audit.</p> <p><b>Persons in hospice or using hospice services.</b></p> <p>Persons who use hospice services (<a href="#">Hospice Encounter Value Set</a>; <a href="#">Hospice Intervention Value Set</a>) or elect to use a hospice benefit any time during the measurement period. Organizations that use the Monthly Membership Detail Data File to identify these persons must use only the run date of the file.</p>
<b>Denominator</b>	The initial population minus denominator exclusions.
<b>Numerator</b>	<p><b>Numerator 1: 30-day follow-up.</b></p> <p>A follow-up visit or event with any practitioner for a diagnosis of substance use disorder within the 30 days after an episode for substance use disorder.</p> <p><b>Numerator 2: 7-day follow-up.</b></p> <p>A follow-up visit or event with any practitioner for a diagnosis of substance use disorder within the 7 days after an episode for substance use disorder.</p>

For both indicators, any of the following meet criteria for a follow-up visit. Do not include visits that occur on the date of the denominator episode.

- An acute or nonacute inpatient admission or residential behavioral health stay **with** a diagnosis of substance use disorder (AOD Abuse and Dependence Value Set) on the discharge claim. To identify acute and nonacute inpatient admissions:
  1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
  2. Identify the admission date for the stay.
- An outpatient visit (Visit Setting Unspecified Value Set) **with** (Outpatient POS Value Set) **with** a diagnosis of substance use disorder (AOD Abuse and Dependence Value Set).
- An outpatient visit (BH Outpatient Value Set) **with** a diagnosis of substance use disorder (AOD Abuse and Dependence Value Set).
- An intensive outpatient encounter or partial hospitalization (Visit Setting Unspecified Value Set) **with** POS code 52 **with** a diagnosis of substance use disorder (AOD Abuse and Dependence Value Set).
- An intensive outpatient encounter or partial hospitalization (Partial Hospitalization or Intensive Outpatient Value Set) **with** a diagnosis of substance use disorder (AOD Abuse and Dependence Value Set).
- A non-residential substance abuse treatment facility visit (Visit Setting Unspecified Value Set) **with** (Nonresidential Substance Abuse Treatment Facility POS Value Set) **with** a diagnosis of substance use disorder (AOD Abuse and Dependence Value Set).
- A community mental health center visit (Visit Setting Unspecified Value Set) **with** POS code 53 **with** a diagnosis of substance use disorder (AOD Abuse and Dependence Value Set).
- A telehealth visit (Visit Setting Unspecified Value Set) **with** (Telehealth POS Value Set) **with** a diagnosis of substance use disorder (AOD Abuse and Dependence Value Set).
- A substance use disorder service (Substance Use Disorder Services Value Set) **with** a diagnosis of substance use disorder (AOD Abuse and Dependence Value Set).
- Substance use disorder counseling and surveillance (Substance Abuse Counseling and Surveillance Value Set\*) **with** a diagnosis of substance use disorder (AOD Abuse and Dependence Value Set\*).
- An opioid treatment service that bills monthly or weekly (OUD Weekly Non Drug Service Value Set; OUD Monthly Office Based Treatment Value Set) **with** a diagnosis of substance use disorder (AOD Abuse and Dependence Value Set).
- Residential behavioral health treatment (Residential Behavioral Health Treatment Value Set) **with** a diagnosis of substance use disorder (AOD Abuse and Dependence Value Set).
- A telephone visit (Telephone Visits Value Set) **with** a diagnosis of substance use disorder (AOD Abuse and Dependence Value Set).

	<ul style="list-style-type: none"> <li>An e-visit or virtual check-in (<a href="#">Online Assessments Value Set</a>) <b>with</b> a diagnosis of substance use disorder (<a href="#">AOD Abuse and Dependence Value Set</a>).</li> <li>Peer support services (<a href="#">Peer Support Services Value Set</a>) <b>with</b> a diagnosis of substance use disorder (<a href="#">AOD Abuse and Dependence Value Set</a>).</li> <li>A pharmacotherapy dispensing event (<a href="#">Alcohol Use Disorder Treatment Medications List</a>; <a href="#">Opioid Use Disorder Treatment Medications List</a>) or medication treatment event (<a href="#">AOD Medication Treatment Value Set</a>; <a href="#">OUD Weekly Drug Treatment Service Value Set</a>).</li> </ul> <p><b>Note:</b> Follow-up does not include withdrawal management. Exclude all withdrawal management events (<a href="#">Detoxification Value Set</a>) when identifying follow-up care for numerator compliance. Detoxification does not need to be excluded from pharmacotherapy dispensing events identified using pharmacy claims (<a href="#">Alcohol Use Disorder Treatment Medications List</a>; <a href="#">Opioid Use Disorder Treatment Medications List</a>), because detoxification codes are not used on pharmacy claims.</p> <p><b>Coding Guidance</b> *Do not include laboratory claims (claims with POS code 81).</p>																																
<b>Summary of changes</b>	<ul style="list-style-type: none"> <li>Moved the definition of “Direct transfer” from the initial population to the <i>Definitions</i> section.</li> <li>Modified the numerators to allow a substance use disorder diagnosis to take any position on the claim.</li> <li>Added peer support services to the numerators.</li> </ul>																																
<b>Data element tables</b>	<p>Organizations that submit HEDIS data to NCQA must provide the following data elements.</p> <p><b>Table FUI-1/2/3: Data Elements for Follow-Up After High Intensity Care for Substance Use Disorder</b></p> <table border="1"> <thead> <tr> <th>Metric</th><th>Age</th><th>Data Element</th><th>Reporting Instructions</th></tr> </thead> <tbody> <tr> <td>FollowUp30Day</td><td>13-17</td><td>Benefit</td><td>Metadata</td></tr> <tr> <td>FollowUp7Day</td><td>18-64</td><td>InitialPopulation</td><td>For each Stratification, repeat per Metric</td></tr> <tr> <td></td><td>65+</td><td>Exclusions</td><td>For each Stratification, repeat per Metric</td></tr> <tr> <td></td><td>Total</td><td>Denominator</td><td>For each Stratification, repeat per Metric</td></tr> <tr> <td></td><td></td><td>NumeratorByAdmin</td><td>For each Metric and Stratification</td></tr> <tr> <td></td><td></td><td>NumeratorBySupplemental</td><td>For each Metric and Stratification</td></tr> <tr> <td></td><td></td><td>Rate</td><td>(Percent)</td></tr> </tbody> </table>	Metric	Age	Data Element	Reporting Instructions	FollowUp30Day	13-17	Benefit	Metadata	FollowUp7Day	18-64	InitialPopulation	For each Stratification, repeat per Metric		65+	Exclusions	For each Stratification, repeat per Metric		Total	Denominator	For each Stratification, repeat per Metric			NumeratorByAdmin	For each Metric and Stratification			NumeratorBySupplemental	For each Metric and Stratification			Rate	(Percent)
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		Rate	(Percent)																														

## Rules for Allowable Adjustments

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

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

### ADJUSTMENTS ALLOWED

- *Product lines.* Organizations are not required to use product line criteria; product lines may be combined, and all (or no) product line criteria may be used.
- *Attribution.* Organizations are not required to use enrollment criteria.
- *Benefits.* Organizations are not required to use a benefit.
- *Ages.* The denominator age range may be expanded. The age determination dates may be changed (13 years as of discharge date).
- *Other.* Organizations may use additional initial population criteria to focus on an area of interest defined by gender, race, ethnicity, socioeconomic or sociodemographic characteristics, geographic region or another characteristic.
- *Measurement period adjustments.* Organizations may adjust the measurement period.
- *Exclusions.* The hospice and deceased person exclusions are not required.
- *Telehealth.* Services/events that allow the use of synchronous telehealth visits, telephone visits and asynchronous telehealth (e-visits, virtual check-ins) may be stratified to identify services performed via telehealth. This adjustment is not allowed for events, numerators and exclusions that do not allow the use of telehealth.
- *Supplemental data.* Supplemental data may be used to identify initial population, denominator, exclusion and numerator events.

### ADJUSTMENTS ALLOWED WITH LIMITS

- *Initial population:* Event. Only events and diagnoses that contain (or map to) codes in the value sets may be used to identify visits with a diagnosis. Value sets and logic may not be changed. Organizations may assess at the person level by applying measure logic appropriately (i.e., percentage of acute inpatient hospitalizations, residential treatment or withdrawal management visits for a diagnosis of substance use disorder that result in a follow-up visit or service for substance use disorder).

### ADJUSTMENTS NOT ALLOWED

- *Numerator.* Medication lists, value sets and logic may not be changed.

## **Follow-Up After Emergency Department Visit for Substance Use (FUA)**

Measure title	Follow-Up After Emergency Department Visit for Substance Use*	Measure ID	FUA
<b>Description</b>	<p>The percentage of emergency department (ED) visits among persons age 13 years and older with a principal diagnosis of substance use disorder (SUD), or any diagnosis of drug overdose, for which there was follow-up. Two rates are reported:</p> <ol style="list-style-type: none"> <li>1. The percentage of ED visits for which the person received follow-up within 30 days of the ED visit (31 total days).</li> <li>2. The percentage of ED visits for which the person received follow-up within 7 days of the ED visit (8 total days).</li> </ol>		
<b>Measurement period</b>	January 1–December 31.		
<b>Copyright and disclaimer notice</b>	<p><i>*Adapted from an NCQA measure with financial support from the Office of the Assistant Secretary for Planning and Evaluation (ASPE) under Prime Contract No. HHSP23320100019WI/HHSP23337001T, in which NCQA was a subcontractor to Mathematica. Additional financial support was provided by the Substance Abuse and Mental Health Services Administration (SAMHSA).</i></p> <p>Refer to the complete copyright and disclaimer information at the front of this publication.</p> <p>NCQA website: <a href="http://www.ncqa.org">www.ncqa.org</a>.</p> <p>Submit policy clarification support questions via My NCQA (<a href="https://my.ncqa.org">https://my.ncqa.org</a>).</p>		
<b>Clinical recommendation statement/ rationale</b>	<p>The use of ED services among the SUD or drug misuse population is common: 1 in 8 ED visits in the U.S. were found to be related to SUDs and mental health disorders in 2007 (Weiss et al, 2016). Utilization of ED services for substance use is growing among certain subpopulations, particularly individuals 18–34, as the Centers for Disease Control and Prevention (CDC) reports that the rate of ED visits for a primary diagnosis or primary complaint of SUD increased from 45.4 to 77.0 visits per 10,000 individuals between 2008 and 2016 (CDC, 2019b). In addition to visits for an SUD diagnosis, ED visits attributed to drug overdose are also prevalent. National surveillance data reveal that approximately 75% (435,983) of all ED visits for drug-related poisonings in the U.S., excluding alcohol, were due to nonfatal drug overdoses of unintentional or undetermined intent in 2016 (age-adjusted rate of 137.2 visits per 100,000 population) (CDC, 2019a).</p> <p>The ED is uniquely positioned to improve care for patients with SUD and prevent overdose death because this care setting is the primary provider of acute illness stabilization, timely diagnosis and links to appropriate follow-up care (Samuels et al, 2016). Individuals who are seen in the ED due to substance misuse are at high-risk of subsequent adverse events, especially within the year following their ED visit (Karmali et al, 2020; Goldman-Mellor et al, 2020; Weiner et al, 2020). This measure focuses on ensuring care</p>		

	coordination for members who are discharged from the ED following high-risk substance use events, since those individuals may be particularly vulnerable to losing contact with the health care system.
<b>Citations</b>	<p>Weiss, A., M. Barrett, K. Heslin, C. Stocks. 2016. <i>Trends in Emergency Department Visits Involving Mental and Substance Use Disorders, 2006–2013</i>. HCUP Statistical Brief #216. Agency for Healthcare Research and Quality. <a href="http://www.hcup-us.ahrq.gov/reports/statbriefs/sb216-Mental-Substance-Use-Disorder-ED-VisitTrends.pdf">http://www.hcup-us.ahrq.gov/reports/statbriefs/sb216-Mental-Substance-Use-Disorder-ED-VisitTrends.pdf</a></p> <p>Centers for Disease Control and Prevention (CDC). 2019b. “QuickStats: Number of Emergency Department Visits for Substance Abuse or Dependence per 10,000 Persons Aged ≥18 Years, by Age Group — United States, 2008–2009 and 2016–2017.” <i>MMWR Morb Mortal Wkly Rep</i> 2019;68:1171. DOI: <a href="http://dx.doi.org/10.15585/mmwr.mm6850a7externalicon">http://dx.doi.org/10.15585/mmwr.mm6850a7externalicon</a></p> <p>CDC. 2019a. <i>Annual Surveillance Report of Drug-Related Risks and Outcomes</i>. CDC National Center for Injury Prevention and Control. <a href="https://www.cdc.gov/drugoverdose/pdf/pubs/2019-cdc-drug-surveillance-report.pdf">https://www.cdc.gov/drugoverdose/pdf/pubs/2019-cdc-drug-surveillance-report.pdf</a></p> <p>Samuels, E.A., K. Dwyer, M.J. Mello, J. Baird, A.R. Kellogg, &amp; E. Bernstein. 2016. “Emergency Department-Based Opioid Harm Reduction: Moving Physicians from Willing to Doing.” <i>Academic Emergency Medicine</i> 23(4), 455–65.</p> <p>Karmali, R., T. Ray, A. Rubinstein, S. Sterling, C. Weisner, C. Campbell. 2020. “The Role of Substance Use Disorders in Experiencing a Repeat Opioid Overdose, and Substance Use Treatment Patterns Among Patients with a Non-Fatal Opioid Overdose.” <i>Drug and Alcohol Dependence</i> 209, 107923.</p> <p>Goldman-Mellor, S., M. Olfson, C. Lidon-Moyano, &amp; M. Schoenbaum. 2020. “Mortality Following Nonfatal Opioid and Sedative/Hypnotic Drug Overdose.” <i>American Journal of Preventive Medicine</i> 59(1), 59–67. doi:10.1016/j.amepre.2020.02.012.</p> <p>Weiner, S.G., O. Baker, D. Bernson, J.D. Schuur. 2020. “One-Year Mortality of Patients after Emergency Department Treatment for Nonfatal Opioid Overdose.” <i>Ann Emerg Med</i> 5(1):13–17.</p>
<b>Characteristics</b>	
<b>Scoring</b>	Proportion.
<b>Type</b>	Process.
<b>Product lines</b>	<ul style="list-style-type: none"> <li>• Commercial.</li> <li>• Medicaid.</li> <li>• Medicare.</li> </ul>
<b>Stratifications</b>	<p>Age as of the ED visit.</p> <ul style="list-style-type: none"> <li>• 13–17 years.</li> <li>• 18 years and older.</li> </ul>

	<p>Race. (Refer to <a href="#">General Guideline: Race and Ethnicity Stratification</a>.)</p> <ul style="list-style-type: none"> <li>• American Indian or Alaska Native.</li> <li>• Asian.</li> <li>• Black or African American.</li> <li>• Middle Eastern or North African.</li> <li>• Native Hawaiian or Pacific Islander.</li> <li>• White.</li> <li>• Some Other Race.</li> <li>• Two or More Races.</li> <li>• Asked But No Answer.</li> <li>• Unknown.</li> </ul> <p>Ethnicity. (Refer to <a href="#">General Guideline: Race and Ethnicity Stratification</a>.)</p> <ul style="list-style-type: none"> <li>• Hispanic or Latino.</li> <li>• Not Hispanic or Latino.</li> <li>• Asked But No Answer.</li> <li>• Unknown.</li> </ul>
<b>Risk adjustment</b>	None.
<b>Improvement notation</b>	Increased score indicates improvement.
<b>Guidance</b>	<p><b>Data collection methodology:</b> Administrative. Refer to <a href="#">General Guideline: Data Collection Methods</a> for additional information.</p> <p><b>Date specificity:</b> Dates must be specific enough to determine the event occurred in the period being measured.</p> <p><b>Which services count?</b> When using claims, include all paid, suspended, pending and denied claims.</p> <p><b>Other guidance:</b></p> <ul style="list-style-type: none"> <li>• Refer to <a href="#">Appendix 1</a> for the definition of <i>mental health provider</i>. Organizations must develop their own methods to identify mental health providers. Methods are subject to review by the HEDIS auditor.</li> <li>• The measure is based on episodes; therefore, it is possible for the denominator to include multiple events for the same person.</li> </ul>
<b>Initial population</b>	<p><b>Measure item count:</b> Episode.</p> <p><b>Attribution basis:</b> Enrollment.</p> <ul style="list-style-type: none"> <li>• <b>Benefits:</b> Medical, chemical dependency and pharmacy. <b>Note:</b> A withdrawal management/detoxification-only chemical dependency benefit does not meet these criteria.</li> <li>• <b>Continuous enrollment:</b> The date of the ED visit through 30 days after the ED visit (31 total days).</li> </ul>

	<ul style="list-style-type: none"> <li>• <b>Allowable gap:</b> None.</li> </ul> <p><b>Ages:</b> 13 years of age or older as of the ED visit.</p> <p><b>Event: Emergency department visit for substance use.</b> An ED visit (<u>ED Value Set</u>) with a principal diagnosis of SUD (<u>AOD Abuse and Dependence Value Set</u>) <b>or</b> any diagnosis of drug overdose (<u>Unintentional Drug Overdose Value Set</u>) on or between January 1 and December 1 of the measurement period.</p> <p><b>Multiple visits in a 31-day period.</b> If a person has more than one ED visit, identify all eligible ED visits between January 1 and December 1 of the measurement period and do not include more than one visit per 31-day period.</p> <ul style="list-style-type: none"> <li>• <i>For example</i>, if a person has an ED visit on January 1, include the January 1 visit and do not include ED visits that occur on or between January 2 and January 31; then, if applicable, include the next ED visit that occurs on or after February 1. Identify visits chronologically, including only one per 31-day period.</li> </ul> <p><b>Note:</b> Removal of multiple visits in a 31-day period is based on <i>eligible</i> visits. Assess each ED visit for exclusions before removing multiple visits in a 31-day period.</p> <p><b>ED visits followed by inpatient admission.</b></p> <ul style="list-style-type: none"> <li>• Exclude ED visits that result in an inpatient stay.</li> <li>• Exclude ED visits followed by an admission to an acute or nonacute inpatient care setting on the date of the ED visit or within the 30 days after the ED visit, regardless of the principal diagnosis for the admission. To identify admissions to an acute or nonacute inpatient care setting:             <ol style="list-style-type: none"> <li>1. Identify all acute and nonacute inpatient stays (<u>Inpatient Stay Value Set</u>).</li> <li>2. Identify the admission date for the stay.</li> </ol> </li> </ul> <p><b>ED visits followed by residential treatment.</b> Exclude ED visits followed by residential treatment on the date of the ED visit or within the 30 days after the ED visit. Any of the following meet criteria for residential treatment:</p> <ul style="list-style-type: none"> <li>• <u>Residential Behavioral Health Treatment Value Set</u>.</li> <li>• Psychiatric Residential Treatment Center (POS code 56).</li> <li>• Residential Substance Abuse Treatment Facility (POS code 55).</li> <li>• <u>Residential Program Detoxification Value Set</u>.</li> </ul> <p>These events are excluded from the measure because admission to an acute or nonacute inpatient setting may prevent an outpatient follow-up visit from taking place.</p>
<b>Denominator exclusions</b>	<p><b>Persons with a date of death.</b> Death in the measurement period, identified using data sources determined by the organization. Method and data sources are subject to review during the HEDIS audit.</p>

	<b>Persons in hospice or using hospice services.</b> Persons who use hospice services ( <u>Hospice Encounter Value Set</u> ; <u>Hospice Intervention Value Set</u> ) or elect to use a hospice benefit any time during the measurement period. Organizations that use the Monthly Membership Detail Data File to identify these persons must use only the run date of the file.
<b>Denominator</b>	The initial population minus denominator exclusions.
<b>Numerator</b>	<p><b>Numerator 1: 30-day follow-up.</b> Follow-up visit or pharmacotherapy dispensing event on the ED visit date or within 30 days after the ED visit (31 days total).</p> <p><b>Numerator 2: 7-day follow-up.</b> Follow-up visit or pharmacotherapy dispensing event on the ED visit date or within 7 days after the ED visit (8 days total).</p> <p>For both indicators, any of the following meet criteria for a follow-up visit:</p> <ul style="list-style-type: none"> <li>• An outpatient visit (<u>Visit Setting Unspecified Value Set</u>) <b>with</b> (<u>Outpatient POS Value Set</u>) <b>with</b> any diagnosis of SUD (AOD Abuse and Dependence Value Set), substance use (<u>Substance Induced Disorders Value Set</u>) or drug overdose (<u>Unintentional Drug Overdose Value Set</u>).</li> <li>• An outpatient visit (<u>Visit Setting Unspecified Value Set</u>) <b>with</b> (<u>Outpatient POS Value Set</u>) <b>with</b> a mental health provider.</li> <li>• An outpatient visit (<u>BH Outpatient Value Set</u>) <b>with</b> any diagnosis of SUD (AOD Abuse and Dependence Value Set), substance use (<u>Substance Induced Disorders Value Set</u>) or drug overdose (<u>Unintentional Drug Overdose Value Set</u>).</li> <li>• An outpatient visit (<u>BH Outpatient Value Set</u>) <b>with</b> a mental health provider.</li> <li>• An intensive outpatient encounter or partial hospitalization (<u>Visit Setting Unspecified Value Set</u>) <b>with</b> POS code 52 <b>with</b> any diagnosis of SUD (AOD Abuse and Dependence Value Set), substance use (<u>Substance Induced Disorders Value Set</u>) or drug overdose (<u>Unintentional Drug Overdose Value Set</u>).</li> <li>• An intensive outpatient encounter or partial hospitalization (<u>Visit Setting Unspecified Value Set</u>) <b>with</b> POS code 52 <b>with</b> a mental health provider.</li> <li>• An intensive outpatient encounter or partial hospitalization (<u>Partial Hospitalization or Intensive Outpatient Value Set</u>) <b>with</b> any diagnosis of SUD (AOD Abuse and Dependence Value Set), substance use (<u>Substance Induced Disorders Value Set</u>) or drug overdose (<u>Unintentional Drug Overdose Value Set</u>).</li> <li>• An intensive outpatient encounter or partial hospitalization (<u>Partial Hospitalization or Intensive Outpatient Value Set</u>) <b>with</b> a mental health provider.</li> <li>• A non-residential substance abuse treatment facility visit (<u>Visit Setting Unspecified Value Set</u>) <b>with</b> (<u>Nonresidential Substance Abuse Treatment Facility POS Value Set</u>) <b>with</b> any diagnosis of SUD (AOD Abuse and Dependence Value Set), substance use (<u>Substance Induced Disorders Value Set</u>) or drug overdose (<u>Unintentional Drug Overdose Value Set</u>).</li> </ul>

- A non-residential substance abuse treatment facility visit (Visit Setting Unspecified Value Set) **with** (Nonresidential Substance Abuse Treatment Facility POS Value Set) **with** a mental health provider.
- A community mental health center visit (Visit Setting Unspecified Value Set) **with** POS code 53 **with** any diagnosis of SUD (AOD Abuse and Dependence Value Set), substance use (Substance Induced Disorders Value Set) or drug overdose (Unintentional Drug Overdose Value Set).
- A community mental health center visit (Visit Setting Unspecified Value Set) **with** POS code 53, **with** a mental health provider.
- A peer support service (Peer Support Services Value Set) **with** any diagnosis of SUD (AOD Abuse and Dependence Value Set), substance use (Substance Induced Disorders Value Set) or drug overdose (Unintentional Drug Overdose Value Set).
- An opioid treatment service that bills monthly or weekly (OUD Weekly Non Drug Service Value Set; OUD Monthly Office Based Treatment Value Set) **with** any diagnosis of SUD (AOD Abuse and Dependence Value Set), substance use (Substance Induced Disorders Value Set) or drug overdose (Unintentional Drug Overdose Value Set).
- A telehealth visit (Visit Setting Unspecified Value Set) **with** (Telehealth POS Value Set) **with** any diagnosis of SUD (AOD Abuse and Dependence Value Set), substance use (Substance Induced Disorders Value Set) or drug overdose (Unintentional Drug Overdose Value Set).
- A telehealth visit (Visit Setting Unspecified Value Set) **with** (Telehealth POS Value Set) **with** a mental health provider.
- A telephone visit (Telephone Visits Value Set) **with** any diagnosis of SUD (AOD Abuse and Dependence Value Set), substance use (Substance Induced Disorders Value Set) or drug overdose (Unintentional Drug Overdose Value Set).
- A telephone visit (Telephone Visits Value Set) **with** a mental health provider.
- An e-visit or virtual check-in (Online Assessments Value Set) **with** any diagnosis of SUD (AOD Abuse and Dependence Value Set), substance use (Substance Induced Disorders Value Set) or drug overdose (Unintentional Drug Overdose Value Set).
- An e-visit or virtual check-in (Online Assessments Value Set) **with** a mental health provider.
- A substance use disorder service (Substance Use Disorder Services Value Set).
- Substance use disorder counseling and surveillance (Substance Abuse Counseling and Surveillance Value Set\*).
- A behavioral health screening or assessment for SUD or mental health disorders (Behavioral Health Assessment Value Set).
- A substance use service (Substance Use Services Value Set).

	<ul style="list-style-type: none"> <li>A pharmacotherapy dispensing event (<a href="#">Alcohol Use Disorder Treatment Medications List</a>; <a href="#">Opioid Use Disorder Treatment Medications List</a>) or medication treatment event (<a href="#">AOD Medication Treatment Value Set</a>; <a href="#">OUD Weekly Drug Treatment Service Value Set</a>).</li> </ul> <p><b>Coding Guidance</b> *Do not include laboratory claims (claims with POS code 81).</p>																																																																												
<b>Summary of changes</b>	<ul style="list-style-type: none"> <li>Updated the race and ethnicity stratification categories to align with OMB SPD 15 2024.</li> <li>Added instructions on allowable adjustments to the race and ethnicity stratification.</li> </ul>																																																																												
<b>Data element tables</b>	<p>Organizations that submit HEDIS data to NCQA must provide the following data elements.</p> <p><b>Table FUA-A-1/2/3: Data Elements for Follow-Up After Emergency Department Visit for Substance Use</b></p> <table border="1"> <thead> <tr> <th>Metric</th> <th>Age</th> <th>Data Element</th> <th>Reporting Instructions</th> </tr> </thead> <tbody> <tr> <td>FollowUp30Day</td> <td>13-17</td> <td>Benefit</td> <td>Metadata</td> </tr> <tr> <td>FollowUp7Day</td> <td>18+</td> <td>InitialPopulation</td> <td>For each Stratification, repeat per Metric</td> </tr> <tr> <td></td> <td>Total</td> <td>Exclusions</td> <td>For each Stratification, repeat per Metric</td> </tr> <tr> <td></td> <td></td> <td>Denominator</td> <td>For each Stratification, repeat per Metric</td> </tr> <tr> <td></td> <td></td> <td>NumeratorByAdmin</td> <td>For each Metric and Stratification</td> </tr> <tr> <td></td> <td></td> <td>NumeratorBySupplemental</td> <td>For each Metric and Stratification</td> </tr> <tr> <td></td> <td></td> <td>Rate</td> <td>(Percent)</td> </tr> </tbody> </table> <p><b>Table FUA-B-1/2/3: Data Elements for Follow-Up After Emergency Department Visit for Substance Use: Stratifications by Race</b></p> <table border="1"> <thead> <tr> <th>Metric</th> <th>Race</th> <th>Data Element</th> <th>Reporting Instructions</th> </tr> </thead> <tbody> <tr> <td>FollowUp30Day</td> <td>AmericanIndianOrAlaskaNative</td> <td>Denominator</td> <td>For each Stratification, repeat per Metric</td> </tr> <tr> <td>FollowUp7Day</td> <td>Asian</td> <td>Numerator</td> <td>For each Metric and Stratification</td> </tr> <tr> <td></td> <td>BlackOrAfricanAmerican</td> <td>Rate</td> <td>(Percent)</td> </tr> <tr> <td></td> <td>MiddleEasternOrNorthAfrican</td> <td></td> <td></td> </tr> <tr> <td></td> <td>NativeHawaiianOrPacificIslander</td> <td></td> <td></td> </tr> <tr> <td></td> <td>White</td> <td></td> <td></td> </tr> <tr> <td></td> <td>SomeOtherRace</td> <td></td> <td></td> </tr> <tr> <td></td> <td>TwoOrMoreRaces</td> <td></td> <td></td> </tr> <tr> <td></td> <td>AskedButNoAnswer</td> <td></td> <td></td> </tr> <tr> <td></td> <td>Unknown</td> <td></td> <td></td> </tr> </tbody> </table>	Metric	Age	Data Element	Reporting Instructions	FollowUp30Day	13-17	Benefit	Metadata	FollowUp7Day	18+	InitialPopulation	For each Stratification, repeat per Metric		Total	Exclusions	For each Stratification, repeat per Metric			Denominator	For each Stratification, repeat per Metric			NumeratorByAdmin	For each Metric and Stratification			NumeratorBySupplemental	For each Metric and Stratification			Rate	(Percent)	Metric	Race	Data Element	Reporting Instructions	FollowUp30Day	AmericanIndianOrAlaskaNative	Denominator	For each Stratification, repeat per Metric	FollowUp7Day	Asian	Numerator	For each Metric and Stratification		BlackOrAfricanAmerican	Rate	(Percent)		MiddleEasternOrNorthAfrican				NativeHawaiianOrPacificIslander				White				SomeOtherRace				TwoOrMoreRaces				AskedButNoAnswer				Unknown		
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<b>Table FUA-C-1/2/3: Data Elements for Follow-Up After Emergency Department Visit for Substance Use: Stratifications by Ethnicity</b>				
Metric	Ethnicity	Data Element	Reporting Instructions	
FollowUp30Day	HispanicOrLatino	Denominator	For each Stratification, repeat per Metric	
FollowUp7Day	NotHispanicOrLatino	Numerator	For each Metric and Stratification	
	AskedButNoAnswer	Rate	(Percent)	
	Unknown			

<b>Rules for Allowable Adjustments</b>	<p><b>Copyright and use:</b> The “Rules for Allowable Adjustments of HEDIS” (the “Rules”) describe how NCQA’s HEDIS measure specifications can be adjusted for other populations, if applicable. The Rules, reviewed and approved by NCQA measure experts, provide for expanded use of HEDIS measures without changing their clinical intent.</p> <p><b>Adjusted HEDIS measures may not be used for HEDIS health plan reporting.</b></p> <p><b>ADJUSTMENTS ALLOWED</b></p> <ul style="list-style-type: none"> <li>• <b>Product lines.</b> Organizations are not required to use product line criteria; product lines may be combined, and all (or no) product line criteria may be used.</li> <li>• <b>Attribution.</b> Organizations are not required to use enrollment criteria.</li> <li>• <b>Benefits.</b> Organizations are not required to use a benefit.</li> <li>• <b>Ages.</b> The denominator age range may be expanded. The age determination date(s) may be changed (i.e., age 13 as of ED visit).</li> <li>• <b>Other.</b> Organizations may use additional initial population criteria to focus on an area of interest defined by gender, race, ethnicity, socioeconomic or sociodemographic characteristics, geographic region, or another characteristic.</li> <li>• <b>Measurement period adjustments.</b> Organizations may adjust the measurement period.</li> <li>• <b>Stratifications:</b> Race and ethnicity stratification. The race and ethnicity stratification is not required. Organizations may adjust this stratification as needed.</li> <li>• <b>Exclusions.</b> The hospice and deceased person exclusions are not required.</li> <li>• <b>Telehealth.</b> Services/events that allow the use of synchronous telehealth visits, telephone visits and asynchronous telehealth (e-visits, virtual check-ins) may be stratified to identify services performed via telehealth. This adjustment is not allowed for events, numerators and exclusions that do not allow the use of telehealth.</li> <li>• <b>Supplemental data.</b> Supplemental data may be used to identify initial population, denominator, exclusion and numerator events.</li> </ul>
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**ADJUSTMENTS ALLOWED WITH LIMITS**

- *Initial population:* Event. Only events/diagnoses that contain (or map to) codes in the value sets may be used to identify visits with a diagnosis. Value sets and logic may not be changed.

**Note:** Organizations may assess at the person level by applying measure logic appropriately (i.e., percentage of persons with documentation of an ED visit, with a principal diagnosis of SUD or any diagnosis of unintentional drug overdose, who had a follow-up visit).

**ADJUSTMENTS NOT ALLOWED**

- *Numerator:* Value sets, medication lists and logic may not be changed.

## Pharmacotherapy for Opioid Use Disorder (POD)

Measure title	Pharmacotherapy for Opioid Use Disorder*	Measure ID	POD
<b>Description</b>	The percentage of opioid use disorder (OUD) pharmacotherapy events that lasted at least 180 days among persons 16 years of age and older with a diagnosis of OUD and a new OUD pharmacotherapy event.		
<b>Measurement period</b>	January 1–December 31.		
<b>Copyright and disclaimer notice</b>	<p>*Adapted with permission by NCQA from the “Continuity of Pharmacotherapy for Opioid Use Disorder” measure owned by The RAND Corporation.</p> <p>Refer to the complete copyright and disclaimer information at the front of this publication.</p> <p>NCQA website: <a href="http://www.ncqa.org">www.ncqa.org</a>.</p> <p>Submit policy clarification support questions via My NCQA (<a href="https://my.ncqa.org">https://my.ncqa.org</a>).</p>		
<b>Clinical recommendation statement/ rationale</b>	<p>In 2022, over 9 million U.S. residents 12 years of age and older required treatment for an opioid use disorder (OUD). OUD includes recurrent use and desire for opioids despite both functional and clinical interference; it can be mild, moderate or severe, according to the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5).</p> <p>Individuals with OUD are at increased risk of death, opioid-related overdose, emergency department visits and readmissions and blood-borne infectious disease. Opioid-related overdose deaths in the U.S. increased more than ten-fold between 1999 and 2022. In 2022, more than 108,000 deaths were due to drug overdose; of those, 76% involved an opioid. Total overall costs of substance misuse and substance use disorders in the U.S., including loss of work productivity, direct health care expenditures and crime-related costs, exceed \$400 billion annually.</p> <p>Use of and adherence to appropriate evidence-based treatment for OUD has been shown to improve outcomes for patients and reduce the burden on the health care system by preventing acute exacerbations and emergencies. The benefits of pharmacotherapy for the treatment of individuals with OUD extends beyond the reduction of substance use, overdose and mortality to include reduced crime and recidivism, reduced risk of infectious disease and improved patient function.</p>		
<b>Citations</b>	<p>Substance Abuse and Mental Health Services Administration. 2022. <i>Key substance use and mental health indicators in the United States: Results from the 2021 National Survey on Drug Use and Health</i> (HHS Publication No. PEP22-07-01-005, NSDUH Series H-57).</p> <p>Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration.  <a href="https://www.samhsa.gov/data/report/2021-nsduh-annual-national-report">https://www.samhsa.gov/data/report/2021-nsduh-annual-national-report</a></p>		

	<p>SAMHSA. 2024. <i>Substance Use Disorders</i>.  <a href="http://www.samhsa.gov/disorders/substance-use">http://www.samhsa.gov/disorders/substance-use</a></p> <p>National Academies of Sciences, Engineering, and Medicine; Health and Medicine Division; Board on Health Sciences Policy; Committee on Pain Management and Regulatory Strategies to Address Prescription Opioid Abuse; Phillips, J.K., M.A. Ford, R.J. Bonnie, editors. 2017. <i>Pain Management and the Opioid Epidemic: Balancing Societal and Individual Benefits and Risks of Prescription Opioid Use</i>. Washington (DC): National Academies Press (US). <a href="https://www.ncbi.nlm.nih.gov/books/NBK458661/">https://www.ncbi.nlm.nih.gov/books/NBK458661/</a></p> <p>Centers for Disease Control and Prevention (CDC). National Center for Injury Prevention and Control. 2024. <i>Understanding the Epidemic</i>. <a href="https://www.cdc.gov/overdose-prevention/about/understanding-the-opioid-overdose-epidemic.html">https://www.cdc.gov/overdose-prevention/about/understanding-the-opioid-overdose-epidemic.html</a></p> <p>The Pew Charitable Trusts. 2016. <i>Medication-Assisted Treatment Improves Outcomes for Patients with Opioid Use Disorder</i>. <a href="https://www.pewtrusts.org/en/research-and-analysis/fact-sheets/2016/11/medication-assisted-treatment-improves-outcomes-for-patients-with-opioid-use-disorder">https://www.pewtrusts.org/en/research-and-analysis/fact-sheets/2016/11/medication-assisted-treatment-improves-outcomes-for-patients-with-opioid-use-disorder</a></p>
<b>Characteristics</b>	
<b>Scoring</b>	Proportion.
<b>Type</b>	Process.
<b>Product lines</b>	<ul style="list-style-type: none"> <li>• Commercial.</li> <li>• Medicaid.</li> <li>• Medicare.</li> </ul>
<b>Stratifications</b>	<p>Ages as of the treatment period start date.</p> <ul style="list-style-type: none"> <li>• 16–64 years.</li> <li>• 65 years and older.</li> </ul> <p>Race. (Refer to <a href="#">General Guideline: Race and Ethnicity Stratification</a>.)</p> <ul style="list-style-type: none"> <li>• American Indian or Alaska Native.</li> <li>• Asian.</li> <li>• Black or African American.</li> <li>• Middle Eastern or North African.</li> <li>• Native Hawaiian or Pacific Islander.</li> <li>• White.</li> <li>• Some Other Race.</li> <li>• Two or More Races.</li> <li>• Asked But No Answer.</li> <li>• Unknown.</li> </ul>

	<p>Ethnicity. (Refer to <a href="#">General Guideline: Race and Ethnicity Stratification</a>.)</p> <ul style="list-style-type: none"> <li>• Hispanic or Latino.</li> <li>• Not Hispanic or Latino.</li> <li>• Asked But No Answer.</li> <li>• Unknown.</li> </ul>
<b>Risk adjustment</b>	None.
<b>Improvement notation</b>	Increased score indicates improvement.
<b>Guidance</b>	<p><b>Data collection methodology:</b> Administrative. Refer to <a href="#">General Guideline: Data Collection Methods</a> for additional information.</p> <p><b>Date specificity:</b> Dates must be specific enough to determine the event occurred in the period being measured.</p> <p><b>Which services count?</b> When using claims, include all paid, suspended, pending and denied claims.</p> <p><b>Medication lists:</b> If an organization uses both pharmacy data (NDC codes) and clinical data (RxNorm codes) for reporting, and there are both NDC and RxNorm codes on the same date of service, use only one data source for the date of service (only NDC codes or only RxNorm codes).</p> <p><b>Other guidance:</b></p> <ul style="list-style-type: none"> <li>• The measure is based on episodes; therefore, it is possible for the denominator to include multiple events for the same person.</li> <li>• Methadone is not included on the medication lists for this measure. Methadone for OUD administered or dispensed by federally certified opioid treatment programs is billed on a medical claim. A pharmacy claim for methadone would be indicative of treatment for pain rather than OUD.</li> <li>• The allowable gaps in the measure numerator of 7 or fewer consecutive days are used to account for weekly billing and other variations in billing practices and do not necessarily indicate that OUD pharmacotherapy ended. For example, persons receiving daily methadone treatment over their 180-day treatment period meet numerator criteria if their treatment is billed weekly.</li> </ul>
<b>Definitions</b>	
<b>Determining same or different medications</b>	<p><b>Same medications:</b> Medication lists and value sets that are in the same row of the Opioid Use Disorder Treatment Medications table.</p> <ul style="list-style-type: none"> <li>• <i>For example</i>, a dispensing event from the <a href="#">Buprenorphine Oral Medications List</a> and an encounter with a code from the <a href="#">Buprenorphine Oral Value Set</a> are considered two dispensing events for the same medication.</li> </ul> <p><b>Different medications:</b> Medication lists and value sets that are in different rows of the Opioid Use Disorder Treatment Medications table.</p>

	<ul style="list-style-type: none"> <li>• <i>For example</i>, a dispensing event from the <u>Buprenorphine Oral Medications List</u> and a dispensing event from the <u>Buprenorphine Injection Medications List</u> are considered two dispensing events for different medications.</li> </ul>
<b>Direct transfer</b>	<p>When the discharge date from the first inpatient setting precedes the admission date to a second inpatient setting by 1 calendar day or less.</p> <ul style="list-style-type: none"> <li>• <i>For example</i>: <ul style="list-style-type: none"> <li>– An inpatient discharge on June 1, followed by an admission to another inpatient setting on June 1, <i>is a direct transfer</i>.</li> <li>– An inpatient discharge on June 1, followed by an admission to an inpatient setting on June 2, <i>is a direct transfer</i>.</li> <li>– An inpatient discharge on June 1, followed by an admission to another inpatient setting on June 3, <i>is not a direct transfer</i>; these are two distinct inpatient stays.</li> </ul> </li> </ul> <p>Use the following method to identify admissions to and discharges from inpatient settings.</p> <ol style="list-style-type: none"> <li>1. Identify all acute and nonacute inpatient stays (<u>Inpatient Stay Value Set</u>).</li> <li>2. Identify the admission and discharge dates for the stay.</li> </ol>
<b>Intake period</b>	July 1 of the year prior to the measurement period to June 30 of the measurement period.
<b>Negative medication history</b>	To qualify for negative medication history, the following criteria must be met: <ul style="list-style-type: none"> <li>• A period of 31 days prior to the OUD dispensing or medication administration event when the person had no OUD dispensing or medication administration events.</li> <li>• A period of 31 days prior to the OUD dispensing or medication administration event when the person was not already receiving OUD pharmacotherapy. <ul style="list-style-type: none"> <li>– <i>For example</i>, for an OUD dispensing event with a date of service of January 1, the 31 days prior includes December 1–31. If a person received a buprenorphine implant (180 days supply) any time during the 179 days prior to December 1, they are already receiving OUD pharmacotherapy on December 1 and do not have a negative medication history.</li> </ul> </li> </ul>
<b>OUD dispensing event</b>	OUD pharmacotherapy identified using pharmacy data (medication lists).
<b>OUD medication administration event</b>	OUD pharmacotherapy identified using medical claims data (value sets).
<b>Treatment period</b>	<p>A period of 180 calendar days beginning on the treatment period start date through 179 days after the treatment period start date.</p> <p><b>Note:</b> Persons can have multiple treatment period start dates and treatment periods during the measurement period. Treatment periods can overlap.</p>

<b>Treatment period start date</b>	The date of an OUD dispensing or medication administration event with a negative medication history during the intake period.
<b>Initial population</b>	<p><i>Measure item count:</i> Episode.</p> <p><i>Attribution basis:</i> Enrollment.</p> <ul style="list-style-type: none"> <li>• <b>Benefits:</b> Medical and pharmacy.</li> <li>• <b>Continuous enrollment:</b> 31 days prior to the treatment period start date through 179 days after the treatment period start date (211 total days).</li> <li>• <b>Allowable gap:</b> None.</li> </ul> <p><b>Ages:</b> 16 years of age and older as of the treatment period start date.</p> <p><b>Event:</b> <b>Opioid use disorder (OUD) pharmacotherapy events.</b></p> <p><b>Step 1.</b> Identify persons with any diagnosis of OUD (<u>Opioid Abuse and Dependence Value Set*</u>) during the intake period.</p> <p><b>Step 2.</b> For each person identified in step 1, identify all OUD dispensing events or OUD medication administration events during the intake period. Use all medication lists and value sets in the Opioid Use Disorder Treatment Medications table below to identify OUD dispensing events and OUD administration events.</p> <p><b>Step 3.</b> Test for negative medication history. For each OUD dispensing event or OUD medication administration event in step 2, test for a negative medication history. Remove events that do not have a negative medication history. All remaining events with a negative medication history are considered treatment period start dates.</p> <p>Identify start and end dates for OUD dispensing events and OUD medication administration events. The start date is the event date and the end date is the start date plus the days supply minus one.</p> <p>For OUD dispensing events and OUD medication administration events with overlapping days supply, apply the following rules:</p> <ul style="list-style-type: none"> <li>• For multiple OUD dispensing events or OUD medication administration events for different medications on the same or different dates of service with overlapping days supply, calculate the start and end dates for each medication individually. <ul style="list-style-type: none"> <li>– <i>For example</i>, if there is a 7 days supply of oral buprenorphine on January 1 and a 31 days supply of buprenorphine injection on January 5: <ul style="list-style-type: none"> <li>▪ The oral buprenorphine start date is January 1 and the end date is January 7.</li> <li>▪ The buprenorphine injection start date is January 5 and the end date is February 4.</li> </ul> </li> </ul> </li> <li>• For multiple OUD dispensing events or OUD medication administration events for the same medication on the same date of service or on different dates of service with overlapping days supply, sum the days supply and then calculate start and end dates.</li> </ul>

	<p><i>For example:</i></p> <ul style="list-style-type: none"> <li>– If a 7 days supply and a 14-days supply of buprenorphine are dispensed on January 1, the start date is January 1 and the end date is January 21.</li> <li>– If a 7 days supply of buprenorphine is dispensed on January 1 and January 5, the start date is January 1 and the end date is January 14.</li> <li>– If a person has three codes (or one code billed as three units) from the <u>Buprenorphine Oral Weekly Value Set</u> on January 1, the start date is January 1 and the end date is January 21.</li> <li>– If a person has four codes (or one code billed as four units) from the <u>Methadone Oral Weekly Value Set</u> on January 1, the start date is January 1 and the end date is January 28.</li> </ul> <p><i>For OUD medication administration events identified using a value set</i>, use the days supply listed in the Opioid Use Disorder Treatment Medications table.</p> <p><i>For OUD dispensing events identified using a medication list</i>, use the days supply in the pharmacy data. If days supply is not available in the pharmacy data then use the days supply listed for the corresponding value set. If the pharmacy data for a buprenorphine oral medication does not contain days supply, count as a 7 days supply.</p> <p><b>Step 4.</b> Remove any treatment period start dates where the person had an acute or nonacute inpatient stay of 8 or more days during the treatment period:</p> <ol style="list-style-type: none"> <li>1. Identify all acute and nonacute inpatient stays (<u>Inpatient Stay Value Set</u>).</li> <li>2. Identify the admission and discharge dates for the stay.</li> <li>3. Calculate length of stay (LOS) as the admission date through and including the discharge date. If there are direct transfers between stays, add the LOS from any subsequent direct transfers to the initial LOS to calculate a total LOS. If direct transfer days overlap, count each day only once.</li> </ol> <p>• <i>For example:</i></p> <ul style="list-style-type: none"> <li>– Remove a July 1 treatment period start date where a person was admitted for an inpatient hospital stay on August 1 and discharged on August 8 (LOS = 8 days).</li> <li>– Remove a July 1 treatment period start date where a person had an acute inpatient stay (admission date August 1; discharge date August 4; LOS = 4 days), followed by a direct transfer to a nonacute inpatient facility (admission date August 5; discharge date August 8; LOS = 4 days). Total LOS = 8 days.</li> </ul> <p>Do not remove a July 1 treatment period start date where a person had an acute inpatient stay (admission date August 1; discharge date August 4; LOS = 4 days), followed by a direct transfer to a nonacute inpatient facility (admission date August 4; discharge date August 7, LOS = 4 days). Total LOS = 7 days (do not double count August 4).</p>
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	<p><b>Step 5.</b> Calculate continuous enrollment.</p> <p><b>Note:</b> All treatment period start dates (OUD dispensing events or OUD medication administration events) that were not removed remain in the initial population. The denominator for this measure is based on events, not persons.</p> <p><b>Coding Guidance</b></p> <p>*Do not include laboratory claims (claims with POS code 81).</p>
<b>Denominator exclusions</b>	<p><b>Persons with a date of death.</b> Death in the measurement period, identified using data sources determined by the organization. Method and data sources are subject to review during the HEDIS audit.</p> <p><b>Persons in hospice or using hospice services.</b> Persons who use hospice services (<u>Hospice Encounter Value Set</u>; <u>Hospice Intervention Value Set</u>) or elect to use a hospice benefit any time during the measurement period. Organizations that use the Monthly Membership Detail Data File to identify these persons must use only the run date of the file.</p>
<b>Denominator</b>	The initial population minus denominator exclusions.
<b>Numerator</b>	<p><b>New OUD pharmacotherapy events with OUD pharmacotherapy.</b> New OUD pharmacotherapy events with OUD pharmacotherapy for 180 or more days without a gap in treatment of 8 or more consecutive days. Use the steps below to identify the numerator.</p> <p><b>Step 1.</b> Identify the treatment period for each treatment period start date in the denominator.</p> <p><b>Step 2.</b> Identify all OUD dispensing events and OUD medication administration events during the treatment period. Use all the medication lists and value sets in the Opioid Use Disorder Treatment Medications table to identify OUD dispensing events and OUD medication administration events.</p> <p><b>Step 3.</b> Identify start and end dates for OUD dispensing events and OUD medication administration events. The start date is the event date and the end date is the start date plus the days supply minus one.</p> <p>For OUD dispensing events and OUD medication administration events with overlapping days supply, apply the following rules:</p> <ul style="list-style-type: none"> <li>• For multiple OUD dispensing or medication administration events for different medications on the same or different dates of service with overlapping days supply, calculate the start and end dates for each medication individually.</li> </ul> <p><i>For example</i>, for a 7 days supply of oral buprenorphine on January 1 and a 31 days supply of buprenorphine injection on January 5:</p> <ul style="list-style-type: none"> <li>– The oral buprenorphine start date is January 1 and the end date is January 7.</li> <li>– The buprenorphine injection start date is January 5 and the end date is February 4.</li> </ul>

- For multiple OUD dispensing or medication administration events for the same medication on the same date of service or on different dates of service with overlapping days supply, sum the days supply and then calculate start and end dates.

*For example:*

- For a 7 days supply and a 14-days supply of buprenorphine dispensed on January 1, the start date is January 1 and the end date is January 21.
- For a 7 days supply of buprenorphine dispensed on January 1 and January 5, the start date is January 1 and the end date is January 14.
- If a person has three codes (or one code billed as three units) from the Buprenorphine Oral Weekly Value Set on January 1, the start date is January 1 and the end date is January 21.
- If a person has four codes (or one code billed as four units) from the Methadone Oral Weekly Value Set on January 1, the start date is January 1 and the end date is January 28.

For OUD medication administration events identified using a value set, use the days supply listed in the Opioid Use Disorder Treatment Medications table. For OUD dispensing events identified using a medication list, use the days supply in the pharmacy data.

- If the days supply is not available in the pharmacy data, use the days supply listed for the corresponding value set.
- If the pharmacy data for a buprenorphine oral medication does not contain days supply, count as a 7 days supply.

**Step 4.** For each treatment period, using the start and end dates identified in step 3, determine calendar days (treatment days) covered by an OUD dispensing or medication administration event.

**Step 5.** Identify gaps in treatment days of 8 or more consecutive days.

**Step 6.** Determine numerator compliance.

- If the treatment period does not contain any gaps in treatment of 8 or more consecutive calendar days, the event is numerator compliant.
- If the treatment period contains at least one gap in treatment of 8 or more consecutive calendar days, the event is not numerator compliant.

#### *Opioid Use Disorder Treatment Medications*

Description	Prescription	Medication Lists	Value Sets and Days Supply
Antagonist	Naltrexone (oral)	<u>Naltrexone Oral Medications List</u>	NA—Codes do not exist
Antagonist	Naltrexone (injectable)	<u>Naltrexone Injection Medications List</u>	<u>Naltrexone Injection Value Set (31 days supply)</u>

	Description	Prescription	Medication Lists	Value Sets and Days Supply																																
Partial agonist	Buprenorphine (sublingual tablet)	<a href="#">Buprenorphine Oral Medications List</a>	<a href="#">Buprenorphine Oral Value Set (1 day supply)</a> <a href="#">Buprenorphine Oral Weekly Value Set (7 days supply)</a>																																	
Partial agonist	Buprenorphine (injection)	<a href="#">Buprenorphine Injection Medications List</a>	<a href="#">Buprenorphine Injection Value Set (31 days supply)</a>																																	
Partial agonist	Buprenorphine (implant)	<a href="#">Buprenorphine Implant Medications List</a>	<a href="#">Buprenorphine Implant Value Set (180 days supply)</a>																																	
Partial agonist	Buprenorphine/naloxone (sublingual tablet, buccal film, sublingual film)	<a href="#">Buprenorphine Naloxone Medications List</a>	<a href="#">Buprenorphine Naloxone Value Set (1 day supply)</a>																																	
Agonist	Methadone (oral)	NA (refer to Note below)	<a href="#">Methadone Oral Value Set (1 day supply)</a> <a href="#">Methadone Oral Weekly Value Set (7 days supply)</a>																																	
<b>Summary of changes</b>	<ul style="list-style-type: none"> <li>Updated the race and ethnicity stratification categories to align with OMB SPD 15 2024.</li> <li>Added instructions on allowable adjustments to the race and ethnicity stratification.</li> </ul>																																			
<b>Data element tables</b>	<p>Organizations that submit HEDIS data to NCQA must provide the following data elements.</p> <p><b>Table POD-A-1/2/3: Data Elements for Pharmacotherapy for Opioid Use Disorder</b></p> <table border="1"> <thead> <tr> <th>Metric</th> <th>Age</th> <th>Data Element</th> <th>Reporting Instructions</th> </tr> </thead> <tbody> <tr> <td>PharmacotherapyOpioid UseDisorder</td> <td>16-64</td> <td>Benefit</td> <td>Metadata</td> </tr> <tr> <td></td> <td>65+</td> <td>InitialPopulation</td> <td>For each Stratification</td> </tr> <tr> <td></td> <td>Total</td> <td>Exclusions</td> <td>For each Stratification</td> </tr> <tr> <td></td> <td></td> <td>Denominator</td> <td>For each Stratification</td> </tr> <tr> <td></td> <td></td> <td>NumeratorByAdmin</td> <td>For each Stratification</td> </tr> <tr> <td></td> <td></td> <td>NumeratorBySupplemental</td> <td>For each Stratification</td> </tr> <tr> <td></td> <td></td> <td>Rate</td> <td>(Percent)</td> </tr> </tbody> </table>				Metric	Age	Data Element	Reporting Instructions	PharmacotherapyOpioid UseDisorder	16-64	Benefit	Metadata		65+	InitialPopulation	For each Stratification		Total	Exclusions	For each Stratification			Denominator	For each Stratification			NumeratorByAdmin	For each Stratification			NumeratorBySupplemental	For each Stratification			Rate	(Percent)
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		NumeratorBySupplemental	For each Stratification																																	
		Rate	(Percent)																																	

	<b>Table POD-B-1/2/3: Data Elements for Pharmacotherapy for Opioid Use: Stratifications by Race</b>			
	Metric	Race	Data Element	Reporting Instructions
PharmacotherapyOpioidUseDisorder	AmericanIndianOrAlaskaNative	Denominator	For each Stratification	
	Asian	Numerator	For each Stratification	
	BlackOrAfricanAmerican	Rate	(Percent)	
	MiddleEasternOrNorthAfrican			
	NativeHawaiianOrPacificIslander			
	White			
	SomeOtherRace			
	TwoOrMoreRaces			
	AskedButNoAnswer			
	Unknown			

	<b>Table POD-C-1/2/3: Data Elements for Pharmacotherapy for Opioid Use: Stratifications by Ethnicity</b>			
	Metric	Ethnicity	Data Element	Reporting Instructions
PharmacotherapyOpioidUseDisorder	HispanicOrLatino	Denominator	For each Stratification	
	NotHispanicOrLatino	Numerator	For each Stratification	
	AskedButNoAnswer	Rate	(Percent)	
	Unknown			

Rules for Allowable Adjustments	<p><b>Copyright and use:</b> The “Rules for Allowable Adjustments of HEDIS” (the “Rules”) describe how NCQA’s HEDIS measure specifications can be adjusted for other populations, if applicable. The Rules, reviewed and approved by NCQA measure experts, provide for expanded use of HEDIS measures without changing their clinical intent.</p> <p><b>Adjusted HEDIS measures may not be used for HEDIS health plan reporting.</b></p> <p><b>ADJUSTMENTS ALLOWED</b></p> <ul style="list-style-type: none"> <li>• <b>Product lines.</b> Organizations are not required to use product line criteria; product lines may be combined, and all (or no) product line criteria may be used.</li> <li>• <b>Attribution.</b> Organizations are not required to use enrollment criteria.</li> <li>• <b>Benefits.</b> Organizations are not required to use a benefit.</li> <li>• <b>Other.</b> Organizations may use additional initial population criteria to focus on an area of interest defined by gender, race, ethnicity, socioeconomic or sociodemographic characteristics, geographic region or another characteristic.</li> </ul>
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- *Stratifications:* Race and ethnicity stratification. The race and ethnicity stratification is not required. Organizations may adjust this stratification as needed.
- *Exclusions.* The hospice and deceased person exclusions are not required.
- *Telehealth.* Services/events that allow the use of synchronous telehealth visits, telephone visits and asynchronous telehealth (e-visits, virtual check-ins) may be stratified to identify services performed via telehealth. This adjustment is not allowed for events, numerators and exclusions that do not allow the use of telehealth.
- *Supplemental data.* Supplemental data may be used to identify initial population, denominator, exclusion and numerator events.

#### **ADJUSTMENTS ALLOWED WITH LIMITS**

- *Ages.* The age determination dates may be changed (e.g., select, "age as of June 30"). Changing the denominator age range is allowed if the limits are within the specified age range. The denominator age may not be expanded.
- *Initial population:* Event. Only events and diagnoses that contain (or map to) codes in the value sets and medication lists may be used to identify visits with a diagnosis. Medication lists, value sets and logic may not be changed.

**Note:** Organizations may assess at the person level by applying measure logic appropriately (i.e., percentage of pharmacotherapy events with OUD pharmacotherapy for 180 or more days with a diagnosis of OUD).

#### **ADJUSTMENTS NOT ALLOWED**

- *Numerator.* Medication lists, value sets and logic may not be changed.

## ***Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)***

<b>Measure title</b>	Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	<b>Measure ID</b>	SSD
<b>Description</b>	The percentage of persons 18–64 years of age with schizophrenia, schizoaffective disorder or bipolar disorder who were dispensed an antipsychotic medication and had a diabetes screening test during the measurement period.		
<b>Measurement period</b>	January 1–December 31.		
<b>Copyright and disclaimer notice</b>	Refer to the complete copyright and disclaimer information at the front of this publication. NCQA website: <a href="http://www.ncqa.org">www.ncqa.org</a> . Submit policy clarification support questions via My NCQA ( <a href="https://my.ncqa.org">https://my.ncqa.org</a> ).		
<b>Clinical recommendation statement/ rationale</b>	Patients with schizophrenia and bipolar disorder who are prescribed antipsychotic medications are at greater risk for diabetes. Regular diabetes screening for this population leads to earlier identification and treatment of diabetes.		
<b>Citations</b>	Vancampfort, D., B. Stubbs, A.J. Mitchell, M. De Hert, M. Wampers, P.B. Ward, S. Rosenbaum, and C.U. Correll. 2015. "Risk of Metabolic Syndrome and Its Components in People with Schizophrenia and Related Psychotic Disorders, Bipolar Disorder and Major Depressive Disorder: A Systematic Review and Meta-Analysis." <i>World Psychiatry</i> 14 (3): 339–47.		
<b>Characteristics</b>			
<b>Scoring</b>	Proportion.		
<b>Type</b>	Process.		
<b>Product lines</b>	Medicaid.		
<b>Stratifications</b>	None.		
<b>Risk adjustment</b>	None.		
<b>Improvement notation</b>	Increased score indicates improvement.		
<b>Guidance</b>	<p><b>Data collection methodology:</b> Administrative. Refer to <a href="#">General Guideline: Data Collection Methods</a> for additional information.</p> <p><b>Date specificity:</b> Dates must be specific enough to determine the event occurred in the period being measured.</p>		

	<b>Which services count?</b> When using claims, include all paid, suspended, pending and denied claims.
<b>Initial population</b>	<p><b>Measure item count:</b> Person.</p> <p><b>Attribution basis:</b> Enrollment.</p> <ul style="list-style-type: none"> <li>• <b>Benefits:</b> Medical and pharmacy.</li> <li>• <b>Continuous enrollment:</b> The measurement period.</li> <li>• <b>Allowable gap:</b> No more than one gap of ≤45 days during the measurement period. No gaps on the last day of the measurement period.</li> </ul> <p><b>Ages:</b> 18–64 years of age as of the last day of the measurement period.</p> <p><b>Event: Persons with schizophrenia or bipolar disorder.</b></p> <p>Identify persons who met at least one of the following criteria during the measurement period.</p> <ul style="list-style-type: none"> <li>• At least one acute inpatient encounter with any diagnosis of schizophrenia, schizoaffective disorder or bipolar disorder. Any of the following combinations meet criteria: <ul style="list-style-type: none"> <li>– BH Stand Alone Acute Inpatient Value Set <b>with</b> (<u>Schizophrenia Value Set</u>; <u>Bipolar Disorder Value Set</u>; <u>Other Bipolar Disorder Value Set</u>).</li> <li>– Visit Setting Unspecified Value Set <b>with</b> Acute Inpatient POS Value Set <b>with</b> <u>Schizophrenia Value Set</u>; <u>Bipolar Disorder Value Set</u>; <u>Other Bipolar Disorder Value Set</u>.</li> </ul> </li> <li>• At least two of the following, on different dates of service, where both encounters have any diagnosis of schizophrenia or schizoaffective disorder (<u>Schizophrenia Value Set</u>) or both encounters have any diagnosis of bipolar disorder (<u>Bipolar Disorder Value Set</u>; <u>Other Bipolar Disorder Value Set</u>): <ul style="list-style-type: none"> <li>– An outpatient visit (<u>Visit Setting Unspecified Value Set with Outpatient POS Value Set</u>).</li> <li>– An outpatient visit (<u>BH Outpatient Value Set</u>).</li> <li>– An intensive outpatient encounter or partial hospitalization (<u>Visit Setting Unspecified Value Set with</u> POS code 52).</li> <li>– An intensive outpatient encounter or partial hospitalization (<u>Partial Hospitalization or Intensive Outpatient Value Set</u>).</li> <li>– A community mental health center visit (<u>Visit Setting Unspecified Value Set with</u> POS code 53).</li> <li>– Electroconvulsive therapy (<u>Electroconvulsive Therapy Value Set</u>).</li> <li>– An ED visit (<u>ED Value Set</u>).</li> <li>– An ED visit (<u>Visit Setting Unspecified Value Set with</u> POS code 23).</li> <li>– A nonacute inpatient encounter (<u>BH Stand Alone Nonacute Inpatient Value Set</u>).</li> <li>– A nonacute inpatient encounter (<u>Visit Setting Unspecified Value Set with</u> <u>Nonacute Inpatient POS Value Set</u>).</li> <li>– A telehealth visit (<u>Visit Setting Unspecified Value Set with</u> <u>Telehealth POS Value Set</u>).</li> </ul> </li> </ul>

	<ul style="list-style-type: none"> <li>– A telephone visit (<a href="#">Telephone Visits Value Set</a>).</li> <li>– An e-visit or virtual check-in (<a href="#">Online Assessments Value Set</a>).</li> </ul>
<b>Denominator exclusions</b>	<p><b>Persons with a date of death.</b> Death in the measurement period, identified using data sources determined by the organization. Method and data sources are subject to review during the HEDIS audit.</p> <p><b>Persons in hospice or using hospice services.</b> Persons who use hospice services (<a href="#">Hospice Encounter Value Set</a>; <a href="#">Hospice Intervention Value Set</a>) or elect to use a hospice benefit any time during the measurement period. Organizations that use the Monthly Membership Detail Data File to identify these persons must use only the run date of the file.</p> <p><b>Persons with a diagnosis of diabetes.</b> Either of the following meets criteria:</p> <ul style="list-style-type: none"> <li>• <i>Claim/encounter data.</i> At least two diagnoses of diabetes (<a href="#">Diabetes Value Set*</a>) on different dates of service during the measurement period or the year prior to the measurement period.</li> <li>• <i>Pharmacy data.</i> At least one diagnosis of diabetes (<a href="#">Diabetes Value Set*</a>) <b>and</b> at least one diabetes medication dispensing event of insulin or a hypoglycemic/antihyperglycemic medication (<a href="#">Diabetes Medications List</a>) during the measurement period or the year prior to the measurement period.</li> </ul> <p><b>Persons without at least one antipsychotic medication dispensing event.</b> Either of the following meets criteria:</p> <ul style="list-style-type: none"> <li>• <i>Claim/encounter data.</i> An antipsychotic medication (<a href="#">Long Acting Injections Value Set</a>).</li> <li>• <i>Pharmacy data.</i> Dispensed an antipsychotic medication (<a href="#">SSD Antipsychotic Medications List</a>).</li> </ul> <p><b>Coding Guidance</b> *Do not include laboratory claims (claims with POS code 81).</p>
<b>Denominator</b>	The initial population minus denominator exclusions.
<b>Numerator</b>	<p><b>Persons with a glucose test or HbA1c test.</b> Any of the following meet criteria:</p> <ul style="list-style-type: none"> <li>• <a href="#">Glucose Lab Test Value Set</a>.</li> <li>• <a href="#">Glucose Test Result or Finding Value Set</a>.</li> <li>• <a href="#">HbA1c Lab Test Value Set</a>.</li> <li>• <a href="#">HbA1c Test Result or Finding Value Set*†</a>.</li> </ul> <p><b>Coding Guidance</b> *Do not include laboratory claims (claims with POS code 81). †Do not include codes with a modifier (<a href="#">CPT CAT II Modifier Value Set</a>).</p>
<b>Summary of changes</b>	<ul style="list-style-type: none"> <li>• No changes to this measure.</li> </ul>

<b>Data element tables</b>	<p>Organizations that submit HEDIS data to NCQA must provide the following data elements.</p> <p><b>Table SSD-1: Data Elements for Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications</b></p> <table border="1" data-bbox="494 361 1470 819"> <thead> <tr> <th>Metric</th><th>Data Element</th><th>Reporting Instructions</th></tr> </thead> <tbody> <tr> <td>DiabetesScreeningSchizophreniaUsingAntipsychotics</td><td>Benefit</td><td>Metadata</td></tr> <tr> <td></td><td>InitialPopulation</td><td>Report once</td></tr> <tr> <td></td><td>Exclusions</td><td>Report once</td></tr> <tr> <td></td><td>Denominator</td><td>Report once</td></tr> <tr> <td></td><td>NumeratorByAdmin</td><td>Report once</td></tr> <tr> <td></td><td>NumeratorBySupplemental</td><td>Report once</td></tr> <tr> <td></td><td>Rate</td><td>(Percent)</td></tr> </tbody> </table>	Metric	Data Element	Reporting Instructions	DiabetesScreeningSchizophreniaUsingAntipsychotics	Benefit	Metadata		InitialPopulation	Report once		Exclusions	Report once		Denominator	Report once		NumeratorByAdmin	Report once		NumeratorBySupplemental	Report once		Rate	(Percent)
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<b>Rules for Allowable Adjustments</b>	<p><b>Copyright and use:</b> The “Rules for Allowable Adjustments of HEDIS” (the “Rules”) describe how NCQA’s HEDIS measure specifications can be adjusted for other populations, if applicable. The Rules, reviewed and approved by NCQA measure experts, provide for expanded use of HEDIS measures without changing their clinical intent.</p> <p><b>Adjusted HEDIS measures may not be used for HEDIS health plan reporting.</b></p> <p><b>ADJUSTMENTS ALLOWED</b></p> <ul style="list-style-type: none"> <li>• <b>Product lines.</b> Organizations are not required to use product line criteria; product lines may be combined, and all (or no) product line criteria may be used.</li> <li>• <b>Attribution.</b> Organizations are not required to use enrollment criteria.</li> <li>• <b>Benefits.</b> Organizations are not required to use a benefit.</li> <li>• <b>Other.</b> Organizations may use additional initial population criteria to focus on an area of interest as defined by gender, race, ethnicity, socioeconomic or sociodemographic characteristics, geographic region or another characteristic.</li> <li>• <b>Measurement period adjustments.</b> Organizations may adjust the measurement period.</li> <li>• <b>Exclusions.</b> The hospice and deceased persons exclusions are not required.</li> <li>• <b>Telehealth.</b> Services/events that allow the use of synchronous telehealth visits, telephone visits and asynchronous telehealth (e-visits, virtual check-ins) may be stratified to identify services performed via telehealth. This adjustment is not allowed for events, numerators and exclusions that do not allow the use of telehealth.</li> <li>• <b>Supplemental data.</b> Supplemental data may be used to identify initial population, denominator, exclusion and numerator events.</li> </ul>																								

**ADJUSTMENTS ALLOWED WITH LIMITS**

- **Ages.** Age determination dates may be changed (e.g., select, “age as of June 30”). Changing the denominator age range is allowed within a specific age range (18 years of age or older).

**ADJUSTMENTS NOT ALLOWED**

- ***Initial population:*** Event. Only events, medications and diagnoses that contain (or map to) codes in the medication lists and value sets may be used to identify visits, medication use and diagnosis. Medication lists, value sets and logic may not be changed.
- ***Exclusions.*** The diabetes and antipsychotic medications exclusions must be applied. Value sets and medication lists may not be changed.
- ***Numerator.*** Medication lists, value sets and logic may not be changed.

## **Diabetes Monitoring for People With Diabetes and Schizophrenia (SMD)**

<b>Measure title</b>	Diabetes Monitoring for People With Diabetes and Schizophrenia	<b>Measure ID</b>	SMD
<b>Description</b>	The percentage of persons 18–64 years of age with schizophrenia or schizoaffective disorder and diabetes who had both an LDL-C test and an HbA1c test during the measurement period.		
<b>Measurement period</b>	January 1–December 31.		
<b>Copyright and disclaimer notice</b>	<p>Refer to the complete copyright and disclaimer information at the front of this publication.</p> <p>NCQA website: <a href="http://www.ncqa.org">www.ncqa.org</a>.</p> <p>Submit policy clarification support questions via My NCQA (<a href="https://my.ncqa.org">https://my.ncqa.org</a>).</p>		
<b>Clinical recommendation statement/ rationale</b>	<p>Among patients with co-occurring schizophrenia and metabolic disorders, the nontreatment rate for diabetes is approximately 32%. In addition to general diabetes risk factors, diabetes is promoted in patients with schizophrenia by initial and current treatment with olanzapine and mid-potency first-generation antipsychotics (FGA), as well as by current treatment with low-potency FGAs and clozapine.</p> <p>Improving blood sugar control has shown to lead to lower use of health care services and better overall satisfaction with diabetes treatment. People who control their diabetes also report improved quality of life and emotional well-being.</p>		
<b>Citations</b>	<p>Vancampfort, D., B. Stubbs, A.J. Mitchell, M. De Hert, M. Wampers, P.B. Ward, S. Rosenbaum, and C.U. Correll. 2015. “Risk of Metabolic Syndrome and Its Components in People with Schizophrenia and Related Psychotic Disorders, Bipolar Disorder and Major Depressive Disorder: A Systematic Review and Meta-Analysis.” <i>World Psychiatry</i> 14 (3): 339–47.</p> <p>Nasrallah, H.A., J.M. Meyer, D.C. Goff, J.P. McEvoy, S.M. Davis, T.S. Stroup, et al. 2006. “Low Rates of Treatment for Hypertension, Dyslipidemia and Diabetes in Schizophrenia: Data from the CATIE Schizophrenia Trial Sample at Baseline.” <i>Schizophr Res</i> 86(1-3): 15–22.</p> <p>Nielsen, J., S. Skadhede, C.U. Correll. 2010. “Antipsychotics Associated with the Development of Type 2 Diabetes in Antipsychotic-Naïve Schizophrenia Patients.” <i>Neuropsychopharmacology</i> 35(9):1997–2004.</p>		
<b>Characteristics</b>			
<b>Scoring</b>	Proportion.		
<b>Type</b>	Process.		
<b>Product lines</b>	Medicaid.		

<b>Stratifications</b>	None.
<b>Risk adjustment</b>	None.
<b>Improvement notation</b>	Increased score indicates improvement.
<b>Guidance</b>	<p><b>Data collection methodology:</b> Administrative. Refer to <a href="#">General Guideline: Data Collection Methods</a> for additional information.</p> <p><b>Date specificity:</b> Dates must be specific enough to determine the event occurred in the period being measured.</p> <p><b>Which services count?</b> When using claims, include all paid, suspended, pending and denied claims.</p>
<b>Initial population</b>	<p><b>Measure item count:</b> Person.</p> <p><b>Attribution basis:</b> Enrollment.</p> <ul style="list-style-type: none"> <li>• <b>Benefits:</b> Medical.</li> <li>• <b>Continuous enrollment:</b> The measurement period.</li> <li>• <b>Allowable gap:</b> No more than one gap of ≤45 days during the measurement period. No gaps on the last day of the measurement period.</li> </ul> <p><b>Ages:</b> 18–64 years of age as of the last day of the measurement period.</p> <p><b>Event:</b> <b>Persons with schizophrenia or schizoaffective disorder and diabetes.</b></p> <p><b>Step 1.</b> Identify persons with schizophrenia or schizoaffective disorder as those who met at least one of the following criteria during the measurement period:</p> <ul style="list-style-type: none"> <li>• At least one acute inpatient encounter with any diagnosis of schizophrenia or schizoaffective disorder. Either of the following combinations meets criteria: <ul style="list-style-type: none"> <li>– <u>BH Stand Alone Acute Inpatient Value Set with Schizophrenia Value Set.</u></li> <li>– <u>Visit Setting Unspecified Value Set with Acute Inpatient POS Value Set with Schizophrenia Value Set.</u></li> </ul> </li> <li>• At least two visits in an outpatient, intensive outpatient, partial hospitalization, ED or nonacute inpatient setting, on different dates of service, with any diagnosis of schizophrenia or schizoaffective disorder. Two of any of the following meets criteria: <ul style="list-style-type: none"> <li>– An outpatient visit with any diagnosis of schizophrenia or schizoaffective disorder (<u>Visit Setting Unspecified Value Set with Outpatient POS Value Set with Schizophrenia Value Set.</u>)</li> <li>– An outpatient visit with any diagnosis of schizophrenia or schizoaffective disorder (<u>BH Outpatient Value Set with Schizophrenia Value Set.</u>)</li> </ul> </li> </ul>

- An intensive outpatient encounter or partial hospitalization with any diagnosis of schizophrenia or schizoaffective disorder (Visit Setting Unspecified Value Set with POS code 52 with Schizophrenia Value Set).
- An intensive outpatient encounter or partial hospitalization with any diagnosis of schizophrenia or schizoaffective disorder (Partial Hospitalization or Intensive Outpatient Value Set with Schizophrenia Value Set).
- A community mental health center visit with any diagnosis of schizophrenia or schizoaffective disorder (Visit Setting Unspecified Value Set with POS code 53 with Schizophrenia Value Set).
- Electroconvulsive therapy (Electroconvulsive Therapy Value Set) **with** any diagnosis of schizophrenia or schizoaffective disorder (Schizophrenia Value Set).
- An ED visit (ED Value Set) **with** any diagnosis of schizophrenia or schizoaffective disorder (Schizophrenia Value Set).
- An ED visit with any diagnosis of schizophrenia or schizoaffective disorder (Visit Setting Unspecified Value Set with POS code 23 with Schizophrenia Value Set).
- A nonacute inpatient encounter (BH Stand Alone Nonacute Inpatient Value Set) **with** any diagnosis of schizophrenia or schizoaffective disorder (Schizophrenia Value Set).
- A nonacute inpatient encounter with any diagnosis of schizophrenia or schizoaffective disorder (Visit Setting Unspecified Value Set with Nonacute Inpatient POS Value Set with Schizophrenia Value Set).
- A telehealth visit with any diagnosis of schizophrenia or schizoaffective disorder (Visit Setting Unspecified Value Set with Telehealth POS Value Set with Schizophrenia Value Set).
- A telephone visit (Telephone Visits Value Set) **with** any diagnosis of schizophrenia or schizoaffective disorder (Schizophrenia Value Set).
- An e-visit or virtual check-in (Online Assessments Value Set) **with** any diagnosis of schizophrenia or schizoaffective disorder (Schizophrenia Value Set).

**Step 2.** Identify persons from step 1 who also have diabetes. Either of the following meets criteria:

- **Claim/encounter data.** At least two diagnoses of diabetes (Diabetes Value Set\*) on different dates of service during the measurement period or the year prior to the measurement period.
- **Pharmacy data.** At least one diagnosis of diabetes (Diabetes Value Set\*) **and** at least one diabetes medication dispensing event of insulin or a hypoglycemic/antihyperglycemic medication (Diabetes Medications List) during the measurement period or the year prior to the measurement period.

#### Coding Guidance

\*Do not include laboratory claims (claims with POS code 81).

<b>Denominator exclusions</b>	<p><b>Persons with a date of death.</b> Death in the measurement period, identified using data sources determined by the organization. Method and data sources are subject to review during the HEDIS audit.</p> <p><b>Persons in hospice or using hospice services.</b> Persons who use hospice services (<a href="#">Hospice Encounter Value Set</a>; <a href="#">Hospice Intervention Value Set</a>) or elect to use a hospice benefit any time during the measurement period. Organizations that use the Monthly Membership Detail Data File to identify these persons must use only the run date of the file.</p>																					
<b>Denominator</b>	The initial population minus denominator exclusions.																					
<b>Numerator</b>	<p><b>Persons who had both an HbA1c and LDL-C test performed during the measurement period.</b> An HbA1c and LDL-C test performed during the measurement period (on the same or different dates of service). The person must have both tests to be included in the numerator. The organization may use a calculated or direct LDL.</p> <ul style="list-style-type: none"> <li>• <a href="#">HbA1c Lab Test Value Set</a>.</li> <li>• <a href="#">HbA1c Test Result or Finding Value Set*†</a>.</li> <li>• <a href="#">LDL C Lab Test Value Set</a>.</li> <li>• <a href="#">LDL C Test Result or Finding Value Set*†</a>.</li> </ul> <p><b>Coding Guidance</b></p> <p>*Do not include laboratory claims (claims with POS code 81). †Do not include codes with a modifier (<a href="#">CPT CAT II Modifier Value Set</a>).</p>																					
<b>Summary of changes</b>	<ul style="list-style-type: none"> <li>• No changes to this measure.</li> </ul>																					
<b>Data element tables</b>	<p>Organizations that submit HEDIS data to NCQA must provide the following data elements.</p> <p><b>Table SMD-1: Data Elements for Diabetes Monitoring for People With Diabetes and Schizophrenia</b></p> <table border="1"> <thead> <tr> <th>Metric</th> <th>Data Element</th> <th>Reporting Instructions</th> </tr> </thead> <tbody> <tr> <td>DiabetesMonitoringSchizophrenia</td> <td>InitialPopulation</td> <td>Report once</td> </tr> <tr> <td></td> <td>Exclusions</td> <td>Report once</td> </tr> <tr> <td></td> <td>Denominator</td> <td>Report once</td> </tr> <tr> <td></td> <td>NumeratorByAdmin</td> <td>Report once</td> </tr> <tr> <td></td> <td>NumeratorBySupplemental</td> <td>Report once</td> </tr> <tr> <td></td> <td>Rate</td> <td>(Percent)</td> </tr> </tbody> </table>	Metric	Data Element	Reporting Instructions	DiabetesMonitoringSchizophrenia	InitialPopulation	Report once		Exclusions	Report once		Denominator	Report once		NumeratorByAdmin	Report once		NumeratorBySupplemental	Report once		Rate	(Percent)
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	Denominator	Report once																				
	NumeratorByAdmin	Report once																				
	NumeratorBySupplemental	Report once																				
	Rate	(Percent)																				
<b>Rules for Allowable Adjustments</b>	<p><b>Copyright and use:</b> The “Rules for Allowable Adjustments of HEDIS” (the “Rules”) describe how NCQA’s HEDIS measure specifications can be adjusted for other populations, if applicable. The Rules, reviewed and approved by NCQA measure experts, provide for expanded use of HEDIS measures without changing their clinical intent.</p>																					

	<p><b>Adjusted HEDIS measures may not be used for HEDIS health plan reporting.</b></p> <p><b>ADJUSTMENTS ALLOWED</b></p> <ul style="list-style-type: none"><li>• <i>Product lines.</i> Organizations are not required to use product line criteria; product lines may be combined, and all (or no) product line criteria may be used.</li><li>• <i>Attribution.</i> Organizations are not required to use enrollment criteria.</li><li>• <i>Benefits.</i> Organizations are not required to use a benefit.</li><li>• <i>Other.</i> Organizations may use additional initial population criteria to focus on an area of interest defined by gender, race, ethnicity, socioeconomic or sociodemographic characteristics, geographic region or another characteristic.</li><li>• <i>Exclusions.</i> The hospice and deceased person exclusions are not required.</li><li>• <i>Telehealth.</i> Services/events that allow the use of synchronous telehealth visits, telephone visits and asynchronous telehealth (e-visits, virtual check-ins) may be stratified to identify services performed via telehealth. This adjustment is not allowed for events, numerators and exclusions that do not allow the use of telehealth.</li><li>• <i>Supplemental data.</i> Supplemental data may be used to identify initial population, denominator, exclusion and numerator events.</li></ul> <p><b>ADJUSTMENTS ALLOWED WITH LIMITS</b></p> <ul style="list-style-type: none"><li>• <i>Ages.</i> The age determination dates may be changed (e.g., select, "age as of June 30"). Expanding the denominator age range to 65 years and older is allowed. Changing the denominator age range is allowed within a specified age range (18 years and older).</li></ul> <p><b>ADJUSTMENTS NOT ALLOWED</b></p> <ul style="list-style-type: none"><li>• <i>Initial population:</i> Event. Only events, medications and diagnoses that contain (or map to) codes in the medication lists and value sets may be used to identify visits and diagnosis. Medication lists, value sets and logic may not be changed.</li><li>• <i>Numerator.</i> Value sets and logic may not be changed.</li></ul>
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## ***Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia (SMC)***

<b>Measure title</b>	Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia	<b>Measure ID</b>	SMC
<b>Description</b>	The percentage of persons 18–64 years of age with schizophrenia or schizoaffective disorder and cardiovascular disease, who had an LDL-C test during the measurement period.		
<b>Measurement period</b>	January 1–December 31.		
<b>Copyright and disclaimer notice</b>	<p>Refer to the complete copyright and disclaimer information at the front of this publication.</p> <p>NCQA website: <a href="http://www.ncqa.org">www.ncqa.org</a>.</p> <p>Submit policy clarification support questions via My NCQA (<a href="https://my.ncqa.org">https://my.ncqa.org</a>).</p>		
<b>Clinical recommendation statement/ rationale</b>	<p>Patients with schizophrenia or schizoaffective disorder are likely to have higher levels of blood cholesterol than the general population. Patients with schizophrenia and elevated blood cholesterol levels are prescribed statins at approximately a quarter of the rate of the general population. Furthermore, certain atypical antipsychotic drugs increase total and low-density lipoprotein (LDL) cholesterol and triglycerides, and decrease high-density lipoprotein (HDL) cholesterol, which increases the risk of coronary heart disease.</p>		
<b>Citations</b>	<p>Rossm, R.C., S.A. Hooker, P.J. O'Connor, A.L. Crain, and J.M. Sperl-Hillen. 2022. "Cardiovascular Risk for Patients With and Without Schizophrenia, Schizoaffective Disorder, or Bipolar Disorder." <i>Journal of the American Heart Association</i> 11 (6): e021444.</p> <p>Pillinger, T., R.A. McCutcheon, L. Vano, Y. Mizuno, A. Arumuham, G. Hindley, K. Beck, et al. 2020. "Comparative Effects of 18 Antipsychotics on Metabolic Function in Patients with Schizophrenia, Predictors of Metabolic Dysregulation, and Association with Psychopathology: A Systematic Review and Network Meta-Analysis." <i>The Lancet Psychiatry</i> 7 (1): 64–77.</p>		
<b>Characteristics</b>			
<b>Scoring</b>	Proportion.		
<b>Type</b>	Process.		
<b>Product lines</b>	Medicaid.		
<b>Stratifications</b>	None.		
<b>Risk adjustment</b>	None.		
<b>Improvement notation</b>	Increased score indicates improvement.		

<b>Guidance</b>	<p><b>Data collection methodology:</b> Administrative. Refer to <a href="#">General Guideline: Data Collection Methods</a> for additional information.</p> <p><b>Date specificity:</b> Dates must be specific enough to determine the event occurred in the period being measured.</p> <p><b>Which services count?</b> When using claims, include all paid, suspended, pending and denied claims.</p>
<b>Initial population</b>	<p><b>Measure item count:</b> Person.</p> <p><b>Attribution basis:</b> Enrollment.</p> <ul style="list-style-type: none"> <li>• <b>Benefits:</b> Medical.</li> <li>• <b>Continuous enrollment:</b> The measurement period and the year prior to the measurement period.</li> <li>• <b>Allowable gap:</b> No more than one gap of ≤45 days during each year in the continuous enrollment period. No gaps on the last day of the measurement period.</li> </ul> <p><b>Ages:</b> 18–64 years of age as of the last day of the measurement period.</p> <p><b>Event:</b> <b>Persons with cardiovascular disease and schizophrenia</b></p> <p><b>Step 1.</b> Identify persons with schizophrenia or schizoaffective disorder as those who met at least one of the following criteria during the measurement period:</p> <ul style="list-style-type: none"> <li>• At least one acute inpatient encounter with any diagnosis of schizophrenia or schizoaffective disorder. Either of the following combinations meets criteria: <ul style="list-style-type: none"> <li>– <u>BH Stand Alone Acute Inpatient Value Set with Schizophrenia Value Set</u>.</li> <li>– <u>Visit Setting Unspecified Value Set with Acute Inpatient POS Value Set with Schizophrenia Value Set</u>.</li> </ul> </li> <li>• At least two visits in an outpatient, intensive outpatient, partial hospitalization, ED or nonacute inpatient setting, on different dates of service, with any diagnosis of schizophrenia or schizoaffective disorder. Two of any of the following meets criteria: <ul style="list-style-type: none"> <li>– An outpatient visit with any diagnosis of schizophrenia or schizoaffective disorder (<u>Visit Setting Unspecified Value Set with Outpatient POS Value Set with Schizophrenia Value Set</u>).</li> <li>– An outpatient visit with any diagnosis of schizophrenia or schizoaffective disorder (<u>BH Outpatient Value Set with Schizophrenia Value Set</u>).</li> <li>– An intensive outpatient encounter or partial hospitalization with any diagnosis of schizophrenia or schizoaffective disorder (<u>Visit Setting Unspecified Value Set</u>) <b>with</b> POS code 52 <b>with</b> <u>Schizophrenia Value Set</u>.</li> <li>– An intensive outpatient encounter or partial hospitalization with any diagnosis of schizophrenia or schizoaffective disorder (<u>Partial Hospitalization or Intensive Outpatient Value Set</u>) <b>with</b> <u>Schizophrenia Value Set</u>).</li> </ul> </li> </ul>

- A community mental health center visit with any diagnosis of schizophrenia or schizoaffective disorder (Visit Setting Unspecified Value Set) **with** POS code 53 **with** Schizophrenia Value Set.
- Electroconvulsive therapy (Electroconvulsive Therapy Value Set) **with** any diagnosis of schizophrenia or schizoaffective disorder (Schizophrenia Value Set).
- An ED visit (ED Value Set) **with** any diagnosis of schizophrenia or schizoaffective disorder (Schizophrenia Value Set).
- An ED visit with any diagnosis of schizophrenia or schizoaffective disorder (Visit Setting Unspecified Value Set with POS code 23 **with** Schizophrenia Value Set).
- A nonacute inpatient encounter (BH Stand Alone Nonacute Inpatient Value Set) **with** any diagnosis of schizophrenia or schizoaffective disorder (Schizophrenia Value Set).
- A nonacute inpatient encounter with any diagnosis of schizophrenia or schizoaffective disorder (Visit Setting Unspecified Value Set with Nonacute Inpatient POS Value Set with Schizophrenia Value Set).
- A telehealth visit with any diagnosis of schizophrenia or schizoaffective disorder (Visit Setting Unspecified Value Set with Telehealth POS Value Set with Schizophrenia Value Set).
- A telephone visit (Telephone Visits Value Set) **with** any diagnosis of schizophrenia or schizoaffective disorder (Schizophrenia Value Set).
- An e-visit or virtual check-in (Online Assessments Value Set) **with** any diagnosis of schizophrenia or schizoaffective disorder (Schizophrenia Value Set).

**Step 2.** Identify persons from step 1 who also have cardiovascular disease.

There are two methods to identify persons with cardiovascular disease: by event **or** by diagnosis. A person 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 period meet criteria:
  - **AMI.** Discharged from an inpatient setting with an AMI diagnosis (AMI 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.** Persons who had CABG (CABG Value Set) in any setting.
  - **PCI.** Persons who had PCI (PCI Value Set) in any setting.
- *Diagnosis.* Identify persons with IVD as those who met at least one of the following criteria during both the measurement period and the year prior to the measurement period. Criteria need not be the same across both years.
  - 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).

	<ul style="list-style-type: none"> <li>– At least one acute inpatient discharge with a diagnosis of IVD (<u>IVD Value Set</u>) on the discharge claim. To identify an acute inpatient discharge:           <ol style="list-style-type: none"> <li>1. Identify all acute and nonacute inpatient stays (<u>Inpatient Stay Value Set</u>).</li> <li>2. Exclude nonacute inpatient stays (<u>Nonacute Inpatient Stay Value Set</u>).</li> <li>3. Identify the discharge date for the stay.</li> </ol> </li> </ul>																					
<b>Denominator exclusions</b>	<p><b>Persons with a date of death.</b> Death in the measurement period, identified using data sources determined by the organization. Method and data sources are subject to review during the HEDIS audit.</p> <p><b>Persons in hospice or using hospice services.</b> Persons who use hospice services (<u>Hospice Encounter Value Set</u>; <u>Hospice Intervention Value Set</u>) or elect to use a hospice benefit any time during the measurement period. Organizations that use the Monthly Membership Detail Data File to identify these persons must use only the run date of the file.</p>																					
<b>Denominator</b>	The initial population minus denominator exclusions.																					
<b>Numerator</b>	<p><b>Persons who had at least one LDL-C test performed in the measurement period.</b> Either of the following meets criteria:</p> <ul style="list-style-type: none"> <li>• <u>LDL C Lab Test Value Set</u>.</li> <li>• <u>LDL C Test Result or Finding Value Set</u>*†.</li> </ul> <p>The organization may use a calculated or direct LDL.</p> <p><b>Coding Guidance</b> *Do not include laboratory claims (claims with POS code 81). †Do not include codes with a modifier (<u>CPT CAT II Modifier Value Set</u>).</p>																					
<b>Summary of changes</b>	<ul style="list-style-type: none"> <li>• No changes to this measure.</li> </ul>																					
<b>Data element tables</b>	<p>Organizations that submit HEDIS data to NCQA must provide the following data elements.</p> <p><b>Table SMC-1: Data Elements for Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia</b></p> <table border="1"> <thead> <tr> <th>Metric</th> <th>Data Element</th> <th>Reporting Instructions</th> </tr> </thead> <tbody> <tr> <td>CardiovascularMonitoringSchizophrenia</td> <td>InitialPopulation</td> <td>Report once</td> </tr> <tr> <td></td> <td>Exclusions</td> <td>Report once</td> </tr> <tr> <td></td> <td>Denominator</td> <td>Report once</td> </tr> <tr> <td></td> <td>NumeratorByAdmin</td> <td>Report once</td> </tr> <tr> <td></td> <td>NumeratorBySupplemental</td> <td>Report once</td> </tr> <tr> <td></td> <td>Rate</td> <td>(Percent)</td> </tr> </tbody> </table>	Metric	Data Element	Reporting Instructions	CardiovascularMonitoringSchizophrenia	InitialPopulation	Report once		Exclusions	Report once		Denominator	Report once		NumeratorByAdmin	Report once		NumeratorBySupplemental	Report once		Rate	(Percent)
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Rules for Allowable Adjustments	<p><b>Copyright and use:</b> The “Rules for Allowable Adjustments of HEDIS” (the “Rules”) describe how NCQA’s HEDIS measure specifications can be adjusted for other populations, if applicable. The Rules, reviewed and approved by NCQA measure experts, provide for expanded use of HEDIS measures without changing their clinical intent.</p> <p><b>Adjusted HEDIS measures may not be used for HEDIS health plan reporting.</b></p> <p><b>ADJUSTMENTS ALLOWED</b></p> <ul style="list-style-type: none"><li>• <i>Product lines.</i> Organizations are not required to use product line criteria; product lines may be combined, and all (or no) product line criteria may be used.</li><li>• <i>Attribution.</i> Organizations are not required to use enrollment criteria.</li><li>• <i>Benefits.</i> Organizations are not required to use a benefit.</li><li>• <i>Other.</i> Organizations may use additional initial population criteria to focus on an area of interest defined by gender, race, ethnicity, socioeconomic or sociodemographic characteristics, geographic region or another characteristic.</li><li>• <i>Exclusions.</i> The hospice and deceased person exclusions are not required.</li><li>• <i>Telehealth.</i> Services/events that allow the use of synchronous telehealth visits, telephone visits and asynchronous telehealth (e-visits, virtual check-ins) may be stratified to identify services performed via telehealth. This adjustment is not allowed for events, numerators and exclusions that do not allow the use of telehealth.</li><li>• <i>Supplemental data.</i> Supplemental data may be used to identify initial population, denominator, exclusion and numerator events.</li></ul> <p><b>ADJUSTMENTS ALLOWED WITH LIMITS</b></p> <ul style="list-style-type: none"><li>• <i>Ages.</i> The age determination dates may be changed (e.g., select, “age as of June 30”). Changing denominator age range is allowed within a specified age range (18 years and older).</li></ul> <p><b>ADJUSTMENTS NOT ALLOWED</b></p> <ul style="list-style-type: none"><li>• <i>Initial population:</i> Event. Only events or diagnoses that contain (or map to) codes in the value sets may be used to identify visits and diagnosis. Value sets and logic may not be changed.</li><li>• <i>Numerator.</i> Value sets and logic may not be changed.</li></ul>
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## ***Adherence to Antipsychotic Medications for Individuals With Schizophrenia (SAA)***

<b>Measure title</b>	Adherence to Antipsychotic Medications for Individuals With Schizophrenia*	<b>Measure ID</b>	SAA
<b>Description</b>	The percentage of persons 18 years of age and older during the measurement period, with schizophrenia or schizoaffective disorder, who were dispensed and remained on an antipsychotic medication for at least 80% of their treatment period.		
<b>Measurement period</b>	January 1–December 31.		
<b>Copyright and disclaimer notice</b>	<p><i>*Adapted by NCQA with permission of the measure developer, CMS.</i></p> <p>Refer to the complete copyright and disclaimer information at the front of this publication.</p> <p>NCQA website: <a href="http://www.ncqa.org">www.ncqa.org</a>.</p> <p>Submit policy clarification support questions via My NCQA (<a href="https://my.ncqa.org">https://my.ncqa.org</a>).</p>		
<b>Clinical recommendation statement/ rationale</b>	Nonadherence to treatment with antipsychotics is common for people with schizophrenia, and medication nonadherence is a significant cause of relapse. Measuring antipsychotic medication adherence may lead to fewer relapses and hospitalizations. There is the potential for interventions to improve adherence and help close the gap in care between people with schizophrenia and the general population.		
<b>Citations</b>	<p>Alvarez-Jimenez, M., A. Priebe, S. E. Hetrick, S. Bendall, E. Killackey, A. G. Parker, P. D. McGorry, and J. F. Gleeson. 2012. "Risk Factors for Relapse Following Treatment for First Episode Psychosis: A Systematic Review and Meta-Analysis of Longitudinal Studies." <i>Schizophrenia Research</i> 139 (1–3): 116–28.</p> <p>Olfson, M., S.C. Marcus, and G.J. Wan. 2009. "Treatment Patterns for Schizoaffective Disorder and Schizophrenia Among Medicaid Patients." <i>Psychiatric Services</i> 60 (2): 210–16.</p>		
<b>Characteristics</b>			
<b>Scoring</b>	Proportion.		
<b>Type</b>	Process.		
<b>Product lines</b>	<ul style="list-style-type: none"> <li>• Commercial.</li> <li>• Medicaid.</li> <li>• Medicare.</li> </ul>		
<b>Stratifications</b>	None.		

<b>Risk adjustment</b>	None.
<b>Improvement notation</b>	Increased score indicates improvement.
<b>Guidance</b>	<p><b>Data collection methodology:</b> Administrative. Refer to <a href="#">General Guideline: Data Collection Methods</a> for additional information.</p> <p><b>Date specificity:</b> Dates must be specific enough to determine the event occurred in the period being measured.</p> <p><b>Which services count?</b> When using claims, include all paid, suspended, pending and denied claims.</p> <p><b>Medication lists:</b> If an organization uses both pharmacy data (NDC codes) and clinical data (RxNorm codes) for reporting, and there are both NDC and RxNorm codes on the same date of service, use only one data source for the date of service (only NDC codes or only RxNorm codes).</p> <p><b>Other guidance:</b></p> <ul style="list-style-type: none"> <li>• If an oral medication and a long-acting injection are dispensed on the same day, calculate the number of days covered by an antipsychotic medication (for the numerator) using the prescription with the longest days supply.</li> <li>• If an oral medication and long-acting injection are dispensed on different days, with some overlapping days of supply, count each day in the treatment period only once toward the numerator.</li> </ul>
<b>Definitions</b>	
<b>Calculating number of days covered for long-acting injections</b>	<p>Calculate number of days covered (for the numerator) for long-acting injections using the days supply specified for the medication in the medication list name or in the value set name.</p> <p>For multiple codes (from the value sets and medication lists) <i>for the same or different medications on the same day</i>, use the medication with the longest days supply.</p> <p>For multiple codes (from the value sets and medication lists) <i>for the same or different medications on different days</i>, with overlapping days supply, count each day in the treatment period only once toward the numerator. Count HCPCS code J2798 (a direct reference code) as a 30-days supply.</p>
<b>Calculating number of days covered for oral medications</b>	<p>If multiple prescriptions for the same or different oral medications are dispensed on the same day, calculate number of days covered by an antipsychotic medication (for the numerator) using the prescription with the longest days supply.</p> <p>If multiple prescriptions for different oral medications are dispensed on different days, count each day in the treatment period only once toward the numerator.</p> <p>If multiple prescriptions for the same oral medication are dispensed on different days, sum the days supply and use the total to calculate the number of days covered by an antipsychotic medication (for the numerator).</p>

	<ul style="list-style-type: none"> <li>• <i>For example</i>, if three antipsychotic prescriptions for the same oral medication are dispensed on different days, each with a 30-day supply; sum the days supply for a total of 90 days covered by an oral antipsychotic (even if there is overlap).</li> </ul> <p>Use the medication lists to determine if drugs are the same or different. Drugs in different lists are considered different drugs. If multiple prescriptions for the same oral medication are dispensed on different days, sum the days supply and use the total to calculate the number of days covered by an antipsychotic medication (for the numerator).</p>
<b>IPSD</b>	Index prescription start date. The earliest prescription dispensing date for any antipsychotic medication during the measurement period.
<b>Long-acting injections dispensing event</b>	Injections count as one dispensing event. Multiple codes (from the value sets and medication lists) for the same or different medication on the same day count as a single dispensing event.
<b>Oral medication dispensing event</b>	<p>One prescription of an amount lasting 30 days or less. To calculate dispensing events for prescriptions longer than 30 days, divide the days supply by 30 and round down to convert.</p> <ul style="list-style-type: none"> <li>• <i>For example</i>, a 100-days prescription is equal to three dispensing events.</li> </ul> <p>Multiple prescriptions for different medications dispensed on the same day count as separate dispensing events. If multiple prescriptions for the same medication are dispensed on the same day, use the prescription with the longest days supply. Use the medication lists to determine if drugs are the same or different. Drugs in different lists are considered different drugs.</p>
<b>PDC</b>	Proportion of days covered. The number of days a person is covered by at least one antipsychotic medication prescription, divided by the number of days in the treatment period.
<b>Treatment period</b>	The period beginning on the PSD through the last day of the measurement period.
<b>Initial population</b>	<p><b>Measure item count:</b> Person.</p> <p><b>Attribution basis:</b> Enrollment.</p> <ul style="list-style-type: none"> <li>• <b>Benefits:</b> Medical and pharmacy.</li> <li>• <b>Continuous enrollment:</b> The measurement period.</li> <li>• <b>Allowable gap:</b> No more than one gap of ≤45 days during the continuous enrollment period. No gaps on the last day of the measurement period.</li> </ul> <p><b>Ages:</b> 18 years of age and older as of the start of the measurement period.</p> <p><b>Event: Persons with a diagnosis of schizophrenia or schizoaffective disorder.</b></p> <p>Identify persons with schizophrenia or schizoaffective disorder as those who met at least one of the following criteria during the measurement period:</p> <ul style="list-style-type: none"> <li>• At least one acute inpatient encounter with any diagnosis of schizophrenia or schizoaffective disorder. Either of the following combinations meets criteria:</li> </ul>

- BH Stand Alone Acute Inpatient Value Set **with** Schizophrenia Value Set.
- Visit Setting Unspecified Value Set **with** Acute Inpatient POS Value Set **with** Schizophrenia Value Set.
- At least two visits in an outpatient, intensive outpatient, partial hospitalization, ED or nonacute inpatient setting, on different dates of service, with any diagnosis of schizophrenia or schizoaffective disorder. Two of any of the following meets criteria:
  - An outpatient visit with any diagnosis of schizophrenia or schizoaffective disorder (Visit Setting Unspecified Value Set with Outpatient POS Value Set with Schizophrenia Value Set).
  - An outpatient visit with any diagnosis of schizophrenia or schizoaffective disorder (BH Outpatient Value Set with Schizophrenia Value Set).
  - An intensive outpatient encounter or partial hospitalization with any diagnosis of schizophrenia or schizoaffective disorder (Visit Setting Unspecified Value Set with POS code 52 with Schizophrenia Value Set).
  - An intensive outpatient encounter or partial hospitalization with any diagnosis of schizophrenia or schizoaffective disorder (Partial Hospitalization or Intensive Outpatient Value Set with Schizophrenia Value Set).
  - A community mental health center visit with any diagnosis of schizophrenia or schizoaffective disorder (Visit Setting Unspecified Value Set with POS code 53 with Schizophrenia Value Set).
  - Electroconvulsive therapy (Electroconvulsive Therapy Value Set) **with** any diagnosis of schizophrenia or schizoaffective disorder (Schizophrenia Value Set).
  - An ED visit (ED Value Set) **with** any diagnosis of schizophrenia or schizoaffective disorder (Schizophrenia Value Set).
  - An ED visit with any diagnosis of schizophrenia or schizoaffective disorder (Visit Setting Unspecified Value Set with POS code 23 with Schizophrenia Value Set).
  - A nonacute inpatient encounter (BH Stand Alone Nonacute Inpatient Value Set) **with** any diagnosis of schizophrenia or schizoaffective disorder (Schizophrenia Value Set).
  - A nonacute inpatient encounter with any diagnosis of schizophrenia or schizoaffective disorder (Visit Setting Unspecified Value Set with Nonacute Inpatient POS Value Set with Schizophrenia Value Set).
  - A telehealth visit with any diagnosis of schizophrenia or schizoaffective disorder (Visit Setting Unspecified Value Set with Telehealth POS Value Set with Schizophrenia Value Set).
  - A telephone visit (Telephone Visits Value Set) **with** any diagnosis of schizophrenia or schizoaffective disorder (Schizophrenia Value Set).
  - An e-visit or virtual check-in (Online Assessments Value Set) **with** any diagnosis of schizophrenia or schizoaffective disorder (Schizophrenia Value Set).

<p><b>Denominator exclusions</b></p>	<p><b>Persons with a date of death.</b> Death in the measurement period, identified using data sources determined by the organization. Method and data sources are subject to review during the HEDIS audit.</p> <p><b>Persons in hospice or using hospice services.</b> Persons who use hospice services (<u>Hospice Encounter Value Set</u>; <u>Hospice Intervention Value Set</u>) or elect to use a hospice benefit any time during the measurement period. Organizations that use the Monthly Membership Detail Data File to identify these persons must use only the run date of the file.</p> <p><b>Medicare enrollees, 66 years of age and older by the last day of the measurement period, in an institutional SNP (I-SNP) or living long-term in an institution (LTI).</b></p> <ul style="list-style-type: none"> <li>• Enrolled in an Institutional SNP (I-SNP) any time during the measurement period.</li> <li>• Living long-term in an institution any time during the measurement period as identified by the LTI flag in the Monthly Membership Detail Data File. Use the run date of the file to determine if a member had an LTI flag during the measurement period.</li> </ul> <p><b>Persons 66–80 years of age by the last day of the measurement period, with both frailty and advanced illness.</b></p> <ol style="list-style-type: none"> <li>1. <b>Frailty.</b> At least two indications of frailty (<u>Frailty Device Value Set</u>; <u>Frailty Diagnosis Value Set*</u>; <u>Frailty Encounter Value Set</u>; <u>Frailty Symptom Value Set*</u>) with different dates of service during the measurement period.</li> <li>2. <b>Advanced Illness.</b> Either of the following during the measurement period or the year prior to the measurement period: <ul style="list-style-type: none"> <li>– Advanced illness (<u>Advanced Illness Value Set*</u>) on at least two different dates of service.</li> <li>– Dispensed dementia medication (<u>Dementia Medications List</u>).</li> </ul> </li> </ol> <p><b>Persons 81 years of age and older by the last day of the measurement period, with frailty.</b> At least two indications of frailty (<u>Frailty Device Value Set</u>; <u>Frailty Diagnosis Value Set*</u>; <u>Frailty Encounter Value Set</u>; <u>Frailty Symptom Value Set*</u>), with different dates of service during the measurement period.</p> <p><b>Persons with dementia.</b> A diagnosis of dementia (<u>Dementia Value Set*</u>) during the measurement period.</p> <p><b>Persons who did not have at least two antipsychotic medication dispensing events.</b> Either of the following meets criteria:</p> <ul style="list-style-type: none"> <li>• <i>Claim/encounter data.</i> An antipsychotic medication (HCPCS code J2798; <u>Long Acting Injections 14 Days Supply Value Set</u>; <u>Long Acting Injections 28 Days Supply Value Set</u>).</li> <li>• <i>Pharmacy data.</i> Dispensed an antipsychotic medication. Use all the medication lists in the Oral Antipsychotic Medications and Long-Acting Injections tables below to identify antipsychotic medication dispensing events.</li> </ul>
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	<p><b>Oral Antipsychotic Medications</b></p> <table border="0"> <tr><td><a href="#">Aripiprazole Oral Medications List</a></td><td><a href="#">Paliperidone Oral Medications List</a></td></tr> <tr><td><a href="#">Asenapine Oral Medications List</a></td><td><a href="#">Quetiapine Oral Medications List</a></td></tr> <tr><td><a href="#">Brexpiprazole Oral Medications List</a></td><td><a href="#">Risperidone Oral Medications List</a></td></tr> <tr><td><a href="#">Cariprazine Oral Medications List</a></td><td><a href="#">Ziprasidone Oral Medications List</a></td></tr> <tr><td><a href="#">Clozapine Oral Medications List</a></td><td><a href="#">Chlorpromazine Oral Medications List</a></td></tr> <tr><td><a href="#">Haloperidol Oral Medications List</a></td><td><a href="#">Fluphenazine Oral Medications List</a></td></tr> <tr><td><a href="#">Iloperidone Oral Medications List</a></td><td><a href="#">Perphenazine Oral Medications List</a></td></tr> <tr><td><a href="#">Loxapine Oral Medications List</a></td><td><a href="#">Prochlorperazine Oral Medications List</a></td></tr> <tr><td><a href="#">Lumateperone Oral Medications List</a></td><td><a href="#">Thioridazine Oral Medications List</a></td></tr> <tr><td><a href="#">Lurasidone Oral Medications List</a></td><td><a href="#">Trifluoperazine Oral Medications List</a></td></tr> <tr><td><a href="#">Molindone Oral Medications List</a></td><td><a href="#">Amitriptyline Perphenazine Oral Medications List</a></td></tr> <tr><td><a href="#">Olanzapine Oral Medications List</a></td><td><a href="#">Thiothixene Oral Medications List</a></td></tr> </table> <p><b>Long-Acting Injections</b></p> <table border="0"> <tr><td><a href="#">Long Acting Injections 14 Days Supply Medications List</a></td><td><a href="#">Long Acting Injections 35 Days Supply Medications List</a></td></tr> <tr><td><a href="#">Long Acting Injections 28 Days Supply Medications List</a></td><td><a href="#">Long Acting Injections 104 Days Supply Medications List</a></td></tr> <tr><td><a href="#">Long Acting Injections 30 Days Supply Medications List</a></td><td><a href="#">Long Acting Injections 201 Days Supply Medications List</a></td></tr> </table>	<a href="#">Aripiprazole Oral Medications List</a>	<a href="#">Paliperidone Oral Medications List</a>	<a href="#">Asenapine Oral Medications List</a>	<a href="#">Quetiapine Oral Medications List</a>	<a href="#">Brexpiprazole Oral Medications List</a>	<a href="#">Risperidone Oral Medications List</a>	<a href="#">Cariprazine Oral Medications List</a>	<a href="#">Ziprasidone Oral Medications List</a>	<a href="#">Clozapine Oral Medications List</a>	<a href="#">Chlorpromazine Oral Medications List</a>	<a href="#">Haloperidol Oral Medications List</a>	<a href="#">Fluphenazine Oral Medications List</a>	<a href="#">Iloperidone Oral Medications List</a>	<a href="#">Perphenazine Oral Medications List</a>	<a href="#">Loxapine Oral Medications List</a>	<a href="#">Prochlorperazine Oral Medications List</a>	<a href="#">Lumateperone Oral Medications List</a>	<a href="#">Thioridazine Oral Medications List</a>	<a href="#">Lurasidone Oral Medications List</a>	<a href="#">Trifluoperazine Oral Medications List</a>	<a href="#">Molindone Oral Medications List</a>	<a href="#">Amitriptyline Perphenazine Oral Medications List</a>	<a href="#">Olanzapine Oral Medications List</a>	<a href="#">Thiothixene Oral Medications List</a>	<a href="#">Long Acting Injections 14 Days Supply Medications List</a>	<a href="#">Long Acting Injections 35 Days Supply Medications List</a>	<a href="#">Long Acting Injections 28 Days Supply Medications List</a>	<a href="#">Long Acting Injections 104 Days Supply Medications List</a>	<a href="#">Long Acting Injections 30 Days Supply Medications List</a>	<a href="#">Long Acting Injections 201 Days Supply Medications List</a>
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<b>Denominator</b>	The initial population minus denominator exclusions.																														
<b>Numerator</b>	<p><b>Persons who achieved a PDC of at least 80% for their antipsychotic medications during the measurement period.</b></p> <p>Follow the steps below to identify numerator compliance. Use HCPCS code J2798, <a href="#">Long Acting Injections 14 Days Supply Value Set</a>, <a href="#">Long Acting Injections 28 Days Supply Value Set</a> and all the medication lists in the Oral Antipsychotic Medications and Long-Acting Injections tables above to identify antipsychotic medication dispensing events.</p> <p><b>Step 1.</b> Identify the PSD.</p> <p><b>Step 2.</b> Determine the treatment period.</p> <p><b>Step 3.</b> Count the days covered by at least one antipsychotic medications during the treatment period. To ensure that days supply that extend beyond the measurement period are not counted, subtract any days supply that extends beyond December 31 of the measurement period.</p> <p><b>Step 4.</b> Calculate the person's PDC using the following equation. Multiply the equation by 100 and round (using the .5 rule) to the nearest whole number.</p> <ul style="list-style-type: none"> <li>• <i>For example</i>, if a person has 291 total days covered by a medication during a 365-day treatment period, this calculates to 0.7972. Multiply this number by 100, convert it to 79.72% and round it to 80%, the nearest whole number.</li> </ul>																														

	<p>Total Days Covered by an Antipsychotic Medication in the Treatment Period (step 3)</p> <p>Total Days in Treatment Period (step 2)</p> <p><b>Step 5.</b> Sum the number of persons whose PDC is ≥80% for their treatment period.</p>																								
<b>Summary of changes</b>	<ul style="list-style-type: none"> <li>No changes to this measure.</li> </ul>																								
<b>Data element tables</b>	<p>Organizations that submit HEDIS data to NCQA must provide the following data elements.</p> <p><b>Table SAA-1/2/3: Data Elements for Adherence to Antipsychotic Medications for Individuals With Schizophrenia</b></p> <table border="1"> <thead> <tr> <th>Metric</th><th>Data Element</th><th>Reporting Instructions</th></tr> </thead> <tbody> <tr> <td>AdherenceAntipsychoticsSchizophrenia</td><td>Benefit</td><td>Metadata</td></tr> <tr> <td></td><td>InitialPopulation</td><td>Report once</td></tr> <tr> <td></td><td>Exclusions</td><td>Report once</td></tr> <tr> <td></td><td>Denominator</td><td>Report once</td></tr> <tr> <td></td><td>NumeratorByAdmin</td><td>Report once</td></tr> <tr> <td></td><td>NumeratorBySupplemental</td><td>Report once</td></tr> <tr> <td></td><td>Rate</td><td>(Percent)</td></tr> </tbody> </table>	Metric	Data Element	Reporting Instructions	AdherenceAntipsychoticsSchizophrenia	Benefit	Metadata		InitialPopulation	Report once		Exclusions	Report once		Denominator	Report once		NumeratorByAdmin	Report once		NumeratorBySupplemental	Report once		Rate	(Percent)
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<b>Rules for Allowable Adjustments</b>	<p><b>Copyright and use:</b> The “Rules for Allowable Adjustments of HEDIS” (the “Rules”) describe how NCQA’s HEDIS measure specifications can be adjusted for other populations, if applicable. The Rules, reviewed and approved by NCQA measure experts, provide for expanded use of HEDIS measures without changing their clinical intent.</p> <p><b>Adjusted HEDIS measures may not be used for HEDIS health plan reporting.</b></p> <p><b>ADJUSTMENTS ALLOWED</b></p> <ul style="list-style-type: none"> <li><b>Product lines.</b> Organizations are not required to use product line criteria; product lines may be combined, and all (or no) product line criteria may be used.</li> <li><b>Attribution.</b> Organizations are not required to use enrollment criteria.</li> <li><b>Benefits.</b> Organizations are not required to use a benefit.</li> <li><b>Other.</b> Organizations may use additional initial population criteria to focus on an area of interest defined by gender, race, ethnicity, socioeconomic or sociodemographic characteristics, geographic region or another characteristic.</li> <li><b>Measurement period adjustments.</b> Organizations may adjust the measurement period.</li> <li><b>Exclusions.</b> The hospice, deceased persons, I-SNP, LTI, frailty and advanced illness exclusions are not required.</li> </ul>																								

- *Telehealth.* Services/events that allow the use of synchronous telehealth visits, telephone visits and asynchronous telehealth (e-visits, virtual check-ins) may be stratified to identify services performed via telehealth. This adjustment is not allowed for events, numerators and exclusions that do not allow the use of telehealth.
- *Supplemental data.* Supplemental data may be used to identify initial population, denominator, exclusion and numerator events.

#### **ADJUSTMENTS ALLOWED WITH LIMITS**

- *Ages.* Age determination dates may be changed (e.g., select, "age as of June 30"). Changing the denominator age range is allowed within a specified age range (18 years of age and older).

#### **ADJUSTMENTS NOT ALLOWED**

- *Initial population:* Event. Only events or diagnoses that contain (or map to) codes in the value sets may be used to identify visits and diagnosis. Medication lists, value sets and logic may not be changed.
- *Exclusions.* The dementia and antipsychotic medication exclusions must be applied. Value sets and medication lists may not be changed.
- *Numerator.* Value sets and medication lists and logic may not be changed.

## ***Care Coordination***

## Advance Care Planning (ACP)

Measure title	Advance Care Planning	Measure ID	ACP
<b>Description</b>	The percentage of persons 66–80 years of age with advanced illness, an indication of frailty or who are receiving palliative care, and persons 81 years of age and older who had advance care planning during the measurement period.		
<b>Measurement period</b>	January 1–December 31.		
<b>Copyright and disclaimer notice</b>	<p>Refer to the complete copyright and disclaimer information at the front of this publication.</p> <p>NCQA website: <a href="http://www.ncqa.org">www.ncqa.org</a>.</p> <p>Submit policy clarification support questions via My NCQA (<a href="https://my.ncqa.org">https://my.ncqa.org</a>).</p>		
<b>Clinical recommendation statement/ rationale</b>	<p>Advance care planning can lead to decreased psychological distress and hospitalizations, improved end-of-life care, increased trust in providers and improved quality of life, and can facilitate hope. It has also been associated with increased knowledge about treatment options, documentation of advance care planning, patient-surrogate congruence, goal-concordant care and compliance with patient wishes, among other benefits.</p> <p>Although it is widely agreed that advance care planning is a critical part of patient care, only about 50% of older adults have engaged in advance care planning. Of those older adults, about one-third have documented their wishes and only 10%–20% have discussed their wishes with clinicians. A 2017 study found that 70% of providers indicated they only have advance care planning conversations with patients experiencing advanced illness. The benefits of advance care planning may only be realized if the care team has access to and follows the patient's advance care plan.</p>		
<b>Citations</b>	<p>Bires, J.L., E.F. Franklin, H.M. Nichols, &amp; J.G. Cagle. 2018. "Advance Care Planning Communication: Oncology Patients and Providers Voice their Perspectives." <i>Journal of Cancer Education</i> 33(5), 1140–7. <a href="https://doi.org/10.1007/s13187-017-1225-4">https://doi.org/10.1007/s13187-017-1225-4</a></p> <p>Bischoff, K.E., R. Sudore, Y. Miao, W.J. Boscardin, &amp; A.K. Smith. 2013. "Advance Care Planning and the Quality of End-of-Life Care in Older Adults." <i>Journal of the American Geriatrics Society</i> 61(2), 209–14. <a href="https://doi.org/10.1111/jgs.12105">https://doi.org/10.1111/jgs.12105</a></p> <p>Martin, R.S., B. Hayes, K. Gregorevic, &amp; W.K. Lim. 2016. "The Effects of Advance Care Planning Interventions on Nursing Home Residents: A Systematic Review." <i>Journal of the American Medical Directors Association</i> 17(4), 284–93. <a href="https://doi.org/10.1016/j.jamda.2015.12.017">https://doi.org/10.1016/j.jamda.2015.12.017</a></p> <p>McMahan, R.D., I. Tellez, &amp; R.L. Sudore. 2021. "Deconstructing the Complexities of Advance Care Planning Outcomes: What Do We Know and Where Do We Go? A Scoping Review." <i>Journal of the American Geriatrics Society</i> 69(1), 234–244. <a href="https://doi.org/10.1111/jgs.16801">https://doi.org/10.1111/jgs.16801</a></p>		

	<p>Rosenberg, A.R., B. Popp, D.S. Dizon, A. El-Jawahri, &amp; R. Spence. 2020. "Now, More Than Ever, Is the Time for Early and Frequent Advance Care Planning." <i>Journal of Clinical Oncology</i> JCO.20.01080. <a href="https://doi.org/10.1200/JCO.20.01080">https://doi.org/10.1200/JCO.20.01080</a></p> <p>Yadav, K.N., N.B. Gabler, E. Cooney, S. Kent, J. Kim, N. Herbst, A. Mante, S.D. Halpern, &amp; K.R. Courtright. 2017. "Approximately One in Three US Adults Completes Any Type of Advance Directive for End-Of-Life Care." <i>Health Affairs</i> 36(7), 1244–51. <a href="https://doi.org/10.1377/hlthaff.2017.0175">https://doi.org/10.1377/hlthaff.2017.0175</a></p>
<b>Characteristics</b>	
<b>Scoring</b>	Proportion.
<b>Type</b>	Process.
<b>Product lines</b>	Medicare.
<b>Stratifications</b>	None.
<b>Risk adjustment</b>	None.
<b>Improvement notation</b>	Increased score indicates improvement.
<b>Guidance</b>	<p><b>Data collection methodology:</b> Administrative. Refer to <a href="#">General Guideline: Data Collection Methods</a> for additional information.</p> <p><b>Date specificity:</b> Dates must be specific enough to determine the event occurred in the period being measured.</p> <p><b>Which services count?</b> When using claims, include all paid, suspended, pended and denied claims.</p>
<b>Definitions</b>	
<b>Advance care planning</b>	A discussion or documentation about preferences for resuscitation, life-sustaining treatment and end of life care.
<b>Initial population</b>	<p><b>Measure item count:</b> Person.</p> <p><b>Attribution basis:</b> Enrollment.</p> <ul style="list-style-type: none"> <li>• <b>Benefits:</b> Medical.</li> <li>• <b>Continuous enrollment:</b> The measurement period.</li> <li>• <b>Allowable gap:</b> No more than one gap of ≤45 days during the measurement period. No gaps on the last day of the measurement period.</li> </ul> <p><b>Ages:</b> 66 years of age and older as of the last day of the measurement period.</p> <p><b>Event:</b></p> <p><b>Step 1.</b> Include persons 66–80 years of age as of the last day of the measurement period who meet any of the following criteria:</p>

	<ul style="list-style-type: none"> <li>• <b>Advanced illness.</b> Either of the following during the measurement period:           <ul style="list-style-type: none"> <li>– Advanced illness (<a href="#">Advanced Illness Value Set*</a>) on at least two different dates of service.</li> <li>– Dispensed dementia medication (<a href="#">Dementia Medications List</a>).</li> </ul> </li> <li>• <b>Frailty.</b> An indication of frailty (<a href="#">Frailty Device Value Set*</a>; <a href="#">Frailty Diagnosis Value Set*</a>; <a href="#">Frailty Encounter Value Set*</a>; <a href="#">Frailty Symptom Value Set*</a>) during the measurement period.</li> <li>• <b>Palliative care.</b> Persons receiving palliative care (<a href="#">Palliative Care Assessment Value Set</a>; <a href="#">Palliative Care Encounter Value Set</a>; <a href="#">Palliative Care Intervention Value Set</a>) or who had an encounter for palliative care (ICD-10-CM code Z51.5*) any time during the measurement period.</li> </ul> <p><b>Step 2.</b> Include all persons 81 years of age and older, as of the last day of the measurement period.</p> <p><b>Coding Guidance</b> *Do not include laboratory claims (claims with POS code 81).</p>
<b>Denominator exclusions</b>	<p><b>Persons with a date of death.</b> Death in the measurement period, identified using data sources determined by the organization. Method and data sources are subject to review during the HEDIS audit.</p> <p><b>Persons in hospice or using hospice services.</b> Persons who use hospice services (<a href="#">Hospice Encounter Value Set</a>; <a href="#">Hospice Intervention Value Set</a>) or elect to use a hospice benefit any time during the measurement period. Organizations that use the Monthly Membership Detail Data File to identify these persons must use only the run date of the file.</p>
<b>Denominator</b>	The initial population minus denominator exclusions.
<b>Numerator</b>	<p><b>Advance care planning.</b> Evidence of advance care planning during the measurement period (<a href="#">Advance Care Planning Value Set*†</a>).</p> <p><b>Coding Guidance</b> *Do not include laboratory claims (claims with POS code 81). †Do not include codes with a modifier (<a href="#">CPT CAT II Modifier Value Set</a>).</p>
<b>Summary of changes</b>	<ul style="list-style-type: none"> <li>• No changes to this measure.</li> </ul>

<b>Data element tables</b>	<p>Organizations that submit HEDIS data to NCQA must provide the following data elements.</p> <p><b>Table ACP-3: Data Elements for Advance Care Planning</b></p> <table border="1" data-bbox="491 333 1470 656"> <thead> <tr> <th>Metric</th><th>Data Element</th><th>Reporting Instructions</th></tr> </thead> <tbody> <tr> <td>AdvanceCarePlanning</td><td>InitialPopulation</td><td>Report once</td></tr> <tr> <td></td><td>Exclusions</td><td>Report once</td></tr> <tr> <td></td><td>Denominator</td><td>Report once</td></tr> <tr> <td></td><td>NumeratorByAdmin</td><td>Report once</td></tr> <tr> <td></td><td>NumeratorBySupplemental</td><td>Report once</td></tr> <tr> <td></td><td>Rate</td><td>(Percent)</td></tr> </tbody> </table>	Metric	Data Element	Reporting Instructions	AdvanceCarePlanning	InitialPopulation	Report once		Exclusions	Report once		Denominator	Report once		NumeratorByAdmin	Report once		NumeratorBySupplemental	Report once		Rate	(Percent)
Metric	Data Element	Reporting Instructions																				
AdvanceCarePlanning	InitialPopulation	Report once																				
	Exclusions	Report once																				
	Denominator	Report once																				
	NumeratorByAdmin	Report once																				
	NumeratorBySupplemental	Report once																				
	Rate	(Percent)																				
<b>Rules for Allowable Adjustments</b>	<p><b>Copyright and use:</b> The “Rules for Allowable Adjustments of HEDIS” (the “Rules”) describe how NCQA’s HEDIS measure specifications can be adjusted for other populations, if applicable. The Rules, reviewed and approved by NCQA measure experts, provide for expanded use of HEDIS measures without changing their clinical intent.</p> <p><b>Adjusted HEDIS measures may not be used for HEDIS health plan reporting.</b></p> <p><b>ADJUSTMENTS ALLOWED</b></p> <ul style="list-style-type: none"> <li>• <b>Product lines.</b> Organizations are not required to use product line criteria; product lines may be combined, and all (or no) product line criteria may be used.</li> <li>• <b>Attribution.</b> Organizations are not required to use enrollment criteria.</li> <li>• <b>Benefits.</b> Organizations are not required to use a benefit.</li> <li>• <b>Other.</b> Organizations may use additional initial population criteria to focus on an area of interest defined by gender, race, ethnicity, socioeconomic or sociodemographic characteristics, geographic region or another characteristic.</li> <li>• <b>Measurement period adjustments.</b> Organizations may adjust the measurement period.</li> <li>• <b>Exclusions.</b> The hospice and deceased person exclusions are not required.</li> <li>• <b>Telehealth.</b> Services/events that allow the use of synchronous telehealth visits, telephone visits and asynchronous telehealth (e-visits, virtual check-ins) may be stratified to identify services performed via telehealth. This adjustment is not allowed for events, numerators and exclusions that do not allow the use of telehealth.</li> <li>• <b>Supplemental data.</b> Supplemental data may be used to identify initial population, denominator, exclusion and numerator events.</li> </ul> <p><b>ADJUSTMENTS ALLOWED WITH LIMITS</b></p> <ul style="list-style-type: none"> <li>• <b>Ages.</b> The age determination dates may be changed (e.g., select “age as of June 30”). Expanding the denominator age range to 18 years and older is allowed.</li> </ul>																					

**ADJUSTMENTS NOT ALLOWED**

- *Initial population:* Event. Medication lists, value sets and logic may not be changed.
- *Numerator.* Value sets and logic may not be changed.

## Transitions of Care (TRC)

Measure title	Transitions of Care	Measure ID	TRC
<b>Description</b>	<p>The percentage of discharges for persons 18 years of age and older who had each of the following. Four rates are reported:</p> <ol style="list-style-type: none"> <li>1. <i>Notification of Inpatient Admission.</i> Documentation of receipt of notification of inpatient admission on the day of admission through 2 days after the admission (3 total days).</li> <li>2. <i>Receipt of Discharge Information.</i> Documentation of receipt of discharge information on the day of discharge through 2 days after the discharge (3 total days).</li> <li>3. <i>Patient Engagement After Inpatient Discharge.</i> Documentation of patient engagement (e.g., office visits, visits to the home, telehealth) provided within 30 days after discharge.</li> <li>4. <i>Medication Reconciliation Post-Discharge.</i> Documentation of medication reconciliation on the date of discharge through 30 days after discharge (31 total days).</li> </ol>		
<b>Measurement period</b>	January 1–December 31.		
<b>Copyright and disclaimer notice</b>	<p>Refer to the complete copyright and disclaimer information at the front of this publication.  NCQA website: <a href="http://www.ncqa.org">www.ncqa.org</a>.  Submit policy clarification support questions via My NCQA (<a href="https://my.ncqa.org">https://my.ncqa.org</a>).</p>		
<b>Clinical recommendation statement/ rationale</b>	<p>Transitions from an inpatient setting to home often result in poor care coordination, including communication lapses between inpatient and outpatient providers; intentional and unintentional medication changes; incomplete diagnostic work-ups; and inadequate beneficiary, caregiver and provider understanding of diagnoses, medication and follow-up needs. Poor hospital transitions are not only associated with poor health outcomes, but also with increased health care utilization and cost, including duplicate medical services, medication errors and increased emergency department visits and readmissions.</p> <p>Effective care coordination efforts must include notifying patients' primary care practitioners (PCP) of admission, PCP receipt of meaningful and timely discharge information, patient engagement through follow-up provided post-discharge and medication reconciliation post-discharge.</p>		
<b>Citations</b>	<p>Rennke, S., O.K. Nguyen, M.H. Shoeb, Y. Magan, R.M. Wachter and S.R. Ranji. 2013. "Hospital-Initiated Transitional Care as a Patient Safety Strategy: A Systematic Review." <i>Annals of Internal Medicine</i> 158(5, Pt. 2), 433–40.</p>		

	<p>Sato, M., T. Shaffer, A.I. Arbaje and I.H. Zuckerman. 2011. "Residential and Health Care Transition Patterns Among Older Medicare Beneficiaries Over Time." <i>The Gerontologist</i> 51(2), 170–8.</p> <p>Centers for Disease Control and Prevention (CDC). 2010. <i>Number, Rate, and Average Length of Stay for Discharges From Short-Stay Hospitals, by Age, Region, and Sex: United States, 2010</i>.</p> <p>Kripalani, S., A.T. Jackson, J.L. Schnipper and E.A. Coleman. 2007. "Promoting Effective Transitions of Care at Hospital Discharge: A Review of Key Issues for Hospitalists." <i>Journal of Hospital Medicine</i> 2(5).</p>
<b>Characteristics</b>	
<b>Scoring</b>	Proportion.
<b>Type</b>	Process.
<b>Product lines</b>	Medicare.
<b>Stratifications</b>	Age as of the last day of the measurement period. <ul style="list-style-type: none"> <li>• 18–64 years.</li> <li>• 65 years and older.</li> </ul>
<b>Risk adjustment</b>	None.
<b>Improvement notation</b>	Increased score indicates improvement.
<b>Guidance</b>	<p><b>Data collection methodology:</b> Administrative and hybrid. Refer to the <a href="#">General Guideline: Data Collection Methods</a> for additional information.</p> <p><b>Date specificity:</b> Dates must be specific enough to determine the event occurred in the period being measured.</p> <p><b>Which services count?</b> When using claims, include all paid, suspended, pending and denied claims.</p> <p><b>Other guidance:</b></p> <ul style="list-style-type: none"> <li>• The measure is based on episodes; therefore, it is possible for the denominator to include multiple events for the same person.</li> <li>• Refer to <a href="#">Appendix 1</a> for the definition of PCP and <i>ongoing care provider</i>.</li> <li>• The denominator is based on the discharge date found in administrative/claims data, but organizations may use other systems (including data found during medical record review) to identify data errors and make corrections. <ul style="list-style-type: none"> <li>– If the organization chooses to use a different discharge date found in the medical record, it must assess all indicators using that date, including those that were previously compliant based on administrative data.</li> </ul> </li> </ul>

<b>Definitions</b>	
<b>Medication list</b>	A list of medications in the medical record. May include medication names only, or may include dosages, frequency, over-the-counter (OTC) medications and herbal or supplemental therapies.
<b>Medication reconciliation</b>	A type of review in which the discharge medications are reconciled with the most recent medication list in the outpatient medical record.
<b>Initial population</b>	<p><i>Measure item count:</i> Episode.</p> <p><i>Attribution basis:</i> Enrollment.</p> <ul style="list-style-type: none"> <li>• <b>Benefits:</b> Medical.</li> <li>• <b>Continuous enrollment:</b> Date of discharge through 30 days after discharge (31 days total).</li> <li>• <b>Allowable gap:</b> None.</li> </ul> <p><b>Ages:</b> 18 years of age and older as of the last day of the measurement period.</p> <p><b>Event: Acute and nonacute inpatient discharges.</b></p> <p>An acute or nonacute inpatient discharge on or between January 1 and December 1 of the measurement period.</p> <p>To identify acute and nonacute inpatient discharges:</p> <ol style="list-style-type: none"> <li>1. Identify all acute and nonacute inpatient stays (<u>Inpatient Stay Value Set</u>).</li> <li>2. Identify the discharge date for the stay.</li> </ol> <p><b>Observation stays that precede the inpatient stay.</b></p> <p>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.</p> <p><b>Readmission or direct transfer.</b></p> <p>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:</p> <ol style="list-style-type: none"> <li>1. Identify all acute and nonacute inpatient stays (<u>Inpatient Stay Value Set</u>).</li> <li>2. Identify the admission date for the stay (the admission date must occur during the 31-day period).</li> <li>3. Identify the discharge date for the stay (the discharge date is the event date).</li> </ol> <p>Exclude both the initial and the readmission/direct transfer discharge if the last discharge occurs after December 1 of the measurement period.</p> <p>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.</p>

	<p>To identify acute inpatient discharges:</p> <ol style="list-style-type: none"> <li>1. Identify all acute and nonacute inpatient stays (<a href="#">Inpatient Stay Value Set</a>).</li> <li>2. Exclude nonacute inpatient stays (<a href="#">Nonacute Inpatient Stay Value Set</a>).</li> <li>3. Identify the admission date for the stay.</li> <li>4. Identify the discharge date for the stay.</li> </ol> <p>To identify nonacute inpatient discharges:</p> <ol style="list-style-type: none"> <li>1. Identify all acute and nonacute inpatient stays (<a href="#">Inpatient Stay Value Set</a>).</li> <li>2. Confirm the stay was for nonacute care based on the presence of a nonacute code (<a href="#">Nonacute Inpatient Stay Value Set</a>).</li> <li>3. Identify the admission date for the stay.</li> <li>4. Identify the discharge date for the stay.</li> </ol> <p><b>Note:</b> If a person remains in an acute or nonacute facility through December 1 of the measurement period, the discharge is not included in the measure, but the organization must have a method for identifying the person's status for the remainder of the measurement period, and may not assume the person remained admitted based only on the absence of a discharge before December 1.</p> <p>If the organization is unable to confirm the person remained in the acute or nonacute care setting through December 1, disregard the readmission or direct transfer and use the initial discharge date.</p>
<b>Denominator exclusions</b>	<p><b>Persons with a date of death.</b> Death in the measurement period, identified using data sources determined by the organization. Method and data sources are subject to review during the HEDIS audit.</p> <p><b>Persons in hospice or using hospice services.</b> Persons who use hospice services (<a href="#">Hospice Encounter Value Set</a>; <a href="#">Hospice Intervention Value Set</a>) or elect to use a hospice benefit any time during the measurement period. Organizations that use the Monthly Membership Detail Data File to identify these persons must use only the run date of the file.</p>
<b>Denominator</b>	<p><b>ADMINISTRATIVE</b> The initial population minus denominator exclusions.</p> <p><b>HYBRID</b> A systematic sample drawn from the administrative denominator. The denominator is based on discharges; therefore, persons may appear more than once in the sample. Organizations may reduce the sample size based only on the prior year's audited, product line-specific rate for the lowest rate of all TRC indicators. Refer to the <a href="#">Guidelines for Calculations and Sampling</a> for information on reducing the sample size.</p>

<b>Numerator</b>	<p><b>ADMINISTRATIVE</b></p> <p><b>Numerator 1: Notification of inpatient admission.</b> Administrative reporting is not available.</p> <p><b>Numerator 2: Receipt of discharge information.</b> Administrative reporting is not available.</p> <p><b>Numerator 3: Patient engagement after inpatient discharge.</b> Patient engagement within 30 days after discharge. Do not include engagement on the date of discharge. Either of the following meets criteria:</p> <ul style="list-style-type: none"> <li>• An outpatient visit, telephone visit, e-visit or virtual check-in (<u>Outpatient and Telehealth Value Set</u>).</li> <li>• Transitional care management services (<u>Transitional Care Management Services Value Set</u>).</li> </ul> <p><b>Numerator 4: Medication reconciliation post-discharge.</b> Medication reconciliation (<u>Medical Reconciliation Encounter Value Set</u>, <u>Medication Reconciliation Intervention Value Set</u>) 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).</p> <p><b>Coding Guidance</b> †Do not include codes with a modifier (<u>CPT CAT II Modifier Value Set</u>).</p> <p><b>HYBRID</b></p> <p><b>Administrative:</b> Refer to administrative specifications to identify positive numerator hits from administrative data. Administrative reporting is not available for numerators 1 and 2.</p> <p><b>Identifying the medical record.</b> Documentation in any outpatient medical record that is accessible to the PCP or ongoing care provider is eligible for use in reporting.</p> <p><b>Numerator 1: Notification of inpatient admission.</b> Documentation of receipt of notification of inpatient admission on the day of admission or on the day of admission through 2 days after the admission (3 total days).</p> <p><b>Medical record:</b> Documentation in the outpatient medical record must include evidence of receipt of notification of inpatient admission on the day of admission through 2 days after the admission (3 total days). Evidence that the information was integrated in the appropriate medical record and is accessible to the PCP or ongoing care provider on the day of admission through 2 days after admission (3 total days) meets criteria.</p> <p>Documentation in the outpatient medical record must include evidence of receipt of notification of inpatient admission that includes evidence of the date when the documentation was received. Any of the following examples meet criteria:</p> <ul style="list-style-type: none"> <li>• Communication between inpatient providers or staff and the PCP or ongoing care provider (e.g., phone call, email, fax).</li> <li>• Communication about admission between emergency department and the PCP or ongoing care provider (e.g., phone call, email, fax).</li> </ul>
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	<ul style="list-style-type: none"> <li>• Communication about admission with the PCP or ongoing care provider, through a health information exchange or automated admission discharge transfer (ADT) alert system.</li> <li>• Communication about admission with the PCP or ongoing care provider through a shared electronic medical record (EMR) system. Evidence that the information was integrated in the EMR and is accessible to the PCP or ongoing care provider on the day of admission through 2 days after the admission (3 total days) meets criteria.</li> <li>• Communication about admission with the PCP or ongoing care provider from the health plan.</li> <li>• Indication that the PCP or ongoing care provider admitted the person to the hospital.</li> <li>• Indication that a specialist admitted the person to the hospital and notified the PCP or ongoing care provider.</li> <li>• Indication that the PCP or ongoing care provider placed orders for tests and treatments any time during the inpatient stay.</li> <li>• Documentation that the PCP or ongoing care provider performed a preadmission exam or received communication about a planned inpatient admission. <ul style="list-style-type: none"> <li>– The time frame for communicating the planned inpatient admission is not limited to the day of admission through 2 days after the admission (3 total days); documentation that the PCP or ongoing care provider performed a preadmission exam or received notification of a planned admission prior to the admission date also meets criteria.</li> <li>– The planned admission documentation or preadmission exam must clearly pertain to the denominator event.</li> </ul> </li> </ul> <p><b>Note:</b> When an ED visit results in an inpatient admission, notification that a provider sent the person to the ED does not meet criteria. Evidence that the PCP or ongoing care provider communicated with the ED about the admission meets criteria.</p> <p><b>Numerator 2: Receipt of discharge information.</b>  Documentation of receipt of discharge information on the day of discharge through 2 days after the discharge (3 total days).</p> <p><b>Medical record:</b> Documentation of receipt of discharge information in the outpatient medical record on the day of discharge through 2 days after the discharge (3 total days), with evidence of the date when the documentation was received. Evidence that the information was integrated in the appropriate medical record and is accessible to the PCP or ongoing care provider on the day of discharge through 2 days after the discharge (3 total days) meets criteria.</p> <p>Discharge information may be included in, but not limited to, a discharge summary or summary of care record, or in structured fields in an EHR. Discharge information must include all of the following:</p> <ul style="list-style-type: none"> <li>• The practitioner responsible for the person's care during the inpatient stay.</li> <li>• Procedures or treatment provided.</li> </ul>
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- Diagnoses at discharge.
- Current medication list.
- Testing results, or documentation of pending tests or no tests pending.
- Instructions for patient care post-discharge.

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

*Evidence that the information was integrated in the EMR and is accessible to the PCP or ongoing care provider on the day of discharge through 2 days after the discharge (3 total days) meets criteria.*

**Numerator 3: Patient engagement after inpatient discharge.**

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

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

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

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

**Numerator 4: Medication reconciliation post-discharge.**

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

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

- Documentation of a current medication list, with a notation that the provider reconciled current and discharge medications.
- Documentation of a current medication list, with a notation that references discharge medications (e.g., no changes in medications since discharge, same medications at discharge, discontinue all discharge medications).
- Documentation of a current medication list, with a notation that discharge medications were reviewed.
- Documentation of a current medication list and discharge medication list, with a notation that both lists were reviewed on the same date.

	<ul style="list-style-type: none"> <li>• Documentation of a current medication list, with evidence that the person was seen for post-discharge hospital follow-up with evidence of medication reconciliation or review.             <ul style="list-style-type: none"> <li>– Evidence of post-discharge hospital follow-up requires documentation that indicates the provider was aware of the hospitalization and/or discharge.</li> </ul> </li> <li>• Documentation in the discharge summary that discharge medications were reconciled with the most recent medication list in the outpatient medical record.             <ul style="list-style-type: none"> <li>– There must be evidence that the discharge summary was filed in the outpatient chart on the date of discharge through 30 days after discharge (31 total days).</li> </ul> </li> <li>• Notation that no medications were prescribed or ordered upon discharge.</li> </ul> <p><b>Note</b></p> <ul style="list-style-type: none"> <li>• <i>The following notations or examples of documentation do not count as numerator compliant:</i> <ul style="list-style-type: none"> <li>– <i>Notification of Inpatient Admission and Receipt of Discharge Information:</i> <ul style="list-style-type: none"> <li>▪ Documentation that the person or the person's family notified the person's PCP or ongoing care provider of the admission or discharge.</li> <li>▪ Documentation of notification that does not include a time frame or date when the documentation was received.</li> </ul> </li> <li>– <i>Medication Reconciliation Post-Discharge:</i> <ul style="list-style-type: none"> <li>▪ The following examples (without a reference to "hospitalization," "admission" or "inpatient stay") are not considered evidence that the provider was aware of the person's hospitalization or discharge:               <ul style="list-style-type: none"> <li>• Documentation of "post-op/surgery follow-up."</li> <li>• Documentation only of a procedure that is typically inpatient (e.g. open-heart surgery).</li> <li>• Documentation indicating that the visit was with the same provider who admitted the person or who performed the surgery.</li> </ul> </li> </ul> </li> <li>• <i>The Medication Reconciliation Post-Discharge numerator assesses whether medication reconciliation occurred. It does not attempt to assess the quality of the medication list documented in the medical record or the process used to document the most recent medication list in the medical record.</i></li> <li>• <i>A medication reconciliation performed without the person present meets criteria.</i></li> </ul> </li> </ul>
<b>Summary of changes</b>	<ul style="list-style-type: none"> <li>• No changes to this measure.</li> </ul>

<b>Data element tables</b>	Organizations that submit HEDIS data to NCQA must provide the following data elements.				
<b>Table TRC-3: Data Elements for Transitions of Care</b>					
Metric	Age	Data Element	Reporting Instructions	A	
MedicationReconciliationPostDischarge	18-64	CollectionMethod	For each Metric, repeat per Stratification	✓	
PatientEngagementAfterInpatientDischarge	65+	InitialPopulation*	For each Metric and Stratification	✓	
NotificationInpatientAdmission	Total	Exclusions*†	For each Metric and Stratification	✓	
ReceiptDischargeInformation		Denominator*	For each Stratification, repeat per Metric	✓	
		NumeratorByAdminDenom†	For each Metric and Stratification		
		CYART	Only for Total (Percent)		
		MinReqSampleSize	For each Metric, repeat per Stratification		
		OversampleRate	For each Metric, repeat per Stratification		
		OversampleRecordsNumber	(Count)		
		ExclusionValidDataErrors	For each Metric, repeat per Stratification		
		ExclusionEmployeeOrDep	For each Metric, repeat per Stratification		
		OversampleRecsAdded	For each Metric, repeat per Stratification		
		NumeratorByAdmin†	For each Metric and Stratification	✓	
		NumeratorByMedicalRecords	For each Metric and Stratification		
		NumeratorBySupplemental	For each Metric and Stratification	✓	
		Rate	(Percent)	✓	

\*Repeat the InitialPopulation, Exclusions and Denominator values for metrics using the administrative method.

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

<b>Rules for Allowable Adjustments</b>	<p><b>Copyright and use:</b> The “Rules for Allowable Adjustments of HEDIS” (the “Rules”) describe how NCQA’s HEDIS measure specifications can be adjusted for other populations, if applicable. The Rules, reviewed and approved by NCQA measure experts, provide for expanded use of HEDIS measures without changing their clinical intent.</p> <p><b>Adjusted HEDIS measures may not be used for HEDIS health plan reporting.</b></p> <p><b>The Rules do not apply to the hybrid portion of the measure; only the administrative sections may be changed.</b></p> <p><b>ADJUSTMENTS ALLOWED</b></p> <ul style="list-style-type: none"> <li>• <i>Product lines.</i> Organizations are not required to use product line criteria; product lines may be combined, and all (or no) product line criteria may be used.</li> <li>• <i>Attribution.</i> Organizations are not required to use enrollment criteria.</li> <li>• <i>Benefits.</i> Organizations are not required to use a benefit.</li> <li>• <i>Other.</i> Organizations may use additional initial population criteria to focus on an area of interest defined by gender, race, ethnicity, socioeconomic or sociodemographic characteristics, geographic region or another characteristic.</li> <li>• <i>Measurement period adjustments.</i> Organizations may adjust the measurement period.</li> <li>• <i>Exclusions.</i> The hospice and deceased person exclusions are not required.</li> <li>• <i>Telehealth.</i> Services/events that allow the use of synchronous telehealth visits, telephone visits and asynchronous telehealth (e-visits, virtual check-ins) may be stratified to identify services performed via telehealth. This adjustment is not allowed for events, numerators and exclusions that do not allow the use of telehealth.</li> <li>• <i>Supplemental data.</i> Supplemental data may be used to identify initial population, denominator, exclusion and numerator events.</li> </ul> <p><b>ADJUSTMENTS ALLOWED WITH LIMITS</b></p> <ul style="list-style-type: none"> <li>• <i>Initial population:</i> Event. Organizations may assess at the person level (vs. discharge level) by applying measure logic appropriately (i.e., percentage of persons with documentation of medication reconciliation after each discharge). Only events that contain (or map to) codes in the value sets may be used to identify the initial population for each rate. The value sets and logic may not be changed.</li> </ul> <p><b>ADJUSTMENTS NOT ALLOWED</b></p> <ul style="list-style-type: none"> <li>• <i>Numerators:</i> Notification of inpatient admission, receipt of discharge information. Allowable adjustments are not permitted for the components of this measure.</li> <li>• <i>Numerators:</i> Patient engagement after inpatient discharge, medication reconciliation post-discharge. Value sets and logic may not be changed.</li> </ul>
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## **Follow-Up After Emergency Department Visit for People With Multiple High-Risk Chronic Conditions (FMC)**

<b>Measure title</b>	Follow-Up After Emergency Department Visit for People With Multiple High-Risk Chronic Conditions	<b>Measure ID</b>	FMC
<b>Description</b>	The percentage of emergency department (ED) visits for persons 18 years of age and older who have multiple high-risk chronic conditions who had a follow-up service within 7 days of the ED visit.		
<b>Measurement period</b>	January 1–December 31.		
<b>Copyright and disclaimer notice</b>	<p>Refer to the complete copyright and disclaimer information at the front of this publication.</p> <p>NCQA website: <a href="http://www.ncqa.org">www.ncqa.org</a>.</p> <p>Submit policy clarification support questions via My NCQA (<a href="https://my.ncqa.org">https://my.ncqa.org</a>).</p>		
<b>Clinical recommendation statement/ rationale</b>	<p>Patients with multiple high-risk chronic conditions (MCC) often receive care from multiple providers and settings and are more likely to experience fragmented care and adverse health care outcomes, including an increased likelihood of ED visits. Poor care coordination following an ED visit for patients with MCC increases the risk of medication errors, repeat ED visits, hospitalizations, nursing home admissions and death.</p> <p>Medicare beneficiaries with MCCs are some of the heaviest users of high-cost, preventable services such as those offered by the ED.</p>		
<b>Citations</b>	<p>Agency for Healthcare Quality and Research (AHRQ). 2012. “Coordinating Care for Adults with Complex Care Needs in the Patient-Centered Medical Home: Challenges and Solutions.” <a href="https://pcmh.ahrq.gov/sites/default/files/attachments/coordinating-care-for-adults-with-complex-care-needs-white-paper.pdf">https://pcmh.ahrq.gov/sites/default/files/attachments/coordinating-care-for-adults-with-complex-care-needs-white-paper.pdf</a></p> <p>Coleman, E.A., R.A. Berenson. 2004. “Lost in Transition: Challenges and Opportunities for Improving the Quality of Transitional Care.” <i>Annals of Internal Medicine</i> 141(7).</p> <p>Dunnion, M.E., and B. Kelly. 2005. “From the Emergency Department to Home.” <i>Journal of Clinical Nursing</i> 14(6), 776–85.</p>		
<b>Characteristics</b>			
<b>Scoring</b>	Proportion.		
<b>Type</b>	Process.		
<b>Product lines</b>	Medicare.		
<b>Stratifications</b>	<p>Age as of the ED visit.</p> <ul style="list-style-type: none"> <li>• 18–64 years.</li> <li>• 65 years and older.</li> </ul>		

<b>Risk adjustment</b>	None.
<b>Improvement notation</b>	Increased score indicates improvement.
<b>Guidance</b>	<p><b>Data collection methodology:</b> Administrative. Refer to <a href="#">General Guideline: Data Collection Methods</a> for additional information.</p> <p><b>Date specificity:</b> Dates must be specific enough to determine the event occurred in the period being measured.</p> <p><b>Which services count?</b> When using claims, include all paid, suspended, pending and denied claims.</p> <p><b>Other guidance:</b> The measure is based on episodes; therefore, it is possible for the denominator to include multiple events for the same person.</p>
<b>Initial population</b>	<p><b>Measure item count:</b> Episode.</p> <p><b>Attribution basis:</b> Enrollment.</p> <ul style="list-style-type: none"> <li>• <b>Benefits:</b> Medical.</li> <li>• <b>Continuous enrollment:</b> 365 days prior to the ED visit through 7 days after the ED visit.</li> <li>• <b>Allowable gap:</b> No more than one gap of ≤45 days during the 365 days prior to the ED visit. No gaps on the date of the ED visit through the 7 days following the visit.</li> </ul> <p><b>Ages:</b> 18 years of age or older as of the ED visit.</p> <p><b>Event:</b> ED visits for persons who have multiple high-risk chronic conditions.</p> <p><b>Step 1.</b> Identify all ED visits (<a href="#">ED Value Set</a>) on or between January 1 and December 24 of the measurement period.</p> <p><b>Step 2.</b> 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.</p> <p>To identify admissions to an acute or nonacute inpatient care setting:</p> <ol style="list-style-type: none"> <li>1. Identify all acute and nonacute inpatient stays (<a href="#">Inpatient Stay Value Set</a>).</li> <li>2. Identify the admission date for the stay.</li> </ol> <p><b>Step 3.</b> Identify ED visits where the person had a chronic condition prior to the ED visit.</p> <p>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):</p> <ul style="list-style-type: none"> <li>• COPD, asthma or unspecified bronchitis (<a href="#">Asthma, COPD and Unspecified Bronchitis Value Set</a>).</li> <li>• Alzheimer's disease and related disorders (<a href="#">Dementia Value Set; Frontotemporal Dementia Value Set</a>).</li> <li>• Chronic kidney disease (<a href="#">Chronic Kidney Disease Value Set</a>).</li> </ul>

- Depression ([Major Depression Value Set](#); [Dysthymic Disorder Value Set](#)).
- Heart failure ([Heart Failure and Cardiomyopathy 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 persons who had any of the following during the measurement period or the year prior to the measurement period, but prior to the ED visit:

- 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. Exclude nonacute inpatient stays ([Nonacute Inpatient Stay Value Set](#)).
  3. Identify the discharge date for the stay.

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

**Step 4.** Identify ED visits where the person had two or more different chronic conditions prior to the ED visit, that meet the criteria included in step 3. These are eligible ED visits.

**Step 5.** Only include the first ED visit with there are multiple visits in 8-day period. If there is more than one ED visit in an 8-day period, include only the first eligible ED visit.

	<ul style="list-style-type: none"> <li>For example, for an eligible ED visit on January 1, include the January 1 visit and do not include ED visits that occur on or between January 2 and January 8. Then, if applicable, include the next eligible ED visit that occurs on or after January 9. Identify visits chronologically, including only one visit per 8-day period.</li> </ul>
<b>Denominator exclusions</b>	<p><b>Persons with a date of death.</b> Death in the measurement period, identified using data sources determined by the organization. Method and data sources are subject to review during the HEDIS audit.</p> <p><b>Persons in hospice or using hospice services.</b> Persons who use hospice services (<a href="#">Hospice Encounter Value Set</a>; <a href="#">Hospice Intervention Value Set</a>) or elect to use a hospice benefit any time during the measurement period. Organizations that use the Monthly Membership Detail Data File to identify these persons must use only the run date of the file.</p>
<b>Denominator</b>	The initial population minus denominator exclusions.
<b>Numerator</b>	<p><b>7-day follow-up.</b> Include visits that occur on the date of the ED visit through 7 days after the ED visit (8 total days).</p> <p>Any of the following meet criteria for a follow-up service.</p> <ul style="list-style-type: none"> <li>An outpatient visit, telephone visit, e-visit or virtual check-in (<a href="#">Outpatient and Telehealth Value Set</a>).</li> <li>Transitional care management services (<a href="#">Transitional Care Management Services Value Set</a>).</li> <li>Case management visits (<a href="#">Case Management Encounter Value Set</a>).</li> <li>Complex Care Management Services (<a href="#">Complex Care Management Services Value Set</a>).</li> <li>An outpatient or telehealth behavioral health visit (<a href="#">Visit Setting Unspecified Value Set with Outpatient POS Value Set</a>).</li> <li>An outpatient or telehealth behavioral health visit (<a href="#">BH Outpatient Value Set</a>).</li> <li>An intensive outpatient encounter or partial hospitalization (<a href="#">Visit Setting Unspecified Value Set with POS code 52</a>).</li> <li>An intensive outpatient encounter or partial hospitalization (<a href="#">Partial Hospitalization or Intensive Outpatient Value Set</a>).</li> <li>A community mental health center visit (<a href="#">Visit Setting Unspecified Value Set with POS code 53</a>).</li> <li>Electroconvulsive therapy (<a href="#">Electroconvulsive Therapy Value Set</a>) <b>with</b> (<a href="#">Outpatient POS Value Set</a>; POS code 24; POS code 52; POS code 53).</li> <li>A telehealth visit (<a href="#">Visit Setting Unspecified Value Set with Telehealth POS Value Set</a>).</li> <li>A substance use disorder service (<a href="#">Substance Use Disorder Services Value Set</a>).</li> <li>Substance use disorder counseling and surveillance (<a href="#">Substance Abuse Counseling and Surveillance Value Set*</a>).</li> </ul>

	<p><b>Coding Guidance</b> *Do not include laboratory claims (claims with POS code 81).</p>																								
<b>Summary of changes</b>	<ul style="list-style-type: none"> <li>Revised the allowable gap language to not allow a gap in enrollment on the date of the ED visit.</li> </ul>																								
<b>Data element tables</b>	<p>Organizations that submit HEDIS data to NCQA must provide the following data elements.</p> <p><b>Table FMC-3: Data Elements for Follow-Up After Emergency Department Visit for People With High-Risk Multiple Chronic Conditions</b></p> <table border="1"> <thead> <tr> <th>Metric</th> <th>Age</th> <th>Data Element</th> <th>Reporting Instructions</th> </tr> </thead> <tbody> <tr> <td rowspan="2">FollowUp7Day</td> <td>18-64</td> <td>InitialPopulation</td> <td>For each Stratification</td> </tr> <tr> <td>65+</td> <td>Exclusions</td> <td>For each Stratification</td> </tr> <tr> <td rowspan="4"></td> <td>Total</td> <td>Denominator</td> <td>For each Stratification</td> </tr> <tr> <td></td> <td>NumeratorByAdmin</td> <td>For each Stratification</td> </tr> <tr> <td></td> <td>NumeratorBySupplemental</td> <td>For each Stratification</td> </tr> <tr> <td></td> <td>Rate</td> <td>(Percent)</td> </tr> </tbody> </table>	Metric	Age	Data Element	Reporting Instructions	FollowUp7Day	18-64	InitialPopulation	For each Stratification	65+	Exclusions	For each Stratification		Total	Denominator	For each Stratification		NumeratorByAdmin	For each Stratification		NumeratorBySupplemental	For each Stratification		Rate	(Percent)
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<b>Rules for Allowable Adjustments</b>	<p><b>Copyright and use:</b> The “Rules for Allowable Adjustments of HEDIS” (the “Rules”) describe how NCQA’s HEDIS measure specifications can be adjusted for other populations, if applicable. The Rules, reviewed and approved by NCQA measure experts, provide for expanded use of HEDIS measures without changing their clinical intent.</p> <p><b>Adjusted HEDIS measures may not be used for HEDIS health plan reporting.</b></p> <p><b>ADJUSTMENTS ALLOWED</b></p> <ul style="list-style-type: none"> <li><b>Product lines.</b> Organizations are not required to use product line criteria; product lines may be combined, and all (or no) product line criteria may be used.</li> <li><b>Ages.</b> The denominator age range may be expanded. The age determination dates may be changed (e.g., select, “age as of June 30”).</li> <li><b>Attribution.</b> Organizations are not required to use enrollment criteria.</li> <li><b>Benefits.</b> Organizations are not required to use a benefit.</li> <li><b>Other.</b> Organizations may use additional initial population criteria to focus on an area of interest defined by gender, race, ethnicity, socioeconomic or sociodemographic characteristics, geographic region or another characteristic.</li> <li><b>Measurement period adjustments.</b> Organizations may adjust the measurement period.</li> <li><b>Exclusions.</b> The hospice and deceased person exclusions are not required.</li> </ul>																								

- *Telehealth.* Services/events that allow the use of synchronous telehealth visits, telephone visits and asynchronous telehealth (e-visits, virtual check-ins) may be stratified to identify services performed via telehealth. This adjustment is not allowed for events, numerators and exclusions that do not allow the use of telehealth.
- *Supplemental data.* Supplemental data may be used to identify initial population, denominator, exclusion and numerator events.

**ADJUSTMENTS ALLOWED WITH LIMITS**

- *Initial population:* Event. Organizations may assess at the person level by applying measure logic appropriately (i.e., percentage of persons with multiple high-risk chronic conditions, with documentation of an emergency department visit, who had a follow-up visit within 7 days). Only events or diagnoses that contain (or map to) codes in the value sets may be used to identify visits with a diagnosis. The value sets and logic may not be changed.

**ADJUSTMENTS NOT ALLOWED**

- *Numerator.* Value sets and logic may not be changed.

## ***Overuse/Appropriateness***

## Non-Recommended PSA-Based Screening in Older Men (PSA)

Measure title	Non-Recommended PSA-Based Screening in Older Men*	Measure ID	PSA
<b>Description</b>	The percentage of men 70 years and older who were screened unnecessarily for prostate cancer using prostate-specific antigen (PSA)-based screening.		
<b>Measurement period</b>	January 1–December 31.		
<b>Copyright and disclaimer notice</b>	<p>* Adapted with financial support from the Centers for Medicare &amp; Medicaid Services.</p> <p>Refer to the complete copyright and disclaimer information at the front of this publication.</p> <p>NCQA website: <a href="http://www.ncqa.org">www.ncqa.org</a>.</p> <p>Submit policy clarification support questions via My NCQA (<a href="https://my.ncqa.org">https://my.ncqa.org</a>).</p>		
<b>Clinical recommendation statement/ rationale</b>	<p>The U.S. Preventive Services Task Force recommends against PSA-based screening for prostate cancer in men in the general U.S. population, regardless of age (D Recommendation, 2012), concluding that the overall benefits do not outweigh the associated harms with testing, subsequent diagnosis procedures and treatments.</p> <p>The American Urological Association recommends against routine PSA screening in men 70 years of age and older, or any man with a life expectancy of less than 10–15 years.</p>		
<b>Citations</b>	<p>U.S. Preventive Services Task Force. 2013. <i>Ann Intern Med</i> 2012;157:120–34. doi:10.7326/0003-4819-157-2-201207170-00459</p> <p>Fenton, J.J., M.S. Weyrich, S. Durbin, Y. Liu, H. Bang, and J. Melnikow. 2018. “Prostate-Specific Antigen-Based Screening for Prostate Cancer: A Systematic Evidence Review for the U.S. Preventive Services Task Force.” U.S. Preventive Services Task Force Evidence Syntheses, Formerly Systematic Evidence Reviews. Rockville (MD): Agency for Healthcare Research and Quality (US). <a href="http://www.ncbi.nlm.nih.gov/books/NBK518890/">http://www.ncbi.nlm.nih.gov/books/NBK518890/</a></p>		
<b>Characteristics</b>			
<b>Scoring</b>	Proportion.		
<b>Type</b>	Process.		
<b>Product lines</b>	Medicare.		
<b>Stratifications</b>	None.		
<b>Risk adjustment</b>	None.		

<b>Improvement notation</b> <b>Guidance</b>	<p>Decreased score indicates improvement.</p> <p><b>Data collection methodology:</b> Administrative. Refer to <a href="#">General Guideline: Data Collection Methods</a> for additional information.</p> <p><b>Date specificity:</b> Dates must be specific enough to determine the event occurred in the period being measured.</p> <p><b>Which services count?</b></p> <ul style="list-style-type: none"> <li>• Include all paid, suspended, pending and denied claims to identify the initial population and denominator exclusions.</li> <li>• Do not include denied claims when identifying numerator events; only include claims the organization paid for or expects to pay for (i.e., claims incurred but not paid).</li> </ul> <p><b>Supplemental data exceptions:</b> Supplemental data may not be used for this measure, except for denominator exclusions.</p>
<b>Initial population</b>	<p><b>Measure item count:</b> Person.</p> <p><b>Attribution basis:</b> Enrollment.</p> <ul style="list-style-type: none"> <li>• <b>Benefits:</b> Medical.</li> <li>• <b>Continuous enrollment:</b> The measurement period.</li> <li>• <b>Allowable gap:</b> No more than one gap of ≤45 days during the measurement period. No gaps on the last day of the measurement period.</li> </ul> <p><b>Ages:</b> 70 years of age and older as of the last day of the measurement period.</p> <p><b>Gender/sex criteria:</b></p> <ul style="list-style-type: none"> <li>• Administrative Gender of Male (AdministrativeGender code male) any time in the person's history.</li> </ul> <p><b>Event:</b> None.</p>
<b>Denominator exclusions</b>	<p><b>Persons with a date of death.</b> Death in the measurement period, identified using data sources determined by the organization. Method and data sources are subject to review during the HEDIS audit.</p> <p><b>Persons in hospice or using hospice services.</b> Persons who use hospice services (<a href="#">Hospice Encounter Value Set</a>; <a href="#">Hospice Intervention Value Set</a>) or elect to use a hospice benefit any time during the measurement period. Organizations that use the Monthly Membership Detail Data File to identify these persons must use only the run date of the file.</p> <p><b>Persons with a diagnosis or event for which PSA-based testing is clinically appropriate.</b> Any of the following meet criteria:</p> <ul style="list-style-type: none"> <li>• Prostate cancer diagnosis (<a href="#">Prostate Cancer and History of Prostate Cancer Value Set*</a>) any time during the person's history through the last day of the measurement period.</li> </ul>

	<ul style="list-style-type: none"> <li>Dysplasia of the prostate (<a href="#">Prostate Dysplasia Value Set*</a>) any time during the measurement period or the year prior to the measurement period.</li> <li>A PSA test (<a href="#">PSA Lab Test Exclusion Value Set</a>) during the year prior to the measurement period where laboratory data indicate an elevated result (&gt;4.0 nanograms/milliliter [ng/mL]).</li> <li>An abnormal PSA test result or finding (<a href="#">Abnormal PSA Test Result or Finding Value Set</a>) during the year prior to the measurement period.</li> <li>Dispensed prescription for a 5-alpha reductase inhibitor (<a href="#">5 ARI Medications List</a>) during the measurement period.</li> </ul> <p><b>Coding Guidance</b> *Do not include laboratory claims (claims with POS code 81).</p>														
<b>Denominator</b>	The initial population minus denominator exclusions.														
<b>Numerator</b>	<p><b>PSA-based screening test.</b> A PSA-based screening test (<a href="#">PSA Lab Test Value Set</a>; <a href="#">PSA Test Result or Finding Value Set</a>) performed during the measurement period.</p>														
<b>Summary of changes</b>	<ul style="list-style-type: none"> <li>Added an administrative gender code to the initial population.</li> </ul>														
<b>Data element tables</b>	<p>Organizations that submit HEDIS data to NCQA must provide the following data elements.</p> <p><b>Table PSA-3: Data Elements for Non-Recommended PSA-Based Screening in Older Men</b></p> <table border="1"> <thead> <tr> <th>Metric</th> <th>Data Element</th> <th>Reporting Instructions</th> </tr> </thead> <tbody> <tr> <td rowspan="5">NonRecommendedPSAScreening</td> <td>InitialPopulation</td> <td>Report once</td> </tr> <tr> <td>Exclusions</td> <td>Report once</td> </tr> <tr> <td>Denominator</td> <td>Report once</td> </tr> <tr> <td>NumeratorByAdmin</td> <td>Report once</td> </tr> <tr> <td>Rate</td> <td>(Percent)</td> </tr> </tbody> </table>	Metric	Data Element	Reporting Instructions	NonRecommendedPSAScreening	InitialPopulation	Report once	Exclusions	Report once	Denominator	Report once	NumeratorByAdmin	Report once	Rate	(Percent)
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- *Benefits.* Organizations are not required to use a benefit.
- *Other.* Organizations may use additional initial population criteria to focus on an area of interest defined by gender, race, ethnicity, socioeconomic or sociodemographic characteristics, geographic region or another characteristic.
- *Measurement period adjustments.* Organizations may adjust the measurement period.
- *Exclusions.* The hospice and deceased person exclusions are not required.
- *Telehealth.* Services/events that allow the use of synchronous telehealth visits, telephone visits and asynchronous telehealth (e-visits, virtual check-ins) may be stratified to identify services performed via telehealth. This adjustment is not allowed for events, numerators and exclusions that do not allow the use of telehealth.
- *Supplemental data.* Supplemental data may be used to identify initial population, denominator, exclusion and numerator events.

#### **ADJUSTMENTS ALLOWED WITH LIMITS**

- *Ages.* The age determination dates may be changed (e.g., select “age as of June 30”). Changing the denominator age range is allowed if the limits are within the specified age range (70 years and older). The denominator age may not be expanded.
- *Exclusions.* The diagnosis or event for which PSA-based testing is clinically appropriate exclusions must be applied. Value sets and logic may not be changed.
- *Numerator.* Value sets and logic may not be changed. Organizations may include denied claims to calculate the numerator.

## **Appropriate Treatment for Upper Respiratory Infection (URI)**

<b>Measure title</b>	Appropriate Treatment for Upper Respiratory Infection	<b>Measure ID</b>	URI
<b>Description</b>	The percentage of episodes for persons 3 months of age and older with a diagnosis of upper respiratory infection (URI) that did not result in an antibiotic dispensing event.		
<b>Measurement period</b>	January 1–December 31.		
<b>Copyright and disclaimer notice</b>	<p>Refer to the complete copyright and disclaimer information at the front of this publication.</p> <p>NCQA website: <a href="http://www.ncqa.org">www.ncqa.org</a>.</p> <p>Submit policy clarification support questions via My NCQA (<a href="https://my.ncqa.org">https://my.ncqa.org</a>).</p>		
<b>Clinical recommendation statement/ rationale</b>	<p>The common cold (or URI) is a frequent reason for patients visiting the doctor's office. Though existing clinical guidelines do not support the use of antibiotics for the common cold, physicians often prescribe them for this ailment. Clinical practice guidelines do not recommend antibiotics for a majority of URIs because of the viral etiology of these infections, including the common cold. A performance measure of antibiotic use for URI sheds light on the prevalence of inappropriate antibiotic prescribing in clinical practice and raises awareness of the importance of reducing inappropriate antibiotic use to combat antibiotic resistance in the community.</p>		
<b>Citations</b>	<p>Sur, D.K.C., &amp; M.L. Plesa. 2022. "Antibiotic Use in Acute Upper Respiratory Tract Infections." <i>Am Fam Physician</i> 106(6):628–36.</p> <p>Kimberlin, D.W., R. Banerjee, E.D. Barnett, et al. 2024. "Principles of Appropriate Use of Antimicrobial Therapy for Upper Respiratory Tract Infections." In: D.W. Kimberlin, R. Banerjee, E.D. Barnett, R. Lynfield, M.H. Sawyer, eds. <i>Red Book: 2024–2027 Report of the Committee on Infectious Diseases</i>. 33rd ed. Committee on Infectious Diseases, American Academy of Pediatrics.</p>		
<b>Characteristics</b>			
<b>Scoring</b>	Proportion.		
<b>Type</b>	Process.		
<b>Product lines</b>	<ul style="list-style-type: none"> <li>• Commercial.</li> <li>• Medicaid.</li> <li>• Medicare.</li> </ul>		
<b>Stratifications</b>	<p>Age as of the episode date.</p> <ul style="list-style-type: none"> <li>• 3 months–17 years.</li> <li>• 18–64 years.</li> <li>• 65 years and older.</li> </ul>		

<b>Risk adjustment</b>	None.
<b>Improvement notation</b>	Increased score indicates improvement.
<b>Guidance</b>	<p><b>Data collection methodology:</b> Administrative. Refer to <a href="#">General Guideline: Data Collection Methods</a> for additional information.</p> <p><b>Date specificity:</b> Dates must be specific enough to determine the event occurred in the period being measured.</p> <p><b>Which services count?</b></p> <ul style="list-style-type: none"> <li>Include all paid, suspended, pending and denied claims to identify the initial population and denominator exclusions.</li> <li>Do not include denied claims when identifying numerator events; only include claims the organization paid for or expects to pay for (i.e., claims incurred but not paid).</li> </ul> <p><b>Supplemental data exceptions:</b> Supplemental data may not be used for this measure, except for denominator exclusions.</p> <p><b>Other guidance:</b></p> <ul style="list-style-type: none"> <li>Reported as an inverted rate [1 – (numerator/denominator)]. A higher rate indicates appropriate treatment (i.e., the proportion of episodes that did not result in an antibiotic dispensing event).</li> <li>The measure is based on episodes; therefore, it is possible for the denominator to include multiple events for the same person.</li> </ul>

## Definitions

<b>Episode date</b>	The date of service for any outpatient, telephone or ED visit, e-visit or virtual check-in during the intake period with a diagnosis of URI.
<b>Intake period</b>	July 1 of the year prior to the measurement period to June 30 of the measurement period. The intake period captures eligible episodes of treatment.
<b>Negative comorbid condition history</b>	A period of 365 days prior to and including the episode date when the person had no claims/encounters with a diagnosis for a comorbid condition (366 days total).
<b>Negative competing diagnosis</b>	The episode date and 3 days following the episode date when the person had no claims/encounters with a competing diagnosis.
<b>Negative medication history</b>	<p>To qualify for negative medication history, the following criteria must be met:</p> <ul style="list-style-type: none"> <li>A period of 30 days prior to the episode date when the person had no pharmacy claims for either new or refill prescriptions for a listed antibiotic drug.</li> <li>No prescriptions dispensed more than 30 days prior to the episode date that are active on the episode date.</li> </ul> <p>A prescription is considered active if the “days supply” indicated on the date when the person was dispensed the prescription is the number of days or more between that date and the relevant service date. The 30-day look-back period for pharmacy data includes the 30 days prior to the intake period.</p>

<b>Initial population</b>	<p><b>Measure item count:</b> Episode.</p> <p><b>Attribution basis:</b> Enrollment.</p> <ul style="list-style-type: none"> <li>• <b>Benefits:</b> Medical and pharmacy.</li> <li>• <b>Continuous enrollment:</b> 30 days prior to the episode date through 3 days after the episode date (34 total days).</li> <li>• <b>Allowable gap:</b> None.</li> </ul> <p><b>Ages:</b> 3 months of age or older as of the episode date.</p> <p><b>Event:</b> <b>Episodes of upper respiratory infection diagnosis.</b></p> <p><b>Step 1.</b> Identify all persons who had an outpatient visit, ED visit telephone visit, e-visit or virtual check-in (<u>Outpatient, ED and Telehealth Value Set</u>) during the intake period, with a diagnosis of URI (<u>URI Value Set</u>).</p> <p><b>Step 2.</b> Determine all URI episode dates. For each person identified in step 1, determine all outpatient, telephone or ED visits, e-visits and virtual check-ins with a URI diagnosis.</p> <p>Exclude visits that result in an inpatient stay (<u>Inpatient Stay Value Set</u>).</p> <p><b>Step 3.</b> Test for negative comorbid condition history. Remove episode dates where the person had a claim/encounter with any diagnosis for a comorbid condition (<u>Comorbid Conditions Value Set*</u>) during the 365 days prior to or on the episode date.</p> <p><b>Step 4.</b> Test for negative medication history. Remove episode dates where a new or refill prescription for an antibiotic medication (<u>AAB Antibiotic Medications List</u>) was dispensed 30 days prior to the episode date or was active on the episode date.</p> <p><b>Step 5.</b> Test for negative competing diagnosis. Remove episode dates where the person had a claim/encounter with a competing diagnosis (<u>Pharyngitis Value Set*</u>; <u>Competing Diagnosis Value Set*</u>) on or three days after the episode date.</p> <p><b>Step 6.</b> Calculate continuous enrollment.</p> <p><b>Step 7.</b> Deduplicate eligible episodes. If a person has more than one eligible episode in a 31-day period, include only the first eligible episode. For example, if a person has an eligible episode on January 1, include the January 1 visit and do not include eligible episodes that occur on or between January 2 and January 31; then, if applicable, include the next eligible episode that occurs on or after February 1. Identify visits chronologically, including only one per 31-day period.</p> <p><b>Coding Guidance</b> *Do not include laboratory claims (claims with POS code 81).</p>
<b>Denominator exclusions</b>	<p><b>Persons with a date of death.</b> Death in the measurement period, identified using data sources determined by the organization. Method and data sources are subject to review during the HEDIS audit.</p>

	<p><b>Persons in hospice or using hospice services.</b> Persons who use hospice services (<a href="#">Hospice Encounter Value Set</a>; <a href="#">Hospice Intervention Value Set</a>) or elect to use a hospice benefit any time during the measurement period. Organizations that use the Monthly Membership Detail Data File to identify these persons must use only the run date of the file.</p>																												
<b>Denominator</b>	The initial population minus denominator exclusions.																												
<b>Numerator</b>	<p><b>Antibiotic medication was dispensed.</b> Dispensed prescription for an antibiotic medication (<a href="#">AAB Antibiotic Medications List</a>) on or 3 days after the episode date.</p>																												
<b>Summary of changes</b>	<ul style="list-style-type: none"> <li>No changes to this measure.</li> </ul>																												
<b>Data element tables</b>	<p>Organizations that submit HEDIS data to NCQA must provide the following data elements.</p> <p><i>Table URI-1/23: Data Elements for Appropriate Treatment for Upper Respiratory Infection</i></p> <table border="1"> <thead> <tr> <th>Metric</th> <th>Age</th> <th>Data Element</th> <th>Reporting Instructions</th> </tr> </thead> <tbody> <tr> <td>AppropriateURITreatment</td> <td>3m-17</td> <td>Benefit</td> <td>Metadata</td> </tr> <tr> <td></td> <td>18-64</td> <td>InitialPopulation</td> <td>For each Stratification</td> </tr> <tr> <td></td> <td>65+</td> <td>Exclusions</td> <td>For each Stratification</td> </tr> <tr> <td></td> <td>Total</td> <td>Denominator</td> <td>For each Stratification</td> </tr> <tr> <td></td> <td></td> <td>NumeratorByAdmin</td> <td>For each Stratification</td> </tr> <tr> <td></td> <td></td> <td>Rate</td> <td>(Percent)</td> </tr> </tbody> </table>	Metric	Age	Data Element	Reporting Instructions	AppropriateURITreatment	3m-17	Benefit	Metadata		18-64	InitialPopulation	For each Stratification		65+	Exclusions	For each Stratification		Total	Denominator	For each Stratification			NumeratorByAdmin	For each Stratification			Rate	(Percent)
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<b>Rules for Allowable Adjustments</b>	<p><b>Copyright and use:</b> The “Rules for Allowable Adjustments of HEDIS” (the “Rules”) describe how NCQA’s HEDIS measure specifications can be adjusted for other populations, if applicable. The Rules, reviewed and approved by NCQA measure experts, provide for expanded use of HEDIS measures without changing their clinical intent.</p> <p><b>Adjusted HEDIS measures may not be used for HEDIS health plan reporting.</b></p> <p><b>ADJUSTMENTS ALLOWED</b></p> <ul style="list-style-type: none"> <li><b>Product lines.</b> Organizations are not required to use product line criteria; product lines may be combined, and all (or no) product line criteria may be used.</li> <li><b>Attribution.</b> Organizations are not required to use enrollment criteria.</li> <li><b>Benefits.</b> Organizations are not required to use a benefit.</li> <li><b>Other.</b> Organizations may use additional initial population criteria to focus on an area of interest defined by gender, race, ethnicity, socioeconomic or sociodemographic characteristics, geographic region or another characteristic.</li> </ul>																												

- *Measurement period adjustments.* Organizations may adjust the measurement period.  
**Note:** Changes to these criteria can affect how the event will be calculated using the intake period, episode date, IESD, negative medication history and negative competing diagnosis.
- *Exclusions.* The hospice and deceased person exclusions are not required.  
*Telehealth.* Services/events that allow the use of synchronous telehealth visits, telephone visits and asynchronous telehealth (e-visits, virtual check-ins) may be stratified to identify services performed via telehealth. This adjustment is not allowed for events, numerators and exclusions that do not allow the use of telehealth.

#### **ADJUSTMENTS ALLOWED WITH LIMITS**

- *Ages.* The age determination dates may be changed (e.g., select, "age as of June 30"). Changing the denominator age range is allowed if the limits are within the specified age range. The denominator age may not be expanded.
- *Numerator.* Organizations may include denied claims to calculate the numerator. Medication lists, value sets and logic may not be changed.

#### **ADJUSTMENTS NOT ALLOWED**

- *Initial population:* Event. Only events that contain (or map to) codes in the medication lists and value sets may be used to identify visits, diagnoses and medication history. Medication lists, value sets and logic may not be changed.

## **Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (AAB)**

<b>Measure title</b>	Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis	<b>Measure ID</b>	AAB
<b>Description</b>	The percentage of episodes for persons 3 months of age and older with a diagnosis of acute bronchitis/bronchiolitis that did not result in an antibiotic dispensing event.		
<b>Measurement period</b>	January 1–December 31.		
<b>Copyright and disclaimer notice</b>	<p>Refer to the complete copyright and disclaimer information at the front of this publication.</p> <p>NCQA website: <a href="http://www.ncqa.org">www.ncqa.org</a>.</p> <p>Submit policy clarification support questions via My NCQA (<a href="https://my.ncqa.org">https://my.ncqa.org</a>).</p>		
<b>Clinical recommendation statement/ rationale</b>	<p>Antibiotics are not indicated in clinical guidelines for treating patients with acute bronchitis who do not have a comorbidity or other infection for which antibiotics may be appropriate. Inappropriate antibiotic treatment of patients with acute bronchitis is of clinical concern, especially since misuse and overuse of antibiotics lead to antibiotic drug resistance. Acute bronchitis ranks among the top 10 most common outpatient illnesses in the U.S. While most acute bronchitis cases (more than 90%) have a nonbacterial cause, inappropriate antibiotic prescriptions are still common, occurring between 58%–72% of the time.</p>		
<b>Citations</b>	<p>Baillie, E.J., G. Merlo, P. Magin, et al. 2033. "Antibiotic Prescribing for Upper Respiratory Tract Infections and Acute Bronchitis: A Longitudinal Analysis of General Practitioner Trainees." <i>Fam Pract</i> 39(6):1063–9. doi:10.1093/fampra/cmac052.</p> <p>Bronchiolitis—Clinical Practice Guideline. American Academy of Family Physicians. Updated 2019. Accessed April 7, 2025. <a href="https://www.aafp.org/family-physician/patient-care/clinical-recommendations/all-clinical-recommendations/bronchiolitis.html">https://www.aafp.org/family-physician/patient-care/clinical-recommendations/all-clinical-recommendations/bronchiolitis.html</a></p> <p>Singh, A., A. Avula, E. Zahn. 2024. <i>Acute Bronchitis</i>. StatPearls Publishing.</p> <p>Snyder, R.L., L.M. King, A.L. Hersh, K.E. Fleming-Dutra. 2020. "Unnecessary Antibiotic Prescribing in Pediatric Ambulatory Care Visits for Bronchitis and Bronchiolitis in the United States, 2006–2015." <i>Infect Control Hosp Epidemiol</i> 42(5):612–15. doi:10.1017/ice.2020.1231.</p>		
<b>Characteristics</b>			
<b>Scoring Type</b>	<p>Proportion.</p> <p>Process.</p>		

<b>Product lines</b>	<ul style="list-style-type: none"> <li>Commercial.</li> <li>Medicaid.</li> <li>Medicare.</li> </ul>
<b>Stratifications</b>	<p>Age as of the episode date.</p> <ul style="list-style-type: none"> <li>3 months–17 years.</li> <li>18–64 years.</li> <li>65 years and older.</li> </ul>
<b>Risk adjustment</b>	None.
<b>Improvement notation</b>	Increased score indicates improvement.
<b>Guidance</b>	<p><b>Data collection methodology:</b> Administrative. Refer to <a href="#">General Guideline: Data Collection Methods</a> for additional information.</p> <p><b>Date specificity:</b> Dates must be specific enough to determine the event occurred in the period being measured.</p> <p><b>Which services count?</b></p> <ul style="list-style-type: none"> <li>Include all paid, suspended, pending and denied claims to identify the initial population and denominator exclusions.</li> <li>Do not include denied claims when identifying numerator events; only include claims the organization paid for or expects to pay for (i.e., claims incurred but not paid).</li> </ul> <p><b>Supplemental data exceptions:</b> Supplemental data may not be used for this measure, except for denominator exclusions.</p> <p><b>Other guidance:</b></p> <ul style="list-style-type: none"> <li>Reported as an inverted rate [1–(numerator/denominator)]. A higher rate indicates appropriate acute bronchitis/bronchiolitis treatment (i.e., the proportion for episodes that did not result in an antibiotic dispensing event).</li> <li>The measure is based on episodes; therefore, it is possible for the denominator to include multiple events for the same person.</li> </ul>
<b>Definitions</b>	
<b>Episode date</b>	The date of service for any outpatient, telephone or ED visit, e-visit or virtual check-in during the intake period with a diagnosis of acute bronchitis/bronchiolitis.
<b>Intake period</b>	July 1 of the year prior to the measurement period to June 30 of the measurement period. The intake period captures eligible episodes of treatment.
<b>Negative comorbid condition history</b>	A period of 365 days prior to and including the episode date when the person had no claims/encounters with any diagnosis for a comorbid condition (366 total days).

<b>Negative competing diagnosis</b> <b>Negative medication dispensed history</b>	<p>The episode date and 3 days following the episode date when the person had no claims/encounters with any competing diagnosis.</p> <p>To qualify for negative medication history, the following criteria must be met:</p> <ul style="list-style-type: none"> <li>• A period of 30 days prior to the episode date when the person had no pharmacy claims for either new or refill prescriptions for a listed antibiotic drug.</li> <li>• No prescriptions dispensed more than 30 days prior to the episode date that are active on the episode date.</li> </ul> <p>A prescription is considered active if the “days supply” indicated on the date when the person was dispensed the prescription is the number of days or more between that date and the relevant service date. The 30-day look-back period for pharmacy data includes the 30 days prior to the intake period.</p>
<b>Initial population</b>	<p><i>Measure item count:</i> Episode.</p> <p><i>Attribution basis:</i> Enrollment.</p> <ul style="list-style-type: none"> <li>• <b>Benefits:</b> Medical and pharmacy.</li> <li>• <b>Continuous enrollment:</b> 30 days prior to the episode date through 3 days after the episode date (34 days total).</li> <li>• <b>Allowable gap:</b> None.</li> </ul> <p><b>Ages:</b> 3 months of age or older as of the episode date.</p> <p><b>Event: Episodes of acute bronchitis/bronchiolitis diagnosis.</b></p> <p><b>Step 1.</b> Identify all persons who had an outpatient, ED, telephone or e-visit or virtual check-in visit (<u>Outpatient, ED and Telehealth Value Set</u>) during the intake period with a diagnosis of acute bronchitis/bronchiolitis (<u>Acute Bronchitis Value Set</u>).</p> <p><b>Step 2.</b> For each person identified in step 1, determine all acute bronchitis/bronchiolitis episode dates. Exclude visits that result in an inpatient stay (<u>Inpatient Stay Value Set</u>).</p> <p><b>Step 3.</b> Test for negative comorbid condition history. Remove episode dates where the person had a claim/encounter with any diagnosis for a comorbid condition (<u>Comorbid Conditions Value Set*</u>) during the 365 days prior to or on the episode date (366 days total).</p> <p><b>Step 4.</b> Test for negative medication history. Remove episode dates where a new or refill prescription for an antibiotic medication (<u>AAB Antibiotic Medications List</u>) was dispensed 30 days prior to the episode date or was active on the episode date.</p> <p><b>Step 5.</b> Test for negative competing diagnoses. Remove episode dates where the person had a claim/encounter with a competing diagnosis (<u>Pharyngitis Value Set*</u>, <u>Competing Diagnosis Value Set*</u>) on or 3 days after the episode date.</p> <p><b>Step 6.</b> Calculate continuous enrollment.</p>

	<p><b>Step 7.</b> Deduplicate eligible episodes. Identify visits chronologically, including only one per 31-day period. If a person has more than one eligible episode in a 31-day period, include only the first eligible episode.</p> <ul style="list-style-type: none"> <li>• <i>For example</i>, if a person has an eligible episode on January 1, include the January 1 visit and do not include eligible episodes that occur on or between January 2 and January 31. Then, if applicable, include the next eligible episode that occurs on or after February 1.</li> </ul> <p><b>Coding Guidance</b> *Do not include laboratory claims (claims with POS code 81).</p>																												
<b>Denominator exclusions</b>	<p><b>Persons with a date of death.</b> Death in the measurement period, identified using data sources determined by the organization. Method and data sources are subject to review during the HEDIS audit.</p> <p><b>Persons in hospice or using hospice services.</b> Persons who use hospice services (<a href="#">Hospice Encounter Value Set</a>; <a href="#">Hospice Intervention Value Set</a>) or elect to use a hospice benefit any time during the measurement period. Organizations that use the Monthly Membership Detail Data File to identify these persons must use only the run date of the file.</p>																												
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<b>Summary of changes</b>	<ul style="list-style-type: none"> <li>• No changes to this measure.</li> </ul>																												
<b>Data element tables</b>	<p>Organizations that submit HEDIS data to NCQA must provide the following data elements.</p> <p><b>Table AAB-1/2/3: Data Elements for Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis</b></p> <table border="1"> <thead> <tr> <th>Metric</th> <th>Age</th> <th>Data Element</th> <th>Reporting Instructions</th> </tr> </thead> <tbody> <tr> <td>AvoidanceAntibioticTreatment</td> <td>3m-17</td> <td>Benefit</td> <td>Metadata</td> </tr> <tr> <td></td> <td>18-64</td> <td>InitialPopulation</td> <td>For each Stratification</td> </tr> <tr> <td></td> <td>65+</td> <td>Exclusions</td> <td>For each Stratification</td> </tr> <tr> <td></td> <td>Total</td> <td>Denominator</td> <td>For each Stratification</td> </tr> <tr> <td></td> <td></td> <td>NumeratorByAdmin</td> <td>For each Stratification</td> </tr> <tr> <td></td> <td></td> <td>Rate</td> <td>(Percent)</td> </tr> </tbody> </table>	Metric	Age	Data Element	Reporting Instructions	AvoidanceAntibioticTreatment	3m-17	Benefit	Metadata		18-64	InitialPopulation	For each Stratification		65+	Exclusions	For each Stratification		Total	Denominator	For each Stratification			NumeratorByAdmin	For each Stratification			Rate	(Percent)
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<b>Rules for Allowable Adjustments</b>	<p><b>Copyright and use:</b> The “Rules for Allowable Adjustments of HEDIS” (the “Rules”) describe how NCQA’s HEDIS measure specifications can be adjusted for other populations, if applicable. The Rules, reviewed and approved by NCQA measure experts, provide for expanded use of HEDIS measures without changing their clinical intent.</p> <p><b>Adjusted HEDIS measures may not be used for HEDIS health plan reporting.</b></p>																												

	<p><b>ADJUSTMENTS ALLOWED</b></p> <ul style="list-style-type: none"> <li>• <i>Product lines.</i> Organizations are not required to use product line criteria; product lines may be combined, and all (or no) product line criteria may be used.</li> <li>• <i>Attribution.</i> Organizations are not required to use enrollment criteria.</li> <li>• <i>Benefits.</i> Organizations are not required to use a benefit.</li> <li>• <i>Other.</i> Organizations may use additional initial population criteria to focus on an area of interest defined by gender, race, ethnicity, socioeconomic or sociodemographic characteristics, geographic region or another characteristic.</li> <li>• <i>Measurement period adjustments.</i> Organizations may adjust the measurement period.</li> </ul> <p><b>Note:</b> Changes to these criteria can affect how the events/diagnoses will be calculated using the intake period, episode date, IESD, negative medication history, negative competing diagnosis, negative comorbid condition history.</p> <ul style="list-style-type: none"> <li>• <i>Exclusions.</i> The hospice and deceased person exclusions are not required.</li> <li>• <i>Telehealth.</i> Services/events that allow the use of synchronous telehealth visits, telephone visits and asynchronous telehealth (e-visits, virtual check-ins) may be stratified to identify services performed via telehealth. This adjustment is not allowed for events, numerators and exclusions that do not allow the use of telehealth.</li> <li>• <i>Supplemental data.</i> Supplemental data may be used to identify initial population, denominator, exclusion and numerator events.</li> </ul> <p><b>ADJUSTMENTS ALLOWED WITH LIMITS</b></p> <ul style="list-style-type: none"> <li>• <i>Ages.</i> The age determination dates may be changed (e.g., select, "age as of June 30"). Changing the denominator age range is allowed if the limits are within the specified age range. The denominator age may not be expanded.</li> <li>• <i>Numerator.</i> Organizations may include denied claims to calculate the numerator. Medication lists, value sets and logic may not be changed.</li> </ul> <p><b>ADJUSTMENTS NOT ALLOWED</b></p> <ul style="list-style-type: none"> <li>• <i>Initial population:</i> Event. Medication lists, value sets and logic may not be changed.</li> </ul>
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## ***Use of Imaging Studies for Low Back Pain (LBP)***

<b>Measure title</b>	Use of Imaging Studies for Low Back Pain	<b>Measure ID</b>	LBP
<b>Description</b>	The percentage of persons 18–75 years of age with a principal diagnosis of low back pain who did not have an imaging study (plain X-ray, MRI, CT scan) within 28 days of the diagnosis.		
<b>Measurement period</b>	January 1–December 31.		
<b>Copyright and disclaimer notice</b>	<p>Refer to the complete copyright and disclaimer information at the front of this publication.</p> <p>NCQA website: <a href="http://www.ncqa.org">www.ncqa.org</a>.</p> <p>Submit policy clarification support questions via My NCQA (<a href="https://my.ncqa.org">https://my.ncqa.org</a>).</p>		
<b>Clinical recommendation statement/ rationale</b>	<p>Approximately 2.6 million emergency department visits in the U.S. each year are due to a low back pain-related disorder. Nine specialty societies have published recommendations regarding the use of imaging for patients with low back pain, indicating the topic's importance to health care providers. Clinical guidelines for treating patients with acute low back pain strongly recommend against imaging in the absence of "red flags" (i.e., indications of a serious underlying pathology such as a fracture or tumor). Organizations can provide information, best-care practice models and other support to providers, imaging centers and members to increase knowledge and ensure that imaging studies are used appropriately for evaluation of lower back pain patients, based on the duration of symptoms and the presence of red flags.</p>		
<b>Citations</b>	<p>Deyo, R.A., S.K. Mirza, B.I. Martin. 2006. "Back Pain Prevalence and Visit Rates: Estimates from U.S. National Surveys, 2002." <i>Spine</i> 31(23):2724–7.</p> <p>Downie, A., et al. 2013. "Red Flags to Screen for Malignancy and Fracture in Patients with Low Back Pain: Systematic Review." <i>BMJ</i> 347:f7095. doi: 10.1136/bmj.f7095.</p> <p>Friedman, B.W., M. Chilstrom, P.E. Bijur, &amp; E.J. Gallagher. 2010. "Diagnostic Testing and Treatment of Low Back Pain in US Emergency Departments. A National Perspective." <i>Spine</i> 35(24), E1406–11. <a href="https://doi.org/10.1097/BRS.0b013e3181d952a5">https://doi.org/10.1097/BRS.0b013e3181d952a5</a></p>		
<b>Characteristics</b>			
<b>Scoring</b>	Proportion.		
<b>Type</b>	Process.		
<b>Product lines</b>	<ul style="list-style-type: none"> <li>• Commercial.</li> <li>• Medicaid.</li> <li>• Medicare.</li> </ul>		

<b>Stratifications</b>	Age as of the last day of measurement period. <ul style="list-style-type: none"> <li>• 18–64 years.</li> <li>• 65–75 years.</li> </ul>
<b>Risk adjustment</b>	None.
<b>Improvement notation</b>	Increased score indicates improvement.
<b>Guidance</b>	<p><b>Data collection methodology:</b> Administrative. Refer to <a href="#">General Guideline: Data Collection Methods</a> for additional information.</p> <p><b>Date specificity:</b> Dates must be specific enough to determine the event occurred in the period being measured.</p> <p><b>Which services count?</b></p> <ul style="list-style-type: none"> <li>• Include all paid, suspended, pending and denied claims to identify the initial population and denominator exclusions.</li> <li>• Do not include denied claims when identifying numerator events; only include claims the organization paid for or expects to pay for (i.e., claims incurred but not paid).</li> </ul> <p><b>Supplemental data exceptions:</b> Supplemental data may not be used for this measure, except for denominator exclusions.</p> <p><b>Other guidance:</b> Reported as an inverted rate [1 – (numerator/denominator)]. A higher score indicates appropriate treatment of low back pain (i.e., the proportion for whom imaging studies did not occur).</p>

<b>Definitions</b>	
<b>IESD</b>	Index episode start date. The earliest date of service for an eligible encounter during the intake period with a principal diagnosis of low back pain.
<b>Intake period</b>	January 1–December 3 of the measurement period. The intake period is used to identify the first eligible encounter with a principal diagnosis of low back pain.
<b>Negative diagnosis history</b>	A period of 180 days prior to the IESD when the person had no claims/encounters with any diagnosis of low back pain.
<b>Initial population</b>	<p><b>Measure item count:</b> Person.</p> <p><b>Attribution basis:</b> Enrollment.</p> <ul style="list-style-type: none"> <li>• <b>Benefits:</b> Medical.</li> <li>• <b>Continuous enrollment:</b> 180 days prior to the IESD through 28 days after the IESD.</li> <li>• <b>Allowable gap:</b> None.</li> </ul> <p><b>Ages:</b> 18–75 years of age as of the last day of measurement period.</p> <p><b>Event: Low back pain diagnosis.</b></p>

	<p><b>Step 1.</b> Identify persons with a principal diagnosis of uncomplicated low back pain (<a href="#">Uncomplicated Low Back Pain Value Set*</a>) during the intake period. Do not include inpatient stays (<a href="#">Inpatient Stay Value Set</a>) or visits that result in an inpatient stay (<a href="#">Inpatient Stay Value Set</a>).</p> <p><b>Step 2.</b> Determine the IESD. For each person identified in step 1, determine the earliest episode of low back pain. If the person had more than one encounter, include only the first encounter.</p> <p><b>Step 3.</b> Test for negative diagnosis history. Remove persons with a diagnosis of uncomplicated low back pain (<a href="#">Uncomplicated Low Back Pain Value Set*</a>) during the 180 days prior to the IESD.</p> <p><b>Step 4.</b> Calculate continuous enrollment.</p> <p><b>Coding Guidance</b> *Do not include laboratory claims (claims with POS code 81).</p>
<b>Denominator exclusions</b>	<p><b>Persons with a date of death.</b> Death in the measurement period, identified using data sources determined by the organization. Method and data sources are subject to review during the HEDIS audit.</p> <p><b>Persons in hospice or using hospice services.</b> Persons who use hospice services (<a href="#">Hospice Encounter Value Set</a>; <a href="#">Hospice Intervention Value Set</a>) or elect to use a hospice benefit any time during the measurement period. Organizations that use the Monthly Membership Detail Data File to identify these persons must use only the run date of the file.</p> <p><b>Persons receiving palliative care.</b> Persons receiving palliative care (<a href="#">Palliative Care Assessment Value Set</a>; <a href="#">Palliative Care Encounter Value Set</a>; <a href="#">Palliative Care Intervention Value Set</a>) or who had an encounter for palliative care (ICD-10-CM code Z51.5*) any time during the measurement period.</p> <p><b>Persons 66 years of age and older by the last day of the measurement period, with both frailty and advanced illness.</b></p> <ol style="list-style-type: none"> <li>1. <b>Frailty.</b> At least two indications of frailty (<a href="#">Frailty Device Value Set</a>; <a href="#">Frailty Diagnosis Value Set*</a>; <a href="#">Frailty Encounter Value Set</a>; <a href="#">Frailty Symptom Value Set*</a>) with different dates of service during the measurement period.</li> <li>2. <b>Advanced illness.</b> Either of the following during the measurement period or the year prior to the measurement period: <ul style="list-style-type: none"> <li>– Advanced illness (<a href="#">Advanced Illness Value Set*</a>) on at least two different dates of service.</li> <li>– Dispensed dementia medication (<a href="#">Dementia Medications List</a>).</li> </ul> </li> </ol> <p><b>Persons with the following diagnoses or procedures that may warrant imaging any time during the person's history through 28 days after the IESD:</b></p> <ul style="list-style-type: none"> <li>• Cancer, HIV, history of organ transplant, osteoporosis or spondylopathy (<a href="#">Diagnosis History That May Warrant Imaging Value Set*</a>).</li> <li>• Organ transplant, lumbar surgery or medication treatment for osteoporosis (<a href="#">Procedure History That May Warrant Imaging Value Set</a>).</li> </ul>

	<ul style="list-style-type: none"> <li>• A dispensed prescription to treat osteoporosis (<a href="#">Osteoporosis Medications List</a>).</li> </ul> <p><b>Persons with a recent diagnosis that may warrant imaging any time during the 365 days prior to the IESD through 28 days after the IESD.</b> IV drug abuse, neurologic impairment or spinal infection (<a href="#">Recent Diagnoses That May Warrant Imaging Value Set*</a>).</p> <p><b>Persons with a recent injury that may warrant imaging any time during the 90 days prior to the IESD through 28 days after the IESD.</b> Trauma or a fragility fracture (<a href="#">Recent Injuries That May Warrant Imaging Value Set*</a>).</p> <p><b>Persons with prolonged use of corticosteroids.</b> 90 consecutive days of corticosteroid treatment any time during the 366-day period that begins 365 days prior to the IESD and ends on the IESD.</p> <p>To identify consecutive treatment days, identify calendar days covered by at least one dispensed corticosteroid (<a href="#">Corticosteroid Medications List</a>). For overlapping prescriptions and multiple prescriptions on the same day assume the person started taking the second prescription after exhausting the first prescription.</p> <ul style="list-style-type: none"> <li>• <i>For example</i>, if there is a 30-day prescription dispensed on June 1 and a 30-day prescription dispensed on June 26, there are 60 covered calendar days (June 1–July 30).</li> </ul> <p>Count only medications dispensed during the 365 days prior to and including the IESD. When identifying consecutive treatment days, do not count days supply that extend beyond the IESD.</p> <ul style="list-style-type: none"> <li>• <i>For example</i>, if there is a 90-day prescription dispensed on the IESD, there is one covered calendar day (the IESD).</li> </ul> <p>No gaps are allowed.</p> <p><b>Coding Guidance</b> *Do not include laboratory claims (claims with POS code 81).</p>
<b>Denominator</b>	The initial population minus denominator exclusions.
<b>Numerator</b>	<b>An imaging study with a diagnosis of uncomplicated low back pain.</b> An imaging study ( <a href="#">Imaging Study Value Set</a> ) with a diagnosis of uncomplicated low back pain ( <a href="#">Uncomplicated Low Back Pain Value Set</a> ) on the IESD or in the 28 days following the IESD.
<b>Summary of changes</b>	<ul style="list-style-type: none"> <li>• No changes to this measure.</li> </ul>

<b>Data element tables</b>	<p>Organizations that submit HEDIS data to NCQA must provide the following data elements.</p> <p><b>Table LBP-1/2/3: Data Elements for Use of Imaging Studies for Low Back Pain</b></p> <table border="1" data-bbox="486 333 1470 614"> <thead> <tr> <th>Metric</th><th>Age</th><th>Data Element</th><th>Reporting Instructions</th></tr> </thead> <tbody> <tr> <td rowspan="4">LowBackPainImaging</td><td>18-64</td><td>InitialPopulation</td><td>For each Stratification</td></tr> <tr> <td>65-75</td><td>Exclusions</td><td>For each Stratification</td></tr> <tr> <td>Total</td><td>Denominator</td><td>For each Stratification</td></tr> <tr> <td></td><td>NumeratorByAdmin</td><td>For each Stratification</td></tr> <tr> <td></td><td></td><td>Rate</td><td>(Percent)</td></tr> </tbody> </table>	Metric	Age	Data Element	Reporting Instructions	LowBackPainImaging	18-64	InitialPopulation	For each Stratification	65-75	Exclusions	For each Stratification	Total	Denominator	For each Stratification		NumeratorByAdmin	For each Stratification			Rate	(Percent)
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	Total	Denominator	For each Stratification																			
		NumeratorByAdmin	For each Stratification																			
		Rate	(Percent)																			
<b>Rules for Allowable Adjustments</b>	<p><b>Copyright and use:</b> The “Rules for Allowable Adjustments of HEDIS” (the “Rules”) describe how NCQA’s HEDIS measure specifications can be adjusted for other populations, if applicable. The Rules, reviewed and approved by NCQA measure experts, provide for expanded use of HEDIS measures without changing their clinical intent.</p> <p><b>Adjusted HEDIS measures may not be used for HEDIS health plan reporting.</b></p> <p><b>ADJUSTMENTS ALLOWED</b></p> <ul style="list-style-type: none"> <li>• <b>Product lines.</b> Organizations are not required to use product line criteria; product lines may be combined, and all (or no) product line criteria may be used.</li> <li>• <b>Allocation.</b> Organizations are not required to use enrollment criteria.</li> <li>• <b>Benefits.</b> Organizations are not required to use a benefit.</li> <li>• <b>Other.</b> Organizations may use additional initial population criteria to focus on a population of interest such as gender, race, ethnicity, socioeconomic or sociodemographic characteristics, geographic region or another characteristic.</li> <li>• <b>Measurement period adjustments.</b> Organizations may adjust the measurement period. <b>Note:</b> Changes to these criteria can affect how the event will be calculated using the intake period, IESD and negative diagnosis history.</li> <li>• <b>Exclusions.</b> The hospice, deceased persons, palliative care, frailty or advanced illness exclusions are not required.</li> <li>• <b>Telehealth.</b> Services/events that allow the use of synchronous telehealth visits, telephone visits and asynchronous telehealth (e-visits, virtual check-ins) may be stratified to identify services performed via telehealth. This adjustment is not allowed for events, numerators and exclusions that do not allow the use of telehealth.</li> <li>• <b>Supplemental data.</b> Supplemental data may be used to identify initial population, denominator, exclusion and numerator events.</li> </ul>																					

	<p><b>ADJUSTMENTS ALLOWED WITH LIMITS</b></p> <ul style="list-style-type: none"><li>• <i>Ages.</i> The age determination dates may be changed (e.g., select “age as of June 30”). Changing the denominator age range is allowed if the limits are within the specified age range (18–50 years). The denominator age may not be expanded.</li><li>• <i>Numerator.</i> Value sets and logic may not be changed. Denied claims may be used to calculate the numerator.</li></ul> <p><b>ADJUSTMENTS NOT ALLOWED</b></p> <ul style="list-style-type: none"><li>• <i>Initial population:</i> Event. Value sets, medication lists and logic may not be changed.</li><li>• <i>Exclusions.</i> The diagnoses and procedures that may warrant imaging and prolonged use of corticosteroids exclusions must be applied. The value sets, medication lists and logic may not be changed.</li></ul>
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## Potentially Harmful Drug-Disease Interactions in Older Adults (DDE)

Measure title	Potentially Harmful Drug-Disease Interactions in Older Adults	Measure ID	DDE
<b>Description</b>	<p>The percentage of persons 67 years of age and older who have evidence of an underlying disease, condition or health concern and who were dispensed an ambulatory prescription for a potentially harmful medication, concurrent with or after the diagnosis. Three rates are reported:</p> <ol style="list-style-type: none"> <li>1. A history of falls and a prescription for anticholinergic agents, antiepileptics, antipsychotics, benzodiazepines, nonbenzodiazepine hypnotics or antidepressants (SSRIs, tricyclic antidepressants and SNRIs).</li> <li>2. Dementia and a prescription for antipsychotics, benzodiazepines, nonbenzodiazepine hypnotics, tricyclic antidepressants or anticholinergic agents.</li> <li>3. Chronic kidney disease and prescription for Cox-2 selective NSAIDs or nonaspirin NSAIDs.</li> </ol>		
<b>Measurement period</b>	January 1–December 31.		
<b>Copyright and disclaimer notice</b>	<p>Refer to the complete copyright and disclaimer information at the front of this publication.  NCQA website: <a href="http://www.ncqa.org">www.ncqa.org</a>.  Submit policy clarification support questions via My NCQA (<a href="https://my.ncqa.org">https://my.ncqa.org</a>).</p>		
<b>Clinical recommendation statement/ rationale</b>	<p>This measure is based on recommendations in the American Geriatrics Society (AGS) 2023 Updated Beers Criteria for Potentially Inappropriate Medication Use in Older Adults. The AGS Beers Criteria are one of the most widely used sources about the safety of medication prescribing in older adults. They include evidence-based recommendations on medications that are potentially harmful in all older adults and those with specific diseases or conditions.</p>		
<b>Citations</b>	<p>2023 American Geriatrics Society Beers Criteria Update Expert Panel. 2023. “American Geriatrics Society 2023 Updated Beers Criteria for Potentially Inappropriate Medication Use in Older Adults.” <i>Journal of the American Geriatrics Society</i> 71(7): 2052–81.</p>		
<b>Characteristics</b>			
<b>Scoring</b>	Proportion.		
<b>Type</b>	Process.		
<b>Product lines</b>	Medicare.		
<b>Stratifications</b>	None.		
<b>Risk adjustment</b>	None.		

<b>Improvement notation</b>  <b>Guidance</b>	<p>Decreased score indicates improvement.</p> <p><b>Data collection methodology:</b> Administrative. Refer to <a href="#">General Guideline: Data Collection Methods</a> for additional information.</p> <p><b>Date specificity:</b> Dates must be specific enough to determine the event occurred in the period being measured.</p> <p><b>Which services count?</b></p> <ul style="list-style-type: none"> <li>Include all paid, suspended, pending and denied claims to identify the initial population and denominator exclusions.</li> <li>Do not include denied claims when identifying numerator events; only include claims the organization paid for or expects to pay for (i.e., claims incurred but not paid).</li> </ul> <p><b>Supplemental data exceptions:</b> Supplemental data may not be used for this measure, except for denominator exclusions.</p> <p><b>Medication lists:</b> If an organization uses both pharmacy data (NDC codes) and clinical data (RxNorm codes) for reporting, and there are both NDC and RxNorm codes on the same date of service, use only one data source for the date of service.</p> <p><b>Other guidance:</b> Persons with more than one disease or condition may appear in the measure multiple times (i.e., in each indicator for which they qualify).</p>
<b>Definitions</b>	
<b>IESD</b>	<p>Index episode start date. The earliest diagnosis, procedure or prescription between January 1 of the year prior to the measurement period and December 1 of the measurement period.</p> <ul style="list-style-type: none"> <li>For an outpatient or ED visit, the <i>IESD is the date of service</i>.</li> <li>For an inpatient discharge, the <i>IESD is the discharge date</i>.</li> <li>For an acute or nonacute inpatient encounter identified only by a professional claim (where the discharge date cannot be determined), the <i>IESD is the date of service</i>.</li> <li>For dispensed prescriptions, the <i>IESD is the dispense date</i>.</li> </ul>
<b>Initial population</b>	<p><b>Measure item count:</b> Person.</p> <p><b>Attribution basis:</b> Enrollment.</p> <ul style="list-style-type: none"> <li><b>Benefits:</b> Medical and pharmacy.</li> <li><b>Continuous enrollment:</b> Measurement period and year prior to the measurement period.</li> <li><b>Allowable gap:</b> No more than one gap of ≤45 days during each year of the continuous enrollment period. No gaps on the last day of the measurement period.</li> </ul> <p><b>Ages:</b> 67 years of age and older as of the last day of the measurement period.</p>

	<p><b>Event:</b> Persons with at least one disease, condition or procedure in the measurement period or year prior to the measurement period.</p> <p>Refer to additional initial population criteria for each rate.</p> <p><b>Additional Initial Population Criteria:</b></p> <p><b>Initial population 1:</b> Drug-disease interactions—History of falls and anticholinergic agents, antiepileptics, antipsychotics, benzodiazepines, nonbenzodiazepine hypnotics or antidepressants (SSRIs, Tricyclic antidepressants and SNRIs).</p> <p>An accidental fall or hip fracture on or between January 1 of the year prior to the measurement period and December 1 of the measurement period.</p> <p><b>Note:</b> Hip fractures are used as a proxy for identifying accidental falls.</p> <p>Identify persons who had an accidental fall or a hip fracture. Persons with any of the following on or between January 1 of the year prior to the measurement period and December 1 of the measurement period meet criteria:</p> <ul style="list-style-type: none"> <li>• An accidental fall (<u>Falls Value Set*</u>).</li> <li>• An outpatient visit, ED visit, acute inpatient encounter or nonacute inpatient encounter (<u>Outpatient, ED, Acute Inpatient and Nonacute Inpatient Value Set</u>) with a hip fracture (<u>Hip Fractures Value Set</u>).</li> <li>• An acute or nonacute inpatient discharge with a hip fracture (<u>Hip Fractures Value Set</u>) on the discharge claim. To identify acute and nonacute inpatient discharges:           <ol style="list-style-type: none"> <li>1. Identify all acute and nonacute inpatient stays (<u>Inpatient Stay Value Set</u>).</li> <li>2. Identify the discharge date for the stay.</li> </ol> </li> </ul> <p>Identify the IESD for each person.</p> <p><b>Initial population 2:</b> Drug-disease interactions—Dementia and antipsychotics, benzodiazepines, nonbenzodiazepine hypnotics, tricyclic antidepressants or anticholinergic agents.</p> <p>Identify persons with a diagnosis of dementia (<u>Dementia Value Set*</u>) or a dispensed dementia medication (<u>Dementia Medications List</u>) on or between January 1 of the period prior to the measurement period and December 1 of the measurement period.</p> <p>Identify the IESD for each person.</p> <p><b>Initial population 3:</b> Drug-disease interactions—Chronic kidney disease and Cox-2 selective NSAIDS or nonaspirin NSAIDS.</p> <p>Identified chronic kidney disease by any of the following on or between January 1 of the period prior to the measurement period and December 1 of the measurement period:</p> <ul style="list-style-type: none"> <li>• ESRD (<u>ESRD Diagnosis Value Set*</u>).</li> <li>• Stage 4 chronic kidney disease (<u>CKD Stage 4 Value Set*</u>).</li> <li>• Dialysis (<u>Dialysis Procedure Value Set</u>).</li> <li>• Nephrectomy (<u>Total Nephrectomy Value Set</u>).</li> <li>• Kidney Transplant (<u>Kidney Transplant Value Set</u>).</li> </ul>
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	<p>Identify the IESD for each person.</p> <p><b>Coding Guidance</b></p> <p>*Do not include laboratory claims (claims with POS code 81).</p>
<b>Denominator exclusions</b>	<p><b>The following exclusions apply to all denominators:</b></p> <ul style="list-style-type: none"> <li>• <b>Persons with a date of death.</b> Death in the measurement period, identified using data sources determined by the organization. Method and data sources are subject to review during the HEDIS audit.</li> <li>• <b>Persons in hospice or using hospice services.</b> Persons who use hospice services (<u>Hospice Encounter Value Set</u>; <u>Hospice Intervention Value Set</u>) or elect to use a hospice benefit any time during the measurement period. Organizations that use the Monthly Membership Detail Data File to identify these persons must use only the run date of the file.</li> <li>• <b>Persons receiving palliative care.</b> Persons receiving palliative care (<u>Palliative Care Assessment Value Set</u>; <u>Palliative Care Encounter Value Set</u>; <u>Palliative Care Intervention Value Set</u>) or who had an encounter for palliative care (ICD-10-CM code Z51.5*) any time during the measurement period.</li> </ul> <p><b>Additional denominator 1 exclusions.</b> Persons with at least one of the following diagnoses on or between January 1 of the year prior to the measurement period and December 1 of the measurement period:</p> <ul style="list-style-type: none"> <li>• Psychosis (<u>Psychosis Value Set*</u>).</li> <li>• Schizophrenia, schizoaffective disorder (<u>Schizophrenia Value Set*</u>).</li> <li>• Bipolar disorder (<u>Bipolar Disorder Value Set*</u>; <u>Other Bipolar Disorder Value Set*</u>).</li> <li>• Major depressive disorder (<u>Major Depression or Dysthymia Value Set*</u>).</li> <li>• Seizure disorder (<u>Seizure Disorders Value Set*</u>).</li> </ul> <p><b>Additional denominator 2 exclusions.</b> Persons with at least one of the following diagnoses on or between January 1 of the year prior to the measurement period and December 1 of the measurement period:</p> <ul style="list-style-type: none"> <li>• Psychosis (<u>Psychosis Value Set*</u>).</li> <li>• Schizophrenia, schizoaffective disorder (<u>Schizophrenia Value Set*</u>).</li> <li>• Bipolar disorder (<u>Bipolar Disorder Value Set*</u>; <u>Other Bipolar Disorder Value Set*</u>).</li> </ul> <p><b>Coding Guideline</b></p> <p>*Do not include laboratory claims (claims with POS code 81).</p>
<b>Denominator</b>	<p><b>Denominator 1:</b> The initial population and additional initial population 1 criteria minus denominator exclusions and additional denominator 1 exclusions.</p> <p><b>Denominator 2:</b> The initial population and additional initial population 2 criteria minus denominator exclusions and additional denominator 2 exclusions.</p>

	<b>Denominator 3:</b> The initial population and additional initial population 3 criteria minus denominator exclusions.																					
<b>Numerator</b>	<p><b>Numerator 1: Drug-Disease Interactions—History of Falls And Antiepileptics, Antipsychotics, Benzodiazepines, Nonbenzodiazepine Hypnotics or Antidepressants (SSRIs, Tricyclic Antidepressants and SNRIs).</b> Dispensed an ambulatory prescription for an antiepileptic, SSRI, SNRI, anticholinergic agent, antipsychotic, benzodiazepine, nonbenzodiazepine hypnotic or tricyclic antidepressant (<a href="#">Potentially Harmful Drugs for Older Adults With a History of Falls Medications List</a>) on or between the IESD and the last day of the measurement period.</p> <p><b>Numerator 2: Drug-Disease Interactions—Dementia and Antipsychotics, Benzodiazepines, Nonbenzodiazepine Hypnotics, Tricyclic Antidepressants or Anticholinergic Agents.</b> Dispensed an ambulatory prescription for an antipsychotic, benzodiazepine, nonbenzodiazepine hypnotic, tricyclic antidepressant or anticholinergic agent (<a href="#">Potentially Harmful Drugs for Older Adults With a History of Dementia Medications List</a>) on or between the IESD and the last day of the measurement period.</p> <p><b>Numerator 3: Drug-Disease Interactions—Chronic Kidney Disease and Cox-2 Selective NSAIDS or Nonaspirin NSAIDS.</b> Dispensed an ambulatory prescription for a Cox-2 selective NSAID or nonaspirin NSAID (<a href="#">Potentially Harmful Drugs for Older Adults With a History of Chronic Kidney Disease Medications List</a>) on or between the IESD and the last day of the measurement period.</p>																					
<b>Summary of changes</b>	<ul style="list-style-type: none"> <li>No changes to this measure.</li> </ul>																					
<b>Data element tables</b>	<p>Organizations that submit HEDIS data to NCQA must provide the following data elements.</p> <p><b>Table DDE-3: Data Elements for Potentially Harmful Drug-Disease Interactions in Older Adults</b></p> <table border="1"> <thead> <tr> <th>Metric</th> <th>Data Element</th> <th>Reporting Instructions</th> </tr> </thead> <tbody> <tr> <td>HistoryOfFalls</td> <td>Benefit</td> <td>Metadata</td> </tr> <tr> <td>Dementia</td> <td>InitialPopulation</td> <td>For each Metric</td> </tr> <tr> <td>ChronicKidneyDisease</td> <td>Exclusions</td> <td>For each Metric</td> </tr> <tr> <td></td> <td>Denominator</td> <td>For each Metric</td> </tr> <tr> <td></td> <td>NumeratorByAdmin</td> <td>For each Metric</td> </tr> <tr> <td></td> <td>Rate</td> <td>(Percent)</td> </tr> </tbody> </table>	Metric	Data Element	Reporting Instructions	HistoryOfFalls	Benefit	Metadata	Dementia	InitialPopulation	For each Metric	ChronicKidneyDisease	Exclusions	For each Metric		Denominator	For each Metric		NumeratorByAdmin	For each Metric		Rate	(Percent)
Metric	Data Element	Reporting Instructions																				
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	Denominator	For each Metric																				
	NumeratorByAdmin	For each Metric																				
	Rate	(Percent)																				
<b>Rules for Allowable Adjustments</b>	<p><b>Copyright and use:</b> The “Rules for Allowable Adjustments of HEDIS” (the “Rules”) describe how NCQA’s HEDIS measure specifications can be adjusted for other populations, if applicable. The Rules, reviewed and approved by NCQA measure experts, provide for expanded use of HEDIS measures without changing their clinical intent.</p>																					

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

#### **ADJUSTMENTS ALLOWED**

- *Product lines.* Organizations are not required to use product line criteria; product lines may be combined, and all (or no) product line criteria may be used.
- *Attribution.* Organizations are not required to use enrollment criteria.
- *Benefits.* Organizations are not required to use a benefit.
- *Other.* Organizations may use additional initial population criteria to focus on an area of interest defined by gender, race, ethnicity, socioeconomic or sociodemographic characteristics, geographic region or another characteristic.
- *Denominator 1–3 exclusions.* The hospice, deceased persons and palliative care exclusions are not required.
- *Telehealth.* Services/events that allow the use of synchronous telehealth visits, telephone visits and asynchronous telehealth (e-visits, virtual check-ins) may be stratified to identify services performed via telehealth. This adjustment is not allowed for events, numerators and exclusions that do not allow the use of telehealth.
- *Supplemental data.* Supplemental data may be used to identify initial population, denominator, exclusion and numerator events.

#### **ADJUSTMENTS ALLOWED WITH LIMITS**

- *Ages.* The age determination dates may be changed (e.g., select, “age as of June 30”). Changing the denominator age range is allowed if the limits are within the specified age range (65 years and older). The denominator age may not be expanded.
- *Initial population 1:* History of falls. Organizations may use multiple episodes during a measurement period (vs. using only the Index Episode).
- *Numerators 1–3:* Organizations may include denied claims to calculate the numerators. Medication lists and logic may not be changed.

#### **ADJUSTMENTS NOT ALLOWED**

- *Initial population 2:* Dementia. The medication lists, value sets and logic may not be changed.
- *Initial population 3:* Chronic kidney disease. The value sets and logic may not be changed.
- *Denominator 1 and denominator 2 exclusions.* The psychosis, schizophrenia, schizoaffective disorder, bipolar disorder, major depressive disorder and seizure disorder exclusions must be applied. The value sets, medication lists and logic may not be changed.

## **Use of High-Risk Medications in Older Adults (DAE)**

<b>Measure title</b>	Use of High-Risk Medications in Older Adults	<b>Measure ID</b>	DAE
<b>Description</b>	<p>The percentage of persons 67 years of age and older who had at least two dispensing events for the same high-risk medication. Three rates are reported:</p> <ol style="list-style-type: none"> <li>1. The percentage of persons 67 years of age and older who had at least two dispensing events for high-risk medications to avoid from the same drug class.</li> <li>2. The percentage of persons 67 years of age and older who had at least two dispensing events for high-risk medications to avoid from the same drug class, except for appropriate diagnoses.</li> <li>3. Total rate (the sum of the two numerators divided by the denominator, deduplicating for persons in both numerators).</li> </ol>		
<b>Measurement period</b>	January 1–December 31.		
<b>Copyright and disclaimer notice</b>	<p>Refer to the complete copyright and disclaimer information at the front of this publication.</p> <p>NCQA website: <a href="http://www.ncqa.org">www.ncqa.org</a>.</p> <p>Submit policy clarification support questions via My NCQA (<a href="https://my.ncqa.org">https://my.ncqa.org</a>).</p>		
<b>Clinical recommendation statement/ rationale</b>	<p>This measure is based on Table 2 of the American Geriatrics Society Beers Criteria, which includes potentially inappropriate medications for use in older adults. In older adults, certain medications are associated with increased risk of harm from drug side-effects and drug toxicity and pose a concern for patient safety. Use of potentially inappropriate medications in older adults can lead to poor health outcomes, including adverse drug events, confusion, falls, hospitalizations, and death (American Geriatrics Society Beers Criteria Update Expert Panel, 2015, 2019, 2023).</p>		
<b>Citations</b>	<p>American Geriatrics Society Beers Criteria Update Expert Panel. 2023. “American Geriatrics Society 2023 Updated Beers Criteria for Potentially Inappropriate Medication Use in Older Adults.” <i>Journal of the American Geriatrics Society</i> 71(7), 2052–81.</p> <p>American Geriatrics Society Beers Criteria Update Expert Panel. 2019. “American Geriatrics Society 2019 Updated Beers Criteria for Potentially Inappropriate Medication Use in Older Adults.” <i>Journal of the American Geriatrics Society</i> 67(4), 674–94.</p> <p>American Geriatrics Society Beers Criteria Update Expert Panel. 2015. “American Geriatrics Society 2015 Updated AGS Beers Criteria for Potentially Inappropriate Medication Use in Older Adults.” <i>Journal of the American Geriatrics Society</i> 63, 2227–46.</p>		

Characteristics	
<b>Scoring</b>	Composite.
<b>Type</b>	Process.
<b>Product lines</b>	Medicare.
<b>Stratifications</b>	None.
<b>Risk adjustment</b>	None.
<b>Improvement notation</b>	Decreased score indicates improvement.
<b>Guidance</b>	<p><b>Data collection methodology:</b> Administrative. Refer to <a href="#">General Guideline: Data Collection Methods</a> for additional information.</p> <p><b>Date specificity:</b> Dates must be specific enough to determine the event occurred in the period being measured.</p> <p><b>Which services count?</b></p> <ul style="list-style-type: none"> <li>Include all paid, suspended, pending and denied claims to identify the initial population and denominator exclusions.</li> <li>Do not include denied claims when identifying numerator events; only include claims the organization paid for or expects to pay for (i.e., claims incurred but not paid).</li> </ul> <p><b>Supplemental data exceptions:</b> Supplemental data may not be used for this measure, except for denominator exclusions.</p> <p><b>Medication lists:</b></p> <ul style="list-style-type: none"> <li>If an organization uses both pharmacy data (NDC codes) and clinical data (RxNorm codes) for reporting, and there are both NDC and RxNorm codes on the same date of service, use only one data source for the date of service.</li> <li>Medication lists used for this measure contain any applicable combination products.</li> </ul> <p><b>Other guidance:</b></p> <ul style="list-style-type: none"> <li>The total rate is the sum of the two numerators divided by the denominator; deduplicate persons in the two numerators prior to calculating and reporting the total rate.</li> <li>The measure reflects potentially inappropriate medication use in older adults, both for medications where any use is inappropriate (Numerator 1) and for medications where use under all but specific indications is potentially inappropriate (Numerator 2).</li> </ul>
Definitions	
<b>IPSD</b>	Index prescription start date. The earliest prescription dispensing date for a high-risk medication during the measurement period.

<b>Initial population</b>	<p><b>Measure item count:</b> Person.</p> <p><b>Attribution basis:</b> Enrollment.</p> <ul style="list-style-type: none"> <li>• <b>Benefits:</b> Medical and pharmacy.</li> <li>• <b>Continuous enrollment:</b> Measurement period and year prior to the measurement period.</li> <li>• <b>Allowable gap:</b> No more than one gap of ≤45 days during each year of the continuous enrollment period. No gaps on the last day of the measurement period.</li> </ul> <p><b>Ages:</b> 67 years of age and older as of the last day of the measurement period.</p> <p><b>Event:</b> None.</p>
<b>Denominator exclusions</b>	<p><b>Persons with a date of death.</b> Death in the measurement period, identified using data sources determined by the organization. Method and data sources are subject to review during the HEDIS audit.</p> <p><b>Persons in hospice or using hospice services.</b> Persons who use hospice services (<a href="#">Hospice Encounter Value Set</a>; <a href="#">Hospice Intervention Value Set</a>) or elect to use a hospice benefit any time during the measurement period. Organizations that use the Monthly Membership Detail Data File to identify these persons must use only the run date of the file.</p> <p><b>Persons receiving palliative care.</b> Persons receiving palliative care (<a href="#">Palliative Care Assessment Value Set</a>; <a href="#">Palliative Care Encounter Value Set</a>; <a href="#">Palliative Care Intervention Value Set</a>) or who had an encounter for palliative care (ICD-10-CM code Z51.5*) any time during the measurement period.</p> <p><b>Coding Guidance</b> *Do not include laboratory claims (claims with POS code 81).</p>
<b>Denominator</b>	The initial population minus denominator exclusions.
<b>Numerator</b>	<p><b>Numerator 1: High-risk medications to avoid.</b> Persons who received at least two dispensing events for high-risk medications from the same drug class during the measurement period.</p> <p>Follow the instructions for each medication group below (high-risk medications, high-risk medications with days supply criteria, high-risk medications with average daily dose criteria) to identify numerator compliance. If a person meets criteria for at least one of the following medication groups, they are numerator compliant. Include people who meet criteria for more than one medication group only once in the numerator.</p> <p><b>High-risk medications.</b> Persons with two or more dispensing events (any days supply) for high-risk medications from the same drug class on different dates of service during the measurement period are numerator compliant.</p>

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

**High-Risk Medications**

Drug Class	Medication Lists
Anticholinergics, first-generation antihistamines	<a href="#">Potentially Harmful Antihistamines for Older Adults Medications List</a>
Anticholinergics, anti-Parkinson agents	<a href="#">Potentially Harmful Antiparkinsonian Agents for Older Adults Medications List</a>
Antispasmodics	<a href="#">Potentially Harmful Gastrointestinal Antispasmodics for Older Adults Medications List</a>
Antithrombotic	<a href="#">Dipyridamole Medications List</a>
Cardiovascular, alpha agonists, central	<a href="#">Guanfacine Medications List</a>
Cardiovascular, other	<a href="#">Nifedipine Medications List</a>
Central nervous system, antidepressants	<a href="#">Potentially Harmful Antidepressants for Older Adults Medications List</a>
Central nervous system, barbiturates	<a href="#">Potentially Harmful Barbiturates for Older Adults Medications List</a>
Central nervous system, vasodilators	<a href="#">Ergoloid Mesylates Medications List</a>
Central nervous system, other	<a href="#">Meprobamate Medications List</a>
Endocrine system, estrogens with or without progestins; include only oral and topical patch products	<a href="#">Potentially Harmful Estrogens for Older Adults Medications List</a>
Endocrine system, sulfonylureas, long-duration	<a href="#">Potentially Harmful Sulfonylureas for Older Adults Medications List</a>
Endocrine system, desiccated thyroid	<a href="#">Desiccated Thyroid Medications List</a>
Endocrine system, megestrol	<a href="#">Megestrol Medications List</a>
Nonbenzodiazepine hypnotics	<a href="#">Potentially Harmful Nonbenzodiazepine Hypnotics for Older Adults Medications List</a>
Pain medications, skeletal muscle relaxants	<a href="#">Potentially Harmful Skeletal Muscle Relaxants for Older Adults Medications List</a>
Pain medications, meperidine	<a href="#">Meperidine Combinations Medications List</a>
Pain medications, other	<a href="#">Potentially Harmful Pain Medications for Older Adults Medications List</a>

**High-risk medications with days supply criteria.**

For each person, identify dispensing events during the measurement period for medications in the [Potentially Harmful Anti Infectives for Older Adults Medications List](#).

Calculate days supply for all dispensing events. Sum the days supply and include any days supply that extends beyond December 31 of the measurement period.

- For example, a prescription of a 90-days supply dispensed on December 1 of the measurement period counts as a 90-days supply.

Persons who meet both of the following are numerator compliant:

- Two or more dispensing events on different dates of service.
- Summed days supply exceeds the days supply criteria.

**Note:** The intent is to identify all persons who had multiple dispensing events where the summed days supply exceeds the days supply criteria; there is no requirement that each dispensing event exceed the days supply criteria.

#### **High-Risk Medications With Days Supply Criteria**

Description	Days Supply Criteria	Medication Lists
Anti-Infectives, other	>90 days	<a href="#">Potentially Harmful Antiinfectives for Older Adults Medications List</a>

#### **High-risk medications with average daily dose criteria.**

Use the medication lists in the High-Risk Medications With Average Daily Dose Criteria table below to identify persons with dispensing events during the measurement period.

Calculate average daily dose for each dispensing event. To calculate average daily dose, multiply the quantity of pills dispensed by the dose of each pill and divide by the days supply.

- For example, a prescription for a 30-days supply of digoxin containing 15 pills, 0.25 mg each pill, has an average daily dose of 0.125 mg.

To calculate average daily dose for elixirs and concentrates, multiply the volume dispensed by daily dose and divide by the days supply.

Do not round when calculating average daily dose.

The High-Risk Medications With Average Daily Dose Criteria table includes a “Medication Lists” column that identifies the same high-risk medication by grouping them on the same row.

Persons who meet both of the following for the same medication are numerator compliant:

- Two or more dispensing events on different dates of service.
- Average daily dose for two or more dispensing events (on different dates of service) exceeds the average daily dose criteria.

#### **High-Risk Medications With Average Daily Dose Criteria**

Description	Average Daily Dose Criteria	Medication Lists
Cardiovascular, other	>0.125 mg/day	<a href="#">Digoxin .05 mg per mL Medications List</a> <a href="#">Digoxin .0625 mg Medications List</a> <a href="#">Digoxin .1 mg per mL Medications List</a> <a href="#">Digoxin .125 mg Medications List</a> <a href="#">Digoxin .25 mg Medications List</a> <a href="#">Digoxin .25 mg per mL Medications List</a>

Description	Average Daily Dose Criteria	Medication Lists
Tertiary TCAs (as single agent or as part of combination products)	>6 mg/day	<a href="#">Doxepin 3 mg Medications List</a> <a href="#">Doxepin 6 mg Medications List</a> <a href="#">Doxepin 10 mg Medications List</a> <a href="#">Doxepin 10 mg per mL Medications List</a> <a href="#">Doxepin 25 mg Medications List</a> <a href="#">Doxepin 50 mg Medications List</a> <a href="#">Doxepin 75 mg Medications List</a> <a href="#">Doxepin 100 mg Medications List</a> <a href="#">Doxepin 150 mg Medications List</a>

**Numerator 2: High-risk medications to avoid except for appropriate diagnosis.**

Persons who had at least two dispensing events for high-risk medications from the same drug class except for appropriate diagnosis during the measurement period.

Follow the instructions for each medication class (antipsychotics and benzodiazepines) to identify numerator compliance. Include persons who are numerator compliant for more than one medication class only once in the numerator.

**Antipsychotics.**

Persons who meet both of the following are numerator compliant:

- Two or more dispensing events for an antipsychotic ([Potentially Harmful Antipsychotics for Older Adults Medications List](#)) on different dates of service during the measurement period.
- The person did not have a diagnosis of schizophrenia or schizoaffective disorder ([Schizophrenia Value Set\\*](#)) or bipolar disorder ([Bipolar Disorder Value Set; Other Bipolar Disorder Value Set\\*](#)) on or between January 1 of the year prior to the measurement period and the IPSD for antipsychotics.

**Benzodiazepines.**

Persons who meet both of the following are numerator compliant:

- Two or more dispensing events for a benzodiazepine ([Potentially Harmful Benzodiazepines for Older Adults Medications List](#)) on different dates of service during the measurement period.
- The person did not have a diagnosis of seizure disorders ([Seizure Disorders Value Set\\*](#)), rapid eye movement sleep behavior disorder ([REM Sleep Behavior Disorder Value Set\\*](#)), benzodiazepine withdrawal ([Benzodiazepine Withdrawal Value Set\\*](#)), ethanol withdrawal ([Alcohol Withdrawal Value Set\\*](#)) or severe generalized anxiety disorder ([Generalized Anxiety Disorder Value Set\\*](#)) on or between January 1 of the year prior to the measurement period and the IPSD for benzodiazepines.

	<p><b>High-Risk Medications Based on Prescription and Diagnosis Data</b></p> <table border="1"> <thead> <tr> <th>Drug Class</th><th>Medication Lists</th></tr> </thead> <tbody> <tr> <td>Antipsychotics, first (conventional) and second (atypical) generation</td><td><a href="#">Potentially Harmful Antipsychotics for Older Adults Medications List</a></td></tr> <tr> <td>Benzodiazepines, long, short and intermediate acting</td><td><a href="#">Potentially Harmful Benzodiazepines for Older Adults Medications List</a></td></tr> </tbody> </table> <p><b>Coding Guidance</b> *Do not include laboratory claims (claims with POS code 81).</p>	Drug Class	Medication Lists	Antipsychotics, first (conventional) and second (atypical) generation	<a href="#">Potentially Harmful Antipsychotics for Older Adults Medications List</a>	Benzodiazepines, long, short and intermediate acting	<a href="#">Potentially Harmful Benzodiazepines for Older Adults Medications List</a>															
Drug Class	Medication Lists																					
Antipsychotics, first (conventional) and second (atypical) generation	<a href="#">Potentially Harmful Antipsychotics for Older Adults Medications List</a>																					
Benzodiazepines, long, short and intermediate acting	<a href="#">Potentially Harmful Benzodiazepines for Older Adults Medications List</a>																					
<b>Summary of changes</b>	<ul style="list-style-type: none"> <li>No changes to this measure.</li> </ul>																					
<b>Data element tables</b>	<p>Organizations that submit HEDIS data to NCQA must provide the following data elements.</p> <p><b>Table DAE-3: Data Elements for Use of High-Risk Medications in Older Adults</b></p> <table border="1"> <thead> <tr> <th>Metric</th><th>Data Element</th><th>Reporting Instructions</th></tr> </thead> <tbody> <tr> <td>HighRiskMedicationsToAvoid</td><td>Benefit</td><td>Metadata</td></tr> <tr> <td>ExceptAppropriateDiagnosis</td><td>InitialPopulation</td><td>Repeat per Metric</td></tr> <tr> <td>Total</td><td>Exclusions</td><td>Repeat per Metric</td></tr> <tr> <td></td><td>Denominator</td><td>Repeat per Metric</td></tr> <tr> <td></td><td>NumeratorByAdmin</td><td>For each Metric</td></tr> <tr> <td></td><td>Rate</td><td>(Percent)</td></tr> </tbody> </table>	Metric	Data Element	Reporting Instructions	HighRiskMedicationsToAvoid	Benefit	Metadata	ExceptAppropriateDiagnosis	InitialPopulation	Repeat per Metric	Total	Exclusions	Repeat per Metric		Denominator	Repeat per Metric		NumeratorByAdmin	For each Metric		Rate	(Percent)
Metric	Data Element	Reporting Instructions																				
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<b>Rules for Allowable Adjustments</b>	<p><b>Copyright and use:</b> The “Rules for Allowable Adjustments of HEDIS” (the “Rules”) describe how NCQA’s HEDIS measure specifications can be adjusted for other populations, if applicable. The Rules, reviewed and approved by NCQA measure experts, provide for expanded use of HEDIS measures without changing their clinical intent.</p> <p><b>Adjusted HEDIS measures may not be used for HEDIS health plan reporting.</b></p> <p><b>ADJUSTMENTS ALLOWED</b></p> <ul style="list-style-type: none"> <li><b>Product lines.</b> Organizations are not required to use product line criteria; product lines may be combined, and all (or no) product line criteria may be used.</li> <li><b>Attribution.</b> Organizations are not required to use enrollment criteria.</li> <li><b>Benefits.</b> Organizations are not required to use a benefit.</li> <li><b>Other.</b> Organizations may use additional initial population criteria to focus on an area of interest defined by gender, race, ethnicity, socioeconomic or sociodemographic characteristics, geographic region or another characteristic.</li> <li><b>Exclusions.</b> The hospice, deceased person and palliative care exclusions are not required.</li> </ul>																					

- *Telehealth.* Services/events that allow the use of synchronous telehealth visits, telephone visits and asynchronous telehealth (e-visits, virtual check-ins) may be stratified to identify services performed via telehealth. This adjustment is not allowed for events, numerators and exclusions that do not allow the use of telehealth.
- *Supplemental data.* Supplemental data may be used to identify initial population, denominator, exclusion and numerator events.

#### **ADJUSTMENTS ALLOWED WITH LIMITS**

- *Ages.* The age determination dates may be changed (e.g., select “age as of June 30”). Changing the denominator age range is allowed if the limits are within the specified age range (67 years and older). The denominator age may not be expanded.
- *Numerator.* Medication lists and logic may not be changed. Organizations may include denied claims to calculate the numerator for High-Risk Medications to Avoid and High-Risk Medications to Avoid Except for Appropriate Diagnosis indicators.

## ***Deprescribing of Benzodiazepines in Older Adults (DBO)***

Measure title	Deprescribing of Benzodiazepines in Older Adults	Measure ID	DBO
<b>Description</b>	The percentage of persons 67 years of age and older who were dispensed benzodiazepines and achieved a 20% decrease or greater in benzodiazepine dose (diazepam milligram equivalent [DME] dose) during the measurement period.		
<b>Measurement period</b>	January 1–December 31.		
<b>Copyright and disclaimer notice</b>	<p>Refer to the complete copyright and disclaimer information at the front of this publication.</p> <p>NCQA website: <a href="http://www.ncqa.org">www.ncqa.org</a>.</p> <p>Submit policy clarification support questions via My NCQA (<a href="https://my.ncqa.org">https://my.ncqa.org</a>).</p>		
<b>Clinical recommendation statement/ rationale</b>	<p>Multiple sources of clinical or other guidance recommend against benzodiazepine use in older adults, including the American Geriatrics Society (AGS) Beers Criteria, which recommend avoiding benzodiazepines—all short-, intermediate- and long-acting forms—for all older adults. The criteria's rationale states: "Older adults have increased sensitivity to benzodiazepines and decreased metabolism of long-acting agents; the continued use of benzodiazepines may lead to clinically significant physical dependence. In general, all benzodiazepines increase the risk of cognitive impairment, delirium, falls, fractures, and motor vehicle crashes in older adults."</p> <p>According to the criteria, only in rare cases may benzodiazepines be appropriate (for seizure disorders, rapid eye movement sleep behavior disorder, benzodiazepine withdrawal, ethanol withdrawal, severe generalized anxiety disorder and periprocedural anesthesia), most notably for benzodiazepine withdrawal, a particular risk when deprescribing benzodiazepines in older adults.</p> <p>Although a single consensus guideline for appropriate deprescribing of benzodiazepines has not yet been published, several clinical algorithms have been produced that share common recommendations. Similar guidance is also reflected in various organization-specific guidelines, such as Kaiser of Washington's Benzodiazepine and Z-Drug Safety Guideline, among others.</p>		
<b>Citations</b>	<p>American Geriatrics Society Beers Criteria Update Expert Panel. 2023. "American Geriatrics Society 2023 Updated AGS Beers Criteria® for Potentially Inappropriate Medication Use in Older Adults." <i>Journal of the American Geriatrics Society</i>, 1–30.</p> <p>Kaiser Permanente. 2019. <i>Benzodiazepine and Z-Drug Safety Guideline</i> (p. 21). <a href="https://wa.kaiserpermanente.org/static/pdf/public/guidelines/benzo-zdrug.pdf">https://wa.kaiserpermanente.org/static/pdf/public/guidelines/benzo-zdrug.pdf</a></p>		

	<p>National Opioid Use Guideline Group. 2010. "Appendix B-6: Benzodiazepine Tapering." In <i>Canadian Guideline for Opioid Use for Pain</i> (v2010). <a href="http://nationalpaincentre.mcmaster.ca/opioid/cgop_b_app_b06.html">http://nationalpaincentre.mcmaster.ca/opioid/cgop_b_app_b06.html</a></p> <p>Nebraska Hospital Association. (n.d.). <i>Quality and Safety: NHA Opioid Toolkit: Treatment Guidelines for Pain: Benzodiazepine Tapering Flow Sheet</i>. <a href="https://www.nebraskahospitals.org/quality_and_safety/nha-opioid-toolkit/treatment-guidelines-for-pain/benzodiazepine-tapering-flow-sheet.html">https://www.nebraskahospitals.org/quality_and_safety/nha-opioid-toolkit/treatment-guidelines-for-pain/benzodiazepine-tapering-flow-sheet.html</a></p> <p>Ogbonna, C.I., &amp; A. Lembke. 2017. "Tapering Patients Off of Benzodiazepines." <i>American Family Physician</i> 96(9), 606–10.</p> <p>Pottie, K., W. Thompson, S. Davies, J. Grenier, C.A. Sadowski, V. Welch, A. Holbrook, C. Boyd, R. Swenson, A. Ma, &amp; B. Farrell. 2018. "Deprescribing Benzodiazepine Receptor Agonists." <i>Canadian Family Physician</i> 64(5), 339–51.</p> <p>VA National Center for PTSD. 2013. <i>Effective Treatments for PTSD: Helping Patients Taper from Benzodiazepines</i> (p. 2). <a href="https://www.va.gov/painmanagement/docs/OSI_6_Toolkit_Taper_Benzodiazepines_Clinicians.pdf">https://www.va.gov/painmanagement/docs/OSI_6_Toolkit_Taper_Benzodiazepines_Clinicians.pdf</a></p>
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<b>Characteristics</b>	
<b>Scoring</b>	Proportion.
<b>Type</b>	Process.
<b>Product lines</b>	Medicare.
<b>Stratifications</b>	<p>Generalized anxiety disorder status.</p> <ul style="list-style-type: none"> <li>Persons with a diagnosis of generalized anxiety disorder (<u>Generalized Anxiety Disorder Value Set*</u>) on or between January 1 of the year prior to the measurement period and the ITE start date.</li> <li>Persons who did not meet criteria for the stratification above (i.e., did not have a diagnosis of generalized anxiety disorder on or between January 1 of the year prior to the measurement period and the ITE start date).</li> </ul> <p><b>Coding Guidance</b> *Do not include laboratory claims (claims with POS code 81).</p>
<b>Risk adjustment</b>	None.
<b>Improvement notation</b>	Increased score indicates improvement.
<b>Guidance</b>	<p><b>Data collection methodology:</b> Administrative. Refer to <a href="#">General Guideline: Data Collection Methods</a> for additional information.</p> <p><b>Date specificity:</b> Dates must be specific enough to determine the event occurred in the period being measured.</p> <p><b>Which services count?</b></p> <ul style="list-style-type: none"> <li>Do not include denied claims when identifying initial population and numerator events; only include claims the organization paid for or expects to pay for (i.e., claims incurred but not paid).</li> </ul>

	<ul style="list-style-type: none"> <li>Include all paid, suspended, pending and denied claims to identify the denominator exclusions.</li> </ul> <p><b>Supplemental data exceptions:</b> Supplemental data may not be used for this measure, except for denominator exclusions.</p> <p><b>Medication lists:</b></p> <ul style="list-style-type: none"> <li>If an organization uses both pharmacy data (NDC codes) and clinical data (RxNorm codes) for reporting, and there are both NDC and RxNorm codes on the same date of service, use only one data source for the date of service.</li> <li>Medication lists used for this measure contain any applicable combination products.</li> </ul>
<b>Definitions</b>	
<b>Average starting DME</b>	<p>The average DME daily dose for all benzodiazepines dispensed during the ITE. Calculate the DME daily dose for each dispensing event in the ITE. To calculate the average starting DME, multiply the dispensing event's DME daily dose by its days supply, then divide by 30 (the length of the ITE).</p> <p>If multiple dispensing events contribute to the ITE, multiply the days supply of each dispensing event by the corresponding DME daily dose, then sum the results. Count the days supply until the end of the ITE; the total number of days supply across all dispensing events should not exceed 30. Do not round when calculating average DME daily dose.</p> <p><i>Note: When calculating average starting DME, the same assumptions from "Calculating number of days covered" apply.</i></p>
<b>Example A</b>	<p><i>ITE with a single dispensing event:</i> A prescription for a 45-days supply of lorazepam containing 40 pills, 2.5 mg each pill.</p> <p>The benzodiazepine dosage unit is 0.8889. The DME daily dose is 0.4445.</p> <p>The average starting DME is <math>(0.4445 * 30) / 30 = 0.4445</math>.</p>
<b>Example B</b>	<p><i>ITE with multiple consecutive dispensing events:</i></p> <ul style="list-style-type: none"> <li>The first dispensing event in the ITE is a 7 days supply of diazepam containing 7 pills, 2 mg each pill. <ul style="list-style-type: none"> <li>The benzodiazepine dosage unit is 1 and the DME daily dose is 2.</li> </ul> </li> <li>The second dispensing event in the ITE is a 60-days supply of diazepam containing 30 pills, 10 mg each pill. <ul style="list-style-type: none"> <li>The benzodiazepine dosage unit is 0.5 and the DME daily dose is 5.</li> </ul> </li> </ul> <p>The average starting DME is: <math>[(2 * 7) + (5 * 23)] / 30 = 4.3</math>.</p>
<b>Benzodiazepine dosage units</b>	<p>For each dispensing event, use the following calculation to determine the benzodiazepine dosage units per day.</p> $\# \text{ of benzodiazepine dosage units per day} = (\text{benzodiazepine quantity dispensed}) / (\text{benzodiazepine days supply})$

<p><b>Calculating number of days covered</b></p>	<p>Use the following steps to identify and calculate covered days.</p> <p><b>Step 1.</b> Identify dispensing events where multiple prescriptions for the same medication are dispensed on the same day. Identify start and end dates for each dispensing event individually. The start date is the dispense date; the end date is the start date plus days supply minus one. The start date through the end date are considered covered days.</p> <p><i>Note:</i> This step assumes prescriptions are taken concurrently.</p> <p><b>Step 2.</b> For multiple prescriptions for different medications dispensed on the same day, sum the days supply. Use the following order of operations for calculating days covered.</p> <ul style="list-style-type: none"> <li>• Order dispensing events by date, from earliest to latest.</li> <li>• Order dispensing events by days supply, from longest to shortest. For dispensing events with the same days supply, order by DME, from highest to lowest, using the same drug, same-day combined dose in scenarios where that occurs.</li> </ul> <p>Identify the start and end dates. The start date is the date of service of the earliest dispensing event; the end date is the start date plus the summed days supply minus one. The start date through the end date are considered covered days.</p> <ul style="list-style-type: none"> <li>• <i>For example</i>, if there are three 7 days supply dispensing events for three different medications on January 1, the start date is January 1 and the end date is January 21. Covered days include January 1–21.</li> </ul> <p><i>Note:</i> This step assumes taking one prescription at a time (and starting the next prescription after exhausting the previous prescription).</p> <p><b>Step 3.</b> For multiple prescriptions of the same or different medication dispensed on different days with overlapping days supply, sum the days supply.</p> <p>Identify the start and end dates. The start date is the date of service of the earliest dispensing event; the end date is the start date plus the summed days supply minus one. The start date through the end date are considered covered days.</p> <ul style="list-style-type: none"> <li>• <i>For example</i>, for different medications, if there are three 7 days supply dispensing events on January 1, a 7 days supply dispensing event on January 20 and a 7 days supply dispensing event on January 28, the start date is January 1 and the end date is February 4. Covered days include January 1–February 4.</li> </ul> <p><i>Note:</i> Use the order of operations outlined in step 2 for calculating days covered. This step assumes taking one prescription at a time (and starting the next prescription after exhausting the previous prescription).</p> <p><b>Step 4.</b> For multiple prescriptions of the same or different medication dispensed on different days without an overlapping days supply, identify the start and end dates for each dispensing event individually. The start date is the date of service of the dispensing event; the end date is the start date plus the days supply minus one. The start date through the end date are considered covered days.</p>
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	<p><b>Note:</b> Use the order of operations in step 2 to calculate days covered. This step assumes taking one prescription at a time (and starting the next prescription after exhausting the previous prescription).</p> <p><b>Step 5.</b> If steps 2–4 create new overlapping dispensing events, concatenate the dispensing events following the order of operations outlined in step 2. This step assumes the person will start taking the next prescriptions after exhausting the previous prescriptions.</p>
<b>DME</b>	Diazepam milligram equivalent. The dose of oral diazepam that is the equivalent of a given dose of another benzodiazepine. Refer to the Oral Benzodiazepine Medications table for conversion factors.
<b>DME daily dose</b>	<p>For each dispensing event, use the following calculation to determine the DME daily dose. Convert each medication into the DME using the appropriate conversion factor and strength associated with the benzodiazepine product of the dispensing event (refer to the Oral Benzodiazepine Medications table for DME conversion factor and strength).</p> $\text{DME daily dose} = (\# \text{ of benzodiazepine dosage units}) \times (\text{strength} \\ [\text{e.g., mg, mcg}]) \times (\text{DME conversion factor} \\ [\text{refer to the Oral Benzodiazepine Medications table}]).$ <p><b>Note:</b> When calculating DME daily dose, the same assumptions from “Calculating number of days covered” apply.</p>
<b>Ending DME</b>	<p>The DME daily dose for the final dispensing event(s) of the treatment period.</p> <p>For overlapping dispensing events, use the last covered day of the treatment period to calculate the ending DME. Do not round when calculating DME daily dose. If there are no pharmacy claims for a benzodiazepine medication for at least 60 days in the measurement period after the last covered day of the treatment period, assume 100% discontinuation and set the ending DME to 0.</p> <p><b>Note:</b> When calculating ending DME, the assumptions from “calculating number of days covered” apply. When calculating the number of benzodiazepine dosage units per day for the ending DME, include any days supply that extends beyond December 31 of the measurement period. For example, if on December 28 a person is dispensed a 30-days supply of a benzodiazepine (quantity 30), the number of benzodiazepine dosage units per day is 1.</p>
<b>Identifying same or different drugs</b>	<p>To identify same or different drugs, use the medication lists specified for the measure in the Oral Benzodiazepine Medications table. The table includes a “Medication Lists” column that identifies the same medications by grouping them on the same row.</p> <ul style="list-style-type: none"> <li>• For example, all medications listed in the “Alprazolam” row in the Oral Benzodiazepine Medications table are considered the “same” medication.</li> </ul>
<b>ITE</b>	<p>Index treatment episode. The first 30 covered days of a benzodiazepine prescription occurring during January 1 and September 1 of the measurement period, with no gaps allowed. The ITE start date is the date of the earliest benzodiazepine prescription dispense date between January 1 and September 1 of the measurement period that is followed by ≥29 consecutive covered days with no gaps. The end date is the start date plus 29 days.</p>

PDC	<p><b>Note:</b> The ITE may comprise multiple dispensing events if there is no gap in covered days between prescriptions.</p> <p>Proportion of days covered. The number of days a person is covered by at least one benzodiazepine medication prescription, divided by the number of days in the treatment period. Multiply by 100 and round (using the .5 rule) to the nearest whole number.</p>
Treatment period	Begins the day after the ITE end date through the last covered day in the measurement period.
Initial population	<p><b>Measure item count:</b> Person.</p> <p><b>Attribution basis:</b> Enrollment.</p> <ul style="list-style-type: none"> <li>• <b>Benefits:</b> Medical and pharmacy.</li> <li>• <b>Continuous enrollment:</b> The measurement period and the year prior to the measurement period.</li> <li>• <b>Allowable gap:</b> <ul style="list-style-type: none"> <li>– <b>Measurement period:</b> None.</li> <li>– <b>Year prior to the measurement period:</b> No more than one gap of ≤45 days.</li> </ul> </li> </ul> <p><b>Ages:</b> 67 years of age and older as of the last day of the measurement period.</p> <p><b>Event: Persons dispensed a benzodiazepine.</b></p> <p><b>Step 1.</b> Identify persons with two or more benzodiazepine dispensing events on different dates of service (refer to the Oral Benzodiazepine Medications table for medication lists for identifying benzodiazepine dispensing events) during the measurement period.</p> <p><b>Step 2.</b> Of the persons identified in step 1, identify those with a qualifying ITE.</p> <p><b>Step 3.</b> Of the persons identified in step 2, identify those with PDC ≥50% during the treatment period.</p>
Denominator exclusions	<p><b>Persons with a date of death.</b> Death in the measurement period, identified using data sources determined by the organization. Method and data sources are subject to review during the HEDIS audit.</p> <p><b>Persons in hospice or using hospice services.</b> Persons who use hospice services (<u>Hospice Encounter Value Set</u>; <u>Hospice Intervention Value Set</u>) or elect to use a hospice benefit any time during the measurement period. Organizations that use the Monthly Membership Detail Data File to identify these persons must use only the run date of the file.</p> <p><b>Persons receiving palliative care.</b> Persons receiving palliative care (<u>Palliative Care Assessment Value Set</u>; <u>Palliative Care Encounter Value Set</u>; <u>Palliative Care Intervention Value Set</u>) or who had an encounter for palliative care (ICD-10-CM code Z51.5*) any time during the measurement period.</p>

	<p><b>Persons with a diagnosis of a seizure disorder, rapid eye movement sleep behavior disorder, or who experienced benzodiazepine or ethanol withdrawal.</b></p> <p>Seizure disorders (<a href="#">Seizure Disorders Value Set*</a>); rapid eye movement sleep behavior disorder (<a href="#">REM Sleep Behavior Disorder Value Set*</a>); benzodiazepine withdrawal (<a href="#">Benzodiazepine Withdrawal Value Set*</a>); or ethanol withdrawal (<a href="#">Alcohol Withdrawal Value Set*</a>) on or between January 1 of the year prior to the measurement period and the ITE start date.</p> <p><b>Coding Guidance</b></p> <p>*Do not include laboratory claims (claims with POS code 81).</p>												
<b>Denominator</b>	The initial population minus denominator exclusions.												
<b>Numerator</b>	<p><b>Persons who achieved a ≥20% decrease or greater in DME daily benzodiazepine dosage.</b></p> <p><b>Step 1.</b> Identify the average starting DME.</p> <ol style="list-style-type: none"> <li>1. Identify the ITE.</li> <li>2. Calculate benzodiazepine dosage units during the ITE.</li> <li>3. Calculate average starting DME daily dose.</li> </ol> <p><b>Step 2.</b> Identify the ending DME.</p> <ol style="list-style-type: none"> <li>1. Identify the final benzodiazepine dispensing event(s) during the treatment period.</li> <li>2. Calculate benzodiazepine dosage units for the final dispensing event(s).</li> <li>3. Calculate ending DME daily dose.</li> </ol> <p><b>Step 3.</b> Calculate the percentage change between the average starting DME and the ending DME.</p> $[(\text{Average Starting DME} - \text{Ending DME}) / \text{Average Starting DME}] \times 100$ <p><b>Step 4.</b> Determine numerator compliance. The person is compliant if either of the following conditions are met:</p> <ul style="list-style-type: none"> <li>• The person's percent reduction is ≥20%.</li> <li>• The person achieves 100% discontinuation with an ending DME set to 0.</li> </ul> <p><b>Oral Benzodiazepine Medications</b></p> <table border="1"> <thead> <tr> <th>Type of Benzodiazepine</th> <th>Medication Lists</th> <th>Strength</th> <th>DME Conversion Factor</th> </tr> </thead> <tbody> <tr> <td>Alprazolam (oral)</td> <td> <a href="#">Alprazolam 0.25 MG Medications List</a>  <a href="#">Alprazolam 0.5 MG Medications List</a>  <a href="#">Alprazolam 1 MG Medications List</a>  <a href="#">Alprazolam 1 MGPML Medications List</a>  <a href="#">Alprazolam 2 MG Medications List</a>  <a href="#">Alprazolam 3 MG Medications List</a> </td> <td>           0.25 mg            0.5 mg            1 mg            1 mg            2 mg            3 mg         </td> <td>0.1</td> </tr> <tr> <td>Chlordiazepoxide (oral)</td> <td> <a href="#">Chlordiazepoxide 5 MG Medications List</a>  <a href="#">Chlordiazepoxide 10 MG Medications List</a>  <a href="#">Chlordiazepoxide 25 MG Medications List</a> </td> <td>           5 mg            10 mg            25 mg         </td> <td>2.5</td> </tr> </tbody> </table>	Type of Benzodiazepine	Medication Lists	Strength	DME Conversion Factor	Alprazolam (oral)	<a href="#">Alprazolam 0.25 MG Medications List</a> <a href="#">Alprazolam 0.5 MG Medications List</a> <a href="#">Alprazolam 1 MG Medications List</a> <a href="#">Alprazolam 1 MGPML Medications List</a> <a href="#">Alprazolam 2 MG Medications List</a> <a href="#">Alprazolam 3 MG Medications List</a>	0.25 mg 0.5 mg 1 mg 1 mg 2 mg 3 mg	0.1	Chlordiazepoxide (oral)	<a href="#">Chlordiazepoxide 5 MG Medications List</a> <a href="#">Chlordiazepoxide 10 MG Medications List</a> <a href="#">Chlordiazepoxide 25 MG Medications List</a>	5 mg 10 mg 25 mg	2.5
Type of Benzodiazepine	Medication Lists	Strength	DME Conversion Factor										
Alprazolam (oral)	<a href="#">Alprazolam 0.25 MG Medications List</a> <a href="#">Alprazolam 0.5 MG Medications List</a> <a href="#">Alprazolam 1 MG Medications List</a> <a href="#">Alprazolam 1 MGPML Medications List</a> <a href="#">Alprazolam 2 MG Medications List</a> <a href="#">Alprazolam 3 MG Medications List</a>	0.25 mg 0.5 mg 1 mg 1 mg 2 mg 3 mg	0.1										
Chlordiazepoxide (oral)	<a href="#">Chlordiazepoxide 5 MG Medications List</a> <a href="#">Chlordiazepoxide 10 MG Medications List</a> <a href="#">Chlordiazepoxide 25 MG Medications List</a>	5 mg 10 mg 25 mg	2.5										

Type of Benzodiazepine	Medication Lists	Strength	DME Conversion Factor
Clonazepam (oral)	<a href="#">Clonazepam 0.125 MG Medications List</a> <a href="#">Clonazepam 0.25 MG Medications List</a> <a href="#">Clonazepam 0.5 MG Medications List</a> <a href="#">Clonazepam 1 MG Medications List</a> <a href="#">Clonazepam 2 MG Medications List</a>	0.125 mg 0.25 mg 0.5 mg 1 mg 2 mg	0.1
Clorazepate (oral)	<a href="#">Clorazepate 3.75 MG Medications List</a> <a href="#">Clorazepate 7.5 MG Medications List</a> <a href="#">Clorazepate 15 MG Medications List</a>	3.75 mg 7.5 mg 15 mg	1.5
Diazepam (oral)	<a href="#">Diazepam 1 MGPML Medications List</a> <a href="#">Diazepam 2 MG Medications List</a> <a href="#">Diazepam 5 MG Medications List</a> <a href="#">Diazepam 5 MGPML Medications List</a> <a href="#">Diazepam 10 MG Medications List</a>	1 mg 2mg 5mg 5mg 10 mg	1
Estazolam (oral)	<a href="#">Estazolam 1 MG Medications List</a> <a href="#">Estazolam 2 MG Medications List</a>	1 mg 2 mg	0.3
Flurazepam (oral)	<a href="#">Flurazepam 15 MG Medications List</a> <a href="#">Flurazepam 30 MG Medications List</a>	15 mg 30 mg	3
Lorazepam (oral)	<a href="#">Lorazepam 1 MG Medications List</a> <a href="#">Lorazepam 2 MGPML Medications List</a>	1 mg 2 mg	0.2
Midazolam (oral)	<a href="#">Midazolam 2 MGPML Medications List</a>	2 mg	1.5
Oxazepam (oral)	<a href="#">Oxazepam 10 MG Medications List</a> <a href="#">Oxazepam 30 MG Medications List</a>	10 mg 30 mg	3
Quazepam (oral)	<a href="#">Quazepam 15 MG Medications List</a>	15 mg	2
Temazepam (oral)	<a href="#">Temazepam 7.5 MG Medications List</a> <a href="#">Temazepam 15 MG Medications List</a> <a href="#">Temazepam 22.5 MG Medications List</a> <a href="#">Temazepam 30 MG Medications List</a>	7.5 mg 15 mg 22.5 mg 30 mg	2
Triazolam (oral)	<a href="#">Triazolam 0.125 MG Medications List</a> <a href="#">Triazolam 0.25 MG Medications List</a>	0.125 mg 0.25 mg	0.025
<b>Summary of changes</b>	<ul style="list-style-type: none"> <li>No changes to this measure.</li> </ul>		

<b>Data element tables</b>	<p>Organizations that submit HEDIS data to NCQA must provide the following data elements.</p> <p><b>Table DBO-3: Data Elements for Deprescribing of Benzodiazepines in Older Adults</b></p> <table border="1"> <thead> <tr> <th>Metric</th><th>Diagnosis</th><th>Data Element</th><th>Reporting Instructions</th></tr> </thead> <tbody> <tr> <td>BenzodiazepinesInOlderAdults</td><td>WithGAD</td><td>Benefit</td><td>Metadata</td></tr> <tr> <td></td><td>WithoutGAD</td><td>InitialPopulation</td><td>For each Stratification</td></tr> <tr> <td></td><td>Total</td><td>Exclusions</td><td>For each Stratification</td></tr> <tr> <td></td><td></td><td>Denominator</td><td>For each Stratification</td></tr> <tr> <td></td><td></td><td>NumeratorByAdmin</td><td>For each Stratification</td></tr> <tr> <td></td><td></td><td>Rate</td><td>(Percent)</td></tr> </tbody> </table>	Metric	Diagnosis	Data Element	Reporting Instructions	BenzodiazepinesInOlderAdults	WithGAD	Benefit	Metadata		WithoutGAD	InitialPopulation	For each Stratification		Total	Exclusions	For each Stratification			Denominator	For each Stratification			NumeratorByAdmin	For each Stratification			Rate	(Percent)
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<b>Rules for Allowable Adjustments</b>	<p><b>Copyright and use:</b> The “Rules for Allowable Adjustments of HEDIS” (the “Rules”) describe how NCQA’s HEDIS measure specifications can be adjusted for other populations, if applicable. The Rules, reviewed and approved by NCQA measure experts, provide for expanded use of HEDIS measures without changing their clinical intent.</p> <p><b>Adjusted HEDIS measures may not be used for HEDIS health plan reporting.</b></p> <p><b>ADJUSTMENTS ALLOWED</b></p> <ul style="list-style-type: none"> <li>• <b>Product lines.</b> Organizations are not required to use product line criteria; product lines may be combined, and all (or no) product line criteria may be used.</li> <li>• <b>Attribution.</b> Organizations are not required to use enrollment criteria.</li> <li>• <b>Benefits.</b> Organizations are not required to use a benefit.</li> <li>• <b>Other.</b> Organizations may use additional initial population criteria to focus on an area of interest defined by gender, race, ethnicity, socioeconomic or sociodemographic characteristics, geographic region or another characteristic.</li> <li>• <b>Measurement period adjustments.</b> Organizations may adjust the measurement period.</li> <li>• <b>Exclusions.</b> Hospice, deceased persons and palliative care exclusions are not required.</li> <li>• <b>Telehealth.</b> Services/events that allow the use of synchronous telehealth visits, telephone visits and asynchronous telehealth (e-visits, virtual check-ins) may be stratified to identify services performed via telehealth. This adjustment is not allowed for events, numerators and exclusions that do not allow the use of telehealth.</li> </ul>																												

- *Supplemental data.* Supplemental data may be used to identify initial population, denominator, exclusion and numerator events.

**ADJUSTMENTS ALLOWED WITH LIMITS**

- *Ages.* The age determination dates may be changed (e.g., select, "age as of June 30"). The denominator age may not be expanded.
- *Stratifications.* Stratifications are not required, but if they are used, value sets and logic may not be changed.
- *Numerator.* Medication lists and logic may not be changed. Organizations may include denied claims to calculate the numerator.

**ADJUSTMENTS NOT ALLOWED**

- *Exclusions.* The diagnosis of seizure disorders, rapid eye movement sleep behavior disorder, benzodiazepine and ethanol withdrawal exclusions must be applied. Value sets and logic may not be changed.
- *Initial population:* Event. Medication lists, value sets and logic may not be changed.

## Use of Opioids at High Dosage (HDO)

Measure title	Use of Opioids at High Dosage*	Measure ID	HDO
<b>Description</b>	The percentage of persons 18 years of age and older who received prescription opioids at a high dosage (average morphine milligram equivalent dose [MME] $\geq 90$ ) for $\geq 15$ days during the measurement period.		
<b>Measurement period</b>	January 1–December 31.		
<b>Copyright and disclaimer notice</b>	<p>*Adapted with financial support from CMS and with permission from the measure developer, Pharmacy Quality Alliance (PQA).</p> <p>Refer to the complete copyright and disclaimer information at the front of this publication.</p> <p>NCQA website: <a href="http://www.ncqa.org">www.ncqa.org</a>.</p> <p>Submit policy clarification support questions via My NCQA (<a href="https://my.ncqa.org">https://my.ncqa.org</a>).</p>		
<b>Clinical recommendation statement/ rationale</b>	<p>Long-term daily use of opioids can lead to increased tolerance, addiction or dependence. Studies suggest a correlation between high opioid dosage and a greater risk of overdoses and fractures. The 2022 CDC guideline on opioid prescribing recommends the use of “additional precautions” when prescribing dosages <math>\geq 50</math> morphine equivalent dose (MED), and generally recommends avoiding dosages <math>\geq 90</math>mg MED. For patients who are already taking doses <math>\geq 90</math>mg MED, the CDC recommends that clinicians should “explain in a nonjudgmental manner” the risks and benefits of continuing high-dose opioids, and should offer these patients the opportunity to taper to a safer, lower dose.</p>		
<b>Citations</b>	<p>CDC. 2022. <i>CDC Clinical Practice Guideline for Prescribing Opioids for Pain — United States</i>, 2022. <a href="http://dx.doi.org/10.15585/mmwr.rr7103a1">http://dx.doi.org/10.15585/mmwr.rr7103a1</a></p> <p>Dunn, K.M., K.W. Saunders, C.M. Rutter, C.J. Banta-Green, J.O. Merrill, M.D. Sullivan, M. Von Korff. 2010. “Overdose and Prescribed Opioids: Associations Among Chronic Non-Cancer Pain Patients.” <i>Annals of Internal Medicine</i> 152(2), 85–92. <a href="http://doi.org/10.1059/0003-4819-152-2-201001190-00006">http://doi.org/10.1059/0003-4819-152-2-201001190-00006</a></p> <p>King, L. 2007. “Pain Medications: How Long is Too Long.” Pain EDU. <a href="http://www.painedu.org/articles_timely.asp?ArticleNumber=10">http://www.painedu.org/articles_timely.asp?ArticleNumber=10</a> (Accessed January 5, 2016)</p> <p>Paulozzi, L.J., et al. 2011. “A History of Being Prescribed Controlled Substances and Risk of Drug Overdose Death.” <i>Pain Medicine</i> 13: 87–95. doi: 10.1111/j.1526-4637.2011.01260.x.</p> <p>Saunders, K.W., K.M. Dunn, J.O. Merrill, M. Sullivan, C. Weisner, J.B. Braden, M. Von Korff. 2010. “Relationship of Opioid Use and Dosage Levels to Fractures in Older Chronic Pain Patients.” <i>Journal of General Internal Medicine</i> 25(4), 310–15. <a href="http://doi.org/10.1007/s11606-009-1218-z">http://doi.org/10.1007/s11606-009-1218-z</a></p>		

Characteristics	
<b>Scoring</b>	Proportion.
<b>Type</b>	Process.
<b>Product lines</b>	<ul style="list-style-type: none"> <li>• Commercial.</li> <li>• Medicaid.</li> <li>• Medicare.</li> </ul>
<b>Stratifications</b>	None.
<b>Risk adjustment</b>	None.
<b>Improvement notation</b>	Decreased score indicates improvement.
<b>Guidance</b>	<p><b>Data collection methodology:</b> Administrative. Refer to <a href="#">General Guideline: Data Collection Methods</a> for additional information.</p> <p><b>Date specificity:</b> Dates must be specific enough to determine the event occurred in the period being measured.</p> <p><b>Which services count?</b></p> <ul style="list-style-type: none"> <li>• Do not include denied claims when identifying initial population and numerator events; only include claims the organization paid for or expects to pay for (i.e., claims incurred but not paid).</li> <li>• Include all paid, suspended, pending and denied claims to identify the denominator exclusions.</li> </ul> <p><b>Supplemental data exceptions:</b> Supplemental data may not be used for this measure, except for denominator exclusions.</p> <p><b>Medication lists:</b></p> <ul style="list-style-type: none"> <li>• If an organization uses both pharmacy data (NDC codes) and clinical data (RxNorm codes) for reporting, and there are both NDC and RxNorm codes on the same date of service, use only one data source for the date of service (only NDC codes or only RxNorm codes).</li> <li>• This measure does not include the following opioid medications: <ul style="list-style-type: none"> <li>– Injectables.</li> <li>– Opioid cough and cold products.</li> <li>– Ionsys® (fentanyl transdermal patch). This is for inpatient use only and is available only through a restricted program under a Risk Evaluation and Mitigation Strategy (REMS).</li> <li>– Methadone for the treatment of opioid use disorder.</li> </ul> </li> </ul>
Definitions	
<b>Average MME</b>	The average MME for all opioids dispensed during the treatment period.

<b>Calculating number of days covered for the denominator</b>	<p><b>Step 1.</b> Identify dispensing events where multiple prescriptions for the same medication are dispensed with overlapping days supply (i.e., dispensed on the same day or dispensed on different days with overlapping days supply). Sum the days supply for these dispensing events.</p> <p>Identify the start and end dates. The start date is the date of service of the earliest dispensing event; the end date is the start date plus the summed days supply minus one. The start date through the end date are considered covered days.</p> <ul style="list-style-type: none"> <li>• <i>For example:</i></li> </ul> <ul style="list-style-type: none"> <li>– If there are three 7 days supply dispensing events for the same medication on January 1, the start date is January 1 and the end date is January 21. Covered days include January 1–21.</li> <li>– If there are two 7 days supply dispensing events for the same medication on January 1 and January 5, the start date is January 1 and the end date is January 14. Covered days include January 1–14.</li> <li>– If there are three 7 days supply dispensing events for the same medication on January 1, a 7 days supply dispensing event on January 20, and a 7 days supply dispensing event on January 28, the start date is January 1 and the end date is February 4. Covered days include January 1–February 4.</li> </ul>
<b>Identifying same or different drugs</b>	<p><b>Step 2.</b> For all other dispensing events (i.e., multiple prescriptions for the same medication on different days, without overlap; multiple prescriptions for different medications on the same or different days, with or without overlap), identify the start and end dates for each dispensing event individually. The start date through the end date are considered covered days.</p> <p><b>Step 3.</b> Count the covered days. Consider each calendar day covered by one or more medications to be one covered day.</p>
<b>MME</b>	<p>To identify “same” or “different” drugs, use Table HDO-A, which identifies the medications lists for the measure. Dispensing events from any of the fentanyl medication lists, even if they are on different rows, are all considered the “same” drug.</p> <p>For all other types of opioids, the table includes a “Medication Lists” column that identifies the “same” high-risk medications by grouping them on the same row.</p> <ul style="list-style-type: none"> <li>• <i>For example:</i></li> </ul> <ul style="list-style-type: none"> <li>– A dispensing event from the <u>Codeine Sulfate 15 mg Medications List</u> is considered the same drug as a dispensing event from the <u>Codeine Sulfate 30 mg Medications List</u>.</li> <li>– Conversely, a dispensing event from the <u>Codeine Sulfate 15 mg Medications List</u> is considered a different drug than a dispensing event from the <u>Acetaminophen Codeine 15 mg Medications List</u> because they are in different table rows.</li> </ul> <p>Morphine milligram equivalent. The dose of oral morphine that is the analgesic equivalent of a given dose of another opioid analgesic (Table HDO-A).</p>

<b>MME daily dose</b>	For each dispensing event, use the following calculation to determine the MME daily dose. Convert each medication into the MME using the appropriate MME conversion factor and strength associated with the opioid product of the dispensing event (refer to Table HDO-A for MME conversion factor and strength).  $\text{MME Daily Dose} = (\# \text{ of opioid dosage units per day}) \times (\text{strength (e.g., mg, mcg)}) \times (\text{MME conversion factor [Table HDO-A]})$ <ul style="list-style-type: none"> <li>• <i>For example:</i> <ul style="list-style-type: none"> <li>– 10 mg oxycodone tablets X (120 tablets / 30 days) X 1.5 = 60 MME/day.</li> <li>– 25 mcg/hr fentanyl patch X (10 patches / 30 days) X 7.2 = 60 MME / day.</li> </ul> </li> </ul>
<b>Opioid dosage unit</b>	For each dispensing event, use the following calculation to determine the opioid dosage unit.  $\# \text{ of Opioid Dosage Units per day} = (\text{opioid quantity dispensed}) / (\text{opioid days supply})$
<b>Total daily MME</b>	The total sum of the MME daily doses for all opioid dispensing events on 1 day.
<b>Treatment period</b>	<i>To identify the treatment period:</i> For all dispensing events, identify the start and end dates for each dispensing event individually. The treatment period start date is the start date of the earliest dispensing event during the measurement period. The treatment period end date is the last end date during the measurement period.
<b>Initial population</b>	<p><i>Measure item count:</i> Person.</p> <p><i>Attribution basis:</i> Enrollment.</p> <ul style="list-style-type: none"> <li>• <i>Benefits:</i> Medical and pharmacy.</li> <li>• <i>Continuous enrollment:</i> The measurement period.</li> <li>• <i>Allowable gap:</i> None.</li> </ul> <p><i>Ages:</i> 18 years of age and older as of the first day of the measurement period.</p> <p><i>Event:</i> Persons who had two or more opioid dispensing events on different dates of service and had ≥15 total days covered by opioids. Use all the medication lists in Table HDO-A to identify opioid medication dispensing events.</p>
<b>Denominator exclusions</b>	<p><b>Persons with a date of death.</b> Death in the measurement period, identified using data sources determined by the organization. Method and data sources are subject to review during the HEDIS audit.</p> <p><b>Persons in hospice or using hospice services.</b> Persons who use hospice services (<u>Hospice Encounter Value Set</u>; <u>Hospice Intervention Value Set</u>) or elect to use a hospice benefit any time during the measurement period. Organizations that use the Monthly Membership Detail Data File to identify these persons must use only the run date of the file.</p>

	<p><b>Persons receiving palliative care.</b> Persons receiving palliative care (<u>Palliative Care Assessment Value Set</u>; <u>Palliative Care Encounter Value Set</u>; <u>Palliative Care Intervention Value Set</u>) or who had an encounter for palliative care (ICD-10-CM code Z51.5*) any time during the measurement period.</p> <p><b>Cancer or sickle cell disease.</b> Persons with cancer (<u>Malignant Neoplasms Value Set*</u>) or sickle cell disease (<u>Sickle Cell Anemia and HB S Disease Value Set*</u>) during the measurement period.</p> <p><b>Coding Guidance</b> *Do not include laboratory claims (claims with POS code 81).</p>																
<b>Denominator</b>	The initial population minus denominator exclusions.																
<b>Numerator</b>	<p><b>Persons whose average MME was <math>\geq 90</math> during the treatment period.</b></p> <p><b>Step 1.</b> Use all the medication lists in Table HDO-A to identify all opioid medication dispensing events during the measurement period.</p> <p><b>Step 2.</b> For each person, calculate the MME daily dose for each medication dispensing event.</p> <p><b>Step 3.</b> For a single dispensing event, multiply the MME daily dose by the dispensing event's days supply.</p> <ul style="list-style-type: none"> <li>• <i>For example</i>, a dispensing event with a MME daily dose of 90 and a days supply of 5 would have a total MME of 450 for that dispensing event.</li> </ul> <p>As multiple dispensing events can overlap on one calendar day, for each day, sum the MME daily doses for all dispensing events to determine the total daily MME for that day.</p> <p><b>Step 4.</b> Determine the treatment period.</p> <p><b>Step 5.</b> Determine the average MME. Sum the total daily MME for the treatment period and divide by the number of days in the treatment period. Persons whose average MME was <math>\geq 90</math> meet the numerator criteria.</p> <p><b>Table HDO-A: Opioid Medications</b></p> <table border="1"> <thead> <tr> <th>Type of Opioid</th> <th>Medication Lists</th> <th>Strength</th> <th>MME Conversion Factor</th> </tr> </thead> <tbody> <tr> <td>Benzhydrocodone</td> <td> <u>Acetaminophen Benzhydrocodone 4.08 mg Medications List</u>  <u>Acetaminophen Benzhydrocodone 6.12 mg Medications List</u>  <u>Acetaminophen Benzhydrocodone 8.16 mg Medications List</u> </td> <td>4.08 mg 6.12 mg 8.16 mg</td> <td>1.2</td> </tr> <tr> <td>Butorphanol</td> <td><u>Butorphanol 10 MGPM Medications List</u></td> <td>10 mg</td> <td>7</td> </tr> <tr> <td>Codeine</td> <td> <u>Codeine Sulfate 15 mg Medications List</u>  <u>Codeine Sulfate 30 mg Medications List</u>  <u>Codeine Sulfate 60 mg Medications List</u> </td> <td>15 mg 30 mg 60 mg</td> <td>0.15</td> </tr> </tbody> </table>	Type of Opioid	Medication Lists	Strength	MME Conversion Factor	Benzhydrocodone	<u>Acetaminophen Benzhydrocodone 4.08 mg Medications List</u> <u>Acetaminophen Benzhydrocodone 6.12 mg Medications List</u> <u>Acetaminophen Benzhydrocodone 8.16 mg Medications List</u>	4.08 mg 6.12 mg 8.16 mg	1.2	Butorphanol	<u>Butorphanol 10 MGPM Medications List</u>	10 mg	7	Codeine	<u>Codeine Sulfate 15 mg Medications List</u> <u>Codeine Sulfate 30 mg Medications List</u> <u>Codeine Sulfate 60 mg Medications List</u>	15 mg 30 mg 60 mg	0.15
Type of Opioid	Medication Lists	Strength	MME Conversion Factor														
Benzhydrocodone	<u>Acetaminophen Benzhydrocodone 4.08 mg Medications List</u> <u>Acetaminophen Benzhydrocodone 6.12 mg Medications List</u> <u>Acetaminophen Benzhydrocodone 8.16 mg Medications List</u>	4.08 mg 6.12 mg 8.16 mg	1.2														
Butorphanol	<u>Butorphanol 10 MGPM Medications List</u>	10 mg	7														
Codeine	<u>Codeine Sulfate 15 mg Medications List</u> <u>Codeine Sulfate 30 mg Medications List</u> <u>Codeine Sulfate 60 mg Medications List</u>	15 mg 30 mg 60 mg	0.15														

Type of Opioid	Medication Lists	Strength	MME Conversion Factor
Codeine	<a href="#">Acetaminophen Codeine 2.4 MGPML Medications List</a> <a href="#">Acetaminophen Codeine 15 mg Medications List</a> <a href="#">Acetaminophen Codeine 30 mg Medications List</a> <a href="#">Acetaminophen Codeine 60 mg Medications List</a>	2.4 mg 15 mg 30 mg 60 mg	0.15
Codeine	<a href="#">Acetaminophen Butalbital Caffeine Codeine 30 mg Medications List</a>	30 mg	0.15
Codeine	<a href="#">Aspirin Butalbital Caffeine Codeine 30 mg Medications List</a>	30 mg	0.15
Codeine	<a href="#">Aspirin Carisoprodol Codeine 16 mg Medications List</a>	16 mg	0.15
Dihydrocodeine	<a href="#">Acetaminophen Caffeine Dihydrocodeine 16 mg Medications List</a>	16 mg	0.25
Fentanyl buccal or sublingual tablet, transmucosal lozenge (mcg) <sup>1</sup>	<a href="#">Fentanyl 100 mcg Medications List</a> <a href="#">Fentanyl 200 mcg Medications List</a> <a href="#">Fentanyl 300 mcg Medications List</a> <a href="#">Fentanyl 400 mcg Medications List</a> <a href="#">Fentanyl 600 mcg Medications List</a> <a href="#">Fentanyl 800 mcg Medications List</a> <a href="#">Fentanyl 1200 mcg Medications List</a> <a href="#">Fentanyl 1600 mcg Medications List</a>	100 mcg 200 mcg 300 mcg 400 mcg 600 mcg 800 mcg 1200 mcg 1600 mcg	0.13
Fentanyl oral spray (mcg) <sup>2</sup>	<a href="#">Fentanyl 100 MCGPS Oral Medications List</a> <a href="#">Fentanyl 200 MCGPS Oral Medications List</a> <a href="#">Fentanyl 400 MCGPS Oral Medications List</a> <a href="#">Fentanyl 600 MCGPS Oral Medications List</a> <a href="#">Fentanyl 800 MCGPS Oral Medications List</a>	100 mcg 200 mcg 400 mcg 600 mcg 800 mcg	0.18
Fentanyl nasal spray (mcg) <sup>3</sup>	<a href="#">Fentanyl 100 MCGPS Nasal Medications List</a> <a href="#">Fentanyl 300 MCGPS Nasal Medications List</a> <a href="#">Fentanyl 400 MCGPS Nasal Medications List</a>	100 mcg 300 mcg 400 mcg	0.16
Fentanyl transdermal film/patch (mcg/hr) <sup>4</sup>	<a href="#">Fentanyl 12 MCGPH Medications List</a> <a href="#">Fentanyl 25 MCGPH Medications List</a> <a href="#">Fentanyl 37.5 MCGPH Medications List</a> <a href="#">Fentanyl 50 MCGPH Medications List</a> <a href="#">Fentanyl 62.5 MCGPH Medications List</a> <a href="#">Fentanyl 75 MCGPH Medications List</a> <a href="#">Fentanyl 87.5 MCGPH Medications List</a> <a href="#">Fentanyl 100 MCGPH Medications List</a>	12 mcg 25 mcg 37.5 mcg 50 mcg 62.5 mcg 75 mcg 87.5 mcg 100 mcg	7.2

Type of Opioid	Medication Lists	Strength	MME Conversion Factor
Hydrocodone	<a href="#">Hydrocodone 10 mg Medications List</a> <a href="#">Hydrocodone 15 mg Medications List</a> <a href="#">Hydrocodone 20 mg Medications List</a> <a href="#">Hydrocodone 30 mg Medications List</a> <a href="#">Hydrocodone 40 mg Medications List</a> <a href="#">Hydrocodone 50 mg Medications List</a> <a href="#">Hydrocodone 60 mg Medications List</a> <a href="#">Hydrocodone 80 mg Medications List</a> <a href="#">Hydrocodone 100 mg Medications List</a> <a href="#">Hydrocodone 120 mg Medications List</a>	10 mg 15 mg 20 mg 30 mg 40 mg 50 mg 60 mg 80 mg 100 mg 120 mg	1
Hydrocodone	<a href="#">Acetaminophen Hydrocodone .5 MGPML Medications List</a> <a href="#">Acetaminophen Hydrocodone .67 MGPML Medications List</a> <a href="#">Acetaminophen Hydrocodone 2.5 mg Medications List</a> <a href="#">Acetaminophen Hydrocodone 5 mg Medications List</a> <a href="#">Acetaminophen Hydrocodone 7.5 mg Medications List</a> <a href="#">Acetaminophen Hydrocodone 10 mg Medications List</a>	.5 mg .67 mg 2.5 mg 5 mg 7.5 mg 10 mg	1
Hydrocodone	<a href="#">Hydrocodone Ibuprofen 2.5 mg Medications List</a> <a href="#">Hydrocodone Ibuprofen 5 mg Medications List</a> <a href="#">Hydrocodone Ibuprofen 7.5 mg Medications List</a> <a href="#">Hydrocodone Ibuprofen 10 mg Medications List</a>	2.5 mg 5 mg 7.5 mg 10 mg	1
Hydromorphone	<a href="#">Hydromorphone 1 MGPML Medications List</a> <a href="#">Hydromorphone 2 mg Medications List</a> <a href="#">Hydromorphone 3 mg Medications List</a> <a href="#">Hydromorphone 4 mg Medications List</a> <a href="#">Hydromorphone 8 mg Medications List</a> <a href="#">Hydromorphone 12 mg Medications List</a> <a href="#">Hydromorphone 16 mg Medications List</a> <a href="#">Hydromorphone 32 mg Medications List</a>	1 mg 2 mg 3 mg 4 mg 8 mg 12 mg 16 mg 32 mg	4
Levorphanol	<a href="#">Levorphanol 2 mg Medications List</a> <a href="#">Levorphanol 3 mg Medications List</a>	2 mg 3 mg	11
Meperidine	<a href="#">Meperidine 10 MGPML Medications List</a> <a href="#">Meperidine 50 mg Medications List</a> <a href="#">Meperidine 100 mg Medications List</a>	10 mg 50 mg 100 mg	0.1

Type of Opioid	Medication Lists	Strength	MME Conversion Factor
Methadone <sup>5</sup>	<a href="#">Methadone 1 MGPM Medications List</a> <a href="#">Methadone 2 MGPM Medications List</a> <a href="#">Methadone 5 mg Medications List</a> <a href="#">Methadone 10 mg Medications List</a> <a href="#">Methadone 10 MGPM Medications List</a> <a href="#">Methadone 40 mg Medications List</a>	1 mg 2 mg 5 mg 10 mg 10 mg 40 mg	3
Morphine	<a href="#">Morphine 2 MGPM Medications List</a> <a href="#">Morphine 4 MGPM Medications List</a> <a href="#">Morphine 5 mg Medications List</a> <a href="#">Morphine 10 mg Medications List</a> <a href="#">Morphine 15 mg Medications List</a> <a href="#">Morphine 20 MGPM Medications List</a> <a href="#">Morphine 20 mg Medications List</a> <a href="#">Morphine 30 mg Medications List</a> <a href="#">Morphine 40 mg Medications List</a> <a href="#">Morphine 45 mg Medications List</a> <a href="#">Morphine 50 mg Medications List</a> <a href="#">Morphine 60 mg Medications List</a> <a href="#">Morphine 75 mg Medications List</a> <a href="#">Morphine 80 mg Medications List</a> <a href="#">Morphine 90 mg Medications List</a> <a href="#">Morphine 100 mg Medications List</a> <a href="#">Morphine 120 mg Medications List</a> <a href="#">Morphine 200 mg Medications List</a>	2 mg 4 mg 5 mg 10 mg 15 mg 20 mg 20 mg 30 mg 40 mg 45 mg 50 mg 60 mg 75 mg 80 mg 90 mg 100 mg 120 mg 200 mg	1
Opium	<a href="#">Belladonna Opium 30 mg Medications List</a> <a href="#">Belladonna Opium 60 mg Medications List</a>	30 mg 60 mg	1
Oxycodone	<a href="#">Oxycodone 1 MGPM Medications List</a> <a href="#">Oxycodone 5 mg Medications List</a> <a href="#">Oxycodone 7.5 mg Medications List</a> <a href="#">Oxycodone 9 mg Medications List</a> <a href="#">Oxycodone 10 mg Medications List</a> <a href="#">Oxycodone 13.5 mg Medications List</a> <a href="#">Oxycodone 15 mg Medications List</a> <a href="#">Oxycodone 18 mg Medications List</a> <a href="#">Oxycodone 20 mg Medications List</a> <a href="#">Oxycodone 20 MGPM Medications List</a> <a href="#">Oxycodone 27 mg Medications List</a> <a href="#">Oxycodone 30 mg Medications List</a> <a href="#">Oxycodone 36 mg Medications List</a> <a href="#">Oxycodone 40 mg Medications List</a> <a href="#">Oxycodone 60 mg Medications List</a>	1 mg 5 mg 7.5 mg 9 mg 10 mg 13.5 mg 15 mg 18 mg 20 mg 20 mg 27 mg 30 mg 36 mg 40 mg 60 mg	1.5

Type of Opioid	Medication Lists	Strength	MME Conversion Factor
	Oxycodone 80 mg Medications List	80 mg	
Oxycodone	<a href="#">Acetaminophen Oxycodone 1 MGPML Medications List</a> <a href="#">Acetaminophen Oxycodone 2 MGPML Medications List</a> <a href="#">Acetaminophen Oxycodone 2.5 mg Medications List</a> <a href="#">Acetaminophen Oxycodone 5 mg Medications List</a> <a href="#">Acetaminophen Oxycodone 7.5 mg Medications List</a> <a href="#">Acetaminophen Oxycodone 10 mg Medications List</a>	1 mg 2 mg 2.5 mg 5 mg 7.5 mg 10 mg	1.5
Oxycodone	<a href="#">Aspirin Oxycodone 4.84 mg Medications List</a>	4.84 mg	1.5
Oxycodone	<a href="#">Ibuprofen Oxycodone 5 mg Medications List</a>	5 mg	1.5
Oxymorphone	<a href="#">Oxymorphone 5 mg Medications List</a> <a href="#">Oxymorphone 7.5 mg Medications List</a> <a href="#">Oxymorphone 10 mg Medications List</a> <a href="#">Oxymorphone 15 mg Medications List</a> <a href="#">Oxymorphone 20 mg Medications List</a> <a href="#">Oxymorphone 30 mg Medications List</a> <a href="#">Oxymorphone 40 mg Medications List</a>	5 mg 7.5 mg 10 mg 15 mg 20 mg 30 mg 40 mg	3
Pentazocine	<a href="#">Naloxone Pentazocine 50 mg Medications List</a>	50 mg	0.37
Tapentadol	<a href="#">Tapentadol 50 mg Medications List</a> <a href="#">Tapentadol 75 mg Medications List</a> <a href="#">Tapentadol 100 mg Medications List</a> <a href="#">Tapentadol 150 mg Medications List</a> <a href="#">Tapentadol 200 mg Medications List</a> <a href="#">Tapentadol 250 mg Medications List</a>	50 mg 75 mg 100 mg 150 mg 200 mg 250 mg	0.4
Tramadol	<a href="#">Tramadol 5 MGPML Medications List</a> <a href="#">Tramadol 50 mg Medications List</a> <a href="#">Tramadol 100 mg Medications List</a> <a href="#">Tramadol 150 mg Medications List</a> <a href="#">Tramadol 200 mg Medications List</a> <a href="#">Tramadol 300 mg Medications List</a>	5 mg 50 mg 100 mg 150 mg 200 mg 300 mg	0.1
Tramadol	<a href="#">Acetaminophen Tramadol 37.5 mg Medications List</a>	37.5 mg	0.1

<sup>1</sup> MME conversion factor for fentanyl buccal tablets, sublingual tablets, and lozenges/troche is 0.13. This conversion factor should be multiplied by the number of micrograms in a given tablet or lozenge/troche.

<sup>2</sup> MME conversion factor for fentanyl films and oral sprays is 0.18. This reflects a 40% greater bioavailability for films compared to lozenges/tablets and 38% greater bioavailability for oral sprays compared to lozenges/tablets.

<sup>3</sup> MME conversion factor for fentanyl nasal spray is 0.16, which reflects a 20% greater bioavailability for sprays compared to lozenges/tablets.

	<p><sup>4</sup> MME conversion factor for fentanyl patches is 7.2 based on the assumption that one milligram of parenteral fentanyl is equivalent to 100 milligrams of oral morphine and that one patch delivers the dispensed micrograms per hour over a 24-hour day and remains in place for 3 days. Using the formula, Strength per Unit * (Number of Units/ Days Supply) * MME conversion factor = MME/Day: 25 µg/hr. fentanyl patch * (10 patches/30 days) * 7.2 = 60 MME/day.</p> <p><sup>5</sup> Adapted from Von Korff M, Saunders K, Ray GT, et al. Clin J Pain 2008;24:521-7 and Washington State Interagency Guideline on Prescribing Opioids for Pain (<a href="http://www.agencymeddirectors.wa.gov/Files/2015AMDGOpioidGuideline.pdf">http://www.agencymeddirectors.wa.gov/Files/2015AMDGOpioidGuideline.pdf</a>).</p>																					
<b>Summary of changes</b>	<ul style="list-style-type: none"> <li>No changes to this measure.</li> </ul>																					
<b>Data element tables</b>	<p>Organizations that submit HEDIS data to NCQA must provide the following data elements.</p> <p><b>Table HDO-1/2/3: Data Elements for Use of Opioids at High Dosage</b></p> <table border="1"> <thead> <tr> <th>Metric</th> <th>Data Element</th> <th>Reporting Instructions</th> </tr> </thead> <tbody> <tr> <td>OpioidUseHighDosage</td> <td>Benefit</td> <td>Metadata</td> </tr> <tr> <td></td> <td>InitialPopulation</td> <td>Report once</td> </tr> <tr> <td></td> <td>Exclusions</td> <td>Report once</td> </tr> <tr> <td></td> <td>Denominator</td> <td>Report once</td> </tr> <tr> <td></td> <td>NumeratorByAdmin</td> <td>Report once</td> </tr> <tr> <td></td> <td>Rate</td> <td>(Percent)</td> </tr> </tbody> </table>	Metric	Data Element	Reporting Instructions	OpioidUseHighDosage	Benefit	Metadata		InitialPopulation	Report once		Exclusions	Report once		Denominator	Report once		NumeratorByAdmin	Report once		Rate	(Percent)
Metric	Data Element	Reporting Instructions																				
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<b>Rules for Allowable Adjustments</b>	<p><b>Copyright and use:</b> The “Rules for Allowable Adjustments of HEDIS” (the “Rules”) describe how NCQA’s HEDIS measure specifications can be adjusted for other populations, if applicable. The Rules, reviewed and approved by NCQA measure experts, provide for expanded use of HEDIS measures without changing their clinical intent.</p> <p><b>Adjusted HEDIS measures may not be used for HEDIS health plan reporting.</b></p> <p><b>ADJUSTMENTS ALLOWED</b></p> <ul style="list-style-type: none"> <li><b>Product lines.</b> Organizations are not required to use product line criteria; product lines may be combined, and all (or no) product line criteria may be used.</li> <li><b>Attribution.</b> Organizations are not required to use enrollment criteria.</li> <li><b>Benefits.</b> Organizations are not required to use a benefit.</li> <li><b>Ages.</b> The denominator age range may be expanded. The age determination dates may be changed (e.g., select, “age as of June 30”).</li> <li><b>Other.</b> Organizations may use additional initial population criteria to focus on an area of interest defined by gender, race, ethnicity, socioeconomic or sociodemographic characteristics, geographic region or another characteristic.</li> <li><b>Measurement period adjustments.</b> Organizations may adjust the measurement period.</li> </ul>																					

- *Telehealth.* Services/events that allow the use of synchronous telehealth visits, telephone visits and asynchronous telehealth (e-visits, virtual check-ins) may be stratified to identify services performed via telehealth. This adjustment is not allowed for events, numerators and exclusions that do not allow the use of telehealth.
- *Supplemental data.* Supplemental data may be used to identify initial population, denominator, exclusion and numerator events.
- *Exclusions.* The hospice, deceased person and palliative care exclusions are not required.

**ADJUSTMENTS ALLOWED WITH LIMITS**

- *Initial population:* Event. Only medications that contain (or map to) codes in the medication lists may be used to identify opioid use. The medication lists and logic may not be changed. Organizations may include denied claims to calculate the denominator.
- *Numerator.* Medication lists and logic may not be changed. Organizations may include denied claims to calculate the numerator.

**ADJUSTMENTS NOT ALLOWED**

- *Exclusions.* The cancer and sickle cell exclusions must be applied. Value sets and logic may not be changed.

## ***Use of Opioids From Multiple Providers (UOP)***

Measure title	Use of Opioids From Multiple Providers*	Measure ID	UOP
<b>Description</b>	<p>The percentage of persons 18 years and older, receiving prescription opioids for <math>\geq 15</math> days during the measurement period, who received opioids from multiple providers. Three rates are reported:</p> <ol style="list-style-type: none"> <li>1. <i>Multiple Prescribers</i>. The percentage of persons receiving prescriptions for opioids from <math>\geq 4</math> different prescribers during the measurement period.</li> <li>2. <i>Multiple Pharmacies</i>. The percentage of persons receiving prescriptions for opioids from <math>\geq 4</math> different pharmacies during the measurement period.</li> <li>3. <i>Multiple Prescribers and Multiple Pharmacies</i>. The percentage of persons receiving prescriptions for opioids from <math>\geq 4</math> different prescribers <b>and</b> <math>\geq 4</math> different pharmacies during the measurement period (i.e., the percentage of persons who are numerator compliant for both the Multiple Prescribers and Multiple Pharmacies rates).</li> </ol>		
<b>Measurement period</b>	January 1–December 31.		
<b>Copyright and disclaimer notice</b>	<p>*Adapted with financial support from the Centers for Medicare &amp; Medicaid Services (CMS) and with permission from the measure developer, the Pharmacy Quality Alliance (PQA).</p> <p>Refer to the complete copyright and disclaimer information at the front of this publication.</p> <p>NCQA website: <a href="http://www.ncqa.org">www.ncqa.org</a>.</p> <p>Submit policy clarification support questions via My NCQA (<a href="https://my.ncqa.org">https://my.ncqa.org</a>).</p>		
<b>Clinical recommendation statement/ rationale</b>	<p>One area of risk related to opioid use is receipt of opioid prescriptions from multiple prescribers and pharmacies. Limiting the number of opioid providers for a single patient is supported by the CDC Guideline for Prescribing Opioids for Chronic Pain (CDC, 2022).</p> <p>Evidence suggests that people who use multiple prescribers or multiple pharmacies are at higher risk of opioid overdose, and patients who use four or more prescribers or pharmacies have a higher likelihood of opioid-related overdose death compared with patients who receive opioids from one prescriber or physician (Gwira et al., 2014; Katz et al., 2010; Carey et al., 2018). Medicare enrollees who received opioids from four prescribers had an adjusted absolute risk (aAR) of 6.4 per 1,000 beneficiary years for opioid overdose in the following year (Carey et al., 2018). Of several risk factors assessed, the risk associated with receipt of opioids from multiple pharmacies was one of the highest observed, with use of five pharmacies associated with an aAR of 12.87 for opioid overdose in the subsequent year among Medicare enrollees (Carey et al., 2018).</p>		

<b>Citations</b>	<p>Carey, C.M., A.B. Jena, and M.L. Barnett. 2018. "Patterns of Potential Opioid Misuse and Subsequent Adverse Outcomes in Medicare, 2008 to 2012." <i>Annals of Internal Medicine</i> 168(12):837–45.</p> <p>CDC. 2016. <i>CDC Guideline for Prescribing Opioids for Chronic Pain—United States, 2016</i>. <a href="https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm">https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm</a>. Accessed October 28, 2020.</p> <p>Gwira Baumblatt, J.A., C. Wiedeman, J.R. Dunn, W. Schaffner, L.J. Paulozzi, T.F. Jones. 2014. "High-Risk Use By Patients Prescribed Opioids for Pain and Its Role in Overdose Deaths." <i>JAMA Intern Med</i> 174(5):796–801. PMID: 24589873.</p> <p>Katz, N., L. Panas, M. Kim, A.D. Audet, A. Bilansky, J. Eadie, P. Kreiner, F.C. Paillard, C. Thomas, and G. Carrow. 2010. "Usefulness of Prescription Monitoring Programs for Surveillance—Analysis of Schedule II Opioid Prescription Data in Massachusetts, 1996–2006." <i>Pharmacoepidemiology and Drug Safety</i> 19: 115–23. doi: 10.1002/pds.1878.</p>
<b>Characteristics</b>	
<b>Scoring</b>	Proportion.
<b>Type</b>	Process.
<b>Product lines</b>	<ul style="list-style-type: none"> <li>Commercial.</li> <li>Medicaid.</li> <li>Medicare.</li> </ul>
<b>Stratifications</b>	None.
<b>Risk adjustment</b>	None.
<b>Improvement notation</b>	Decreased score indicates improvement.
<b>Guidance</b>	<p><b>Data collection methodology:</b> Administrative. Refer to <a href="#">General Guideline: Data Collection Methods</a> for additional information.</p> <p><b>Date specificity:</b> Dates must be specific enough to determine the event occurred in the period being measured.</p> <p><b>Which services count?</b></p> <ul style="list-style-type: none"> <li>Do not include denied claims when identifying initial population and numerator events; only include claims the organization paid for or expects to pay for (i.e., claims incurred but not paid).</li> <li>Include all paid, suspended, pending and denied claims to identify the denominator exclusions.</li> </ul> <p><b>Supplemental data exceptions:</b> Supplemental data may not be used for this measure, except for denominator exclusions.</p>

	<p><b>Medication list:</b></p> <ul style="list-style-type: none"> <li>• If an organization uses both pharmacy data (NDC codes) and clinical data (RxNorm codes) for reporting, and there are both NDC and RxNorm codes on the same date of service, use only one data source for the date of service.</li> <li>• This measure does not include the following opioid medications:           <ul style="list-style-type: none"> <li>– Injectables.</li> <li>– Cough and cold products that contain opioids.</li> <li>– Single-agent and combination buprenorphine products used as part of medication-assisted treatment of opioid use disorder (buprenorphine sublingual tablets, buprenorphine subcutaneous implant and all buprenorphine/naloxone combination products).</li> <li>– Ionsys® (fentanyl transdermal patch). This is for inpatient use only, and is available only through a restricted program under a Risk Evaluation and Mitigation Strategy.</li> <li>– Methadone for the treatment of opioid use disorder.</li> </ul> </li> </ul>
<b>Definitions</b>	
<b>Calculating number of days covered for the denominator</b>	<p>Use the following steps to identify and calculate covered days for the denominator.</p> <p><b>Step 1.</b> Identify dispensing events where multiple prescriptions for the same medication are dispensed with overlapping days supply (i.e., dispensed on the same day or dispensed on different days with overlapping days supply). Sum the days supply for these dispensing events.</p> <p>Identify the start date (date of service of the earliest dispensing event) and end dates (the start date plus the summed days supply minus one). The start date through the end date are considered covered days.</p> <ul style="list-style-type: none"> <li>• <i>For example:</i> <ul style="list-style-type: none"> <li>– If there are three 7 days supply dispensing events for the same medication on January 1, the start date is January 1 and the end date is January 21. Covered days include January 1–21.</li> <li>– If there are two 7 days supply dispensing events for the same medication on January 1 and January 5, the start date is January 1 and the end date is January 14. Covered days include January 1–14.</li> <li>– If there are three 7 days supply dispensing events for the same medication on January 1, a 7 days supply dispensing event on January 20, and a 7 days supply dispensing event on January 28, the start date is January 1 and the end date is February 4. Covered days include January 1–February 4.</li> </ul> </li> </ul> <p><b>Note:</b> This step assumes that the person will take one prescription at a time (and start taking the next prescription after exhausting the previous prescription).</p> <p><b>Step 2.</b> For all other dispensing events (i.e., multiple prescriptions for the same medication on different days without overlap, and multiple prescriptions for different medications on the same or different days, with or without overlap),</p>

	<p>identify the start and end dates for each dispensing event individually. The start date through the end date are considered covered days.</p> <p><b>Note:</b> This step assumes the person will take the different medications concurrently.</p> <p><b>Step 3.</b> Count the covered days. Consider each calendar day covered by one or more medications to be 1 covered day.</p>
<b>Identifying pharmacies</b>	Use the National Provider Identifier (NPI) to determine if the pharmacy for medication dispensing events was the same or different. If the pharmacy NPI is missing, count each dispensing event with a missing NPI number as a new pharmacy when reporting the measure.
<b>Identifying prescribers</b>	Use the NPI to determine if the prescriber for medication dispensing events was the same or different. If the provider NPI is missing, count each dispensing event with a missing NPI number as a new prescriber when reporting the measure.
<b>Identifying same or different drugs</b>	To identify same or different drugs, use the medication lists specified for the measure in the Opioid Medications table. Drugs in different medication lists are considered different drugs. For example, a dispensing event from the <u>Acetaminophen Codeine Medications List</u> is considered a different drug than a dispensing event from the <u>Codeine Sulfate Medications List</u> .
<b>Initial population</b>	<p><b>Measure item count:</b> Person.</p> <p><b>Attribution basis:</b> Enrollment.</p> <ul style="list-style-type: none"> <li>• <b>Benefits:</b> Medical and pharmacy.</li> <li>• <b>Continuous enrollment:</b> The measurement period.</li> <li>• <b>Allowable gap:</b> No more than one gap of ≤45 days during the measurement period. No gaps on the last day of the measurement period.</li> </ul> <p><b>Ages:</b> 18 years of age and older as of the start of the measurement period.</p> <p><b>Event:</b> Persons receiving prescription opioids for ≥15 days.</p> <p>Persons who meet <i>both</i> of the following criteria during the measurement period:</p> <ul style="list-style-type: none"> <li>• At least two or more opioid dispensing events (<u>Opioid Medications List</u>) on different dates of service.</li> <li>• ≥15 total days covered by opioids.</li> </ul>
<b>Denominator exclusions</b>	<p><b>Persons with a date of death.</b> Death in the measurement period, identified using data sources determined by the organization. Method and data sources are subject to review during the HEDIS audit.</p> <p><b>Persons in hospice or using hospice services.</b> Persons who use hospice services (<u>Hospice Encounter Value Set</u>; <u>Hospice Intervention Value Set</u>) or elect to use a hospice benefit any time during the measurement period. Organizations that use the Monthly Membership Detail Data File to identify these persons must use only the run date of the file.</p>

<b>Denominator</b>	The initial population minus denominator exclusions.																							
<b>Numerator</b>	<p><b>Numerator 1: Multiple prescribers.</b> Identify all opioid medication dispensing events during the measurement period. Include persons who received opioids from four or more different prescribers during the measurement period. Use the NPI to determine if the prescriber for medication dispensing events was the same or different.</p> <p><b>Numerator 2: Multiple pharmacies.</b> Identify all opioid medication dispensing events during the measurement period. Include persons who received opioids from four or more different pharmacies during the measurement period. Use the NPI to determine if the pharmacy for medication dispensing events was the same or different.</p> <p><b>Numerator 3: Multiple prescribers and multiple pharmacies.</b> Identify all opioid medication dispensing events during the measurement period. Include persons who received opioids from four or more different prescribers and four or more different pharmacies during the measurement period (i.e., persons who are numerator compliant for both the Multiple prescribers and Multiple pharmacies rates).</p> <p><b>Opioid Medications</b></p> <table border="1"> <thead> <tr> <th>Medication Lists</th> </tr> </thead> <tbody> <tr> <td><a href="#">Acetaminophen Benzyhydrocodone Medications List</a></td> </tr> <tr> <td><a href="#">Buprenorphine Medications List</a></td> </tr> <tr> <td><a href="#">Butorphanol Medications List</a></td> </tr> <tr> <td><a href="#">Acetaminophen Butalbital Caffeine Codeine Medications List</a></td> </tr> <tr> <td><a href="#">Acetaminophen Codeine Medications List</a></td> </tr> <tr> <td><a href="#">Aspirin Butalbital Caffeine Codeine Medications List</a></td> </tr> <tr> <td><a href="#">Aspirin Carisoprodol Codeine Medications List</a></td> </tr> <tr> <td><a href="#">Codeine Sulfate Medications List</a></td> </tr> <tr> <td><a href="#">Acetaminophen Caffeine Dihydrocodeine Medications List</a></td> </tr> <tr> <td><a href="#">Fentanyl Medications List</a></td> </tr> <tr> <td><a href="#">Acetaminophen Hydrocodone Medications List</a></td> </tr> <tr> <td><a href="#">Hydrocodone Medications List</a></td> </tr> <tr> <td><a href="#">Hydrocodone Ibuprofen Medications List</a></td> </tr> <tr> <td><a href="#">Hydromorphone Medications List</a></td> </tr> <tr> <td><a href="#">Levorphanol Medications List</a></td> </tr> <tr> <td><a href="#">Meperidine Medications List</a></td> </tr> <tr> <td><a href="#">Methadone Medications List</a></td> </tr> <tr> <td><a href="#">Morphine Medications List</a></td> </tr> <tr> <td><a href="#">Belladonna Opium Medications List</a></td> </tr> <tr> <td><a href="#">Opium Medications List</a></td> </tr> <tr> <td><a href="#">Acetaminophen Oxycodone Medications List</a></td> </tr> <tr> <td><a href="#">Aspirin Oxycodone Medications List</a></td> </tr> </tbody> </table>	Medication Lists	<a href="#">Acetaminophen Benzyhydrocodone Medications List</a>	<a href="#">Buprenorphine Medications List</a>	<a href="#">Butorphanol Medications List</a>	<a href="#">Acetaminophen Butalbital Caffeine Codeine Medications List</a>	<a href="#">Acetaminophen Codeine Medications List</a>	<a href="#">Aspirin Butalbital Caffeine Codeine Medications List</a>	<a href="#">Aspirin Carisoprodol Codeine Medications List</a>	<a href="#">Codeine Sulfate Medications List</a>	<a href="#">Acetaminophen Caffeine Dihydrocodeine Medications List</a>	<a href="#">Fentanyl Medications List</a>	<a href="#">Acetaminophen Hydrocodone Medications List</a>	<a href="#">Hydrocodone Medications List</a>	<a href="#">Hydrocodone Ibuprofen Medications List</a>	<a href="#">Hydromorphone Medications List</a>	<a href="#">Levorphanol Medications List</a>	<a href="#">Meperidine Medications List</a>	<a href="#">Methadone Medications List</a>	<a href="#">Morphine Medications List</a>	<a href="#">Belladonna Opium Medications List</a>	<a href="#">Opium Medications List</a>	<a href="#">Acetaminophen Oxycodone Medications List</a>	<a href="#">Aspirin Oxycodone Medications List</a>
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<b>Summary of changes</b>	<ul style="list-style-type: none"> <li>No changes to this measure.</li> </ul>																					
<b>Data element tables</b>	<p>Organizations that submit HEDIS data to NCQA must provide the following data elements.</p> <p><b>Table UOP-1/2/3: Data Elements for Use of Opioids From Multiple Providers</b></p> <table border="1"> <thead> <tr> <th>Metric</th> <th>Data Element</th> <th>Reporting Instructions</th> </tr> </thead> <tbody> <tr> <td>MultiplePrescribers</td> <td>Benefit</td> <td>Metadata</td> </tr> <tr> <td>MultiplePharmacies</td> <td>InitialPopulation</td> <td>Repeat per Metric</td> </tr> <tr> <td>MultiplePrescribersMultiplePharmacies</td> <td>Exclusions</td> <td>Repeat per Metric</td> </tr> <tr> <td></td> <td>Denominator</td> <td>Repeat per Metric</td> </tr> <tr> <td></td> <td>NumeratorByAdmin</td> <td>For each Metric</td> </tr> <tr> <td></td> <td>Rate</td> <td>(Percent)</td> </tr> </tbody> </table>	Metric	Data Element	Reporting Instructions	MultiplePrescribers	Benefit	Metadata	MultiplePharmacies	InitialPopulation	Repeat per Metric	MultiplePrescribersMultiplePharmacies	Exclusions	Repeat per Metric		Denominator	Repeat per Metric		NumeratorByAdmin	For each Metric		Rate	(Percent)
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<b>Rules for Allowable Adjustments</b>	<p><b>Copyright and use:</b> The “Rules for Allowable Adjustments of HEDIS” (the “Rules”) describe how NCQA’s HEDIS measure specifications can be adjusted for other populations, if applicable. The Rules, reviewed and approved by NCQA measure experts, provide for expanded use of HEDIS measures without changing their clinical intent.</p> <p><b>Adjusted HEDIS measures may not be used for HEDIS health plan reporting.</b></p> <p><b>ADJUSTMENTS ALLOWED</b></p> <ul style="list-style-type: none"> <li><b>Product lines.</b> Organizations are not required to use product line criteria; product lines may be combined, and all (or no) product line criteria may be used.</li> <li><b>Attribution.</b> Organizations are not required to use enrollment criteria.</li> <li><b>Benefits.</b> Organizations are not required to use a benefit.</li> <li><b>Ages.</b> The denominator age range may be expanded. The age determination dates may be changed (e.g., select, “age as of June 30”).</li> </ul>																					

- *Other.* Organizations may use additional initial population criteria to focus on an area of interest defined by gender, race, ethnicity, socioeconomic or sociodemographic characteristics, geographic region or another characteristic.
- *Measurement period adjustments.* Organizations may adjust the measurement period.
- *Exclusions.* Hospice and deceased person exclusions are not required.
- *Telehealth.* Services/events that allow the use of synchronous telehealth visits, telephone visits and asynchronous telehealth (e-visits, virtual check-ins) may be stratified to identify services performed via telehealth. This adjustment is not allowed for events, numerators and exclusions that do not allow the use of telehealth.
- *Supplemental data.* Supplemental data may be used to identify initial population, denominator, exclusion and numerator events.

#### **ADJUSTMENTS ALLOWED WITH LIMITS**

- *Initial population:* Event. Organizations may include denied claims to calculate the initial population. Only medications that contain (or map to) codes in the medication lists may be used to identify opioid use. Medication lists and logic may not be changed.
- *Numerator.* Organizations may include denied claims to calculate the numerator. Medication lists and logic may not be changed.

## ***Risk of Continued Opioid Use (COU)***

Measure title	Risk of Continued Opioid Use*	Measure ID	COU
<b>Description</b>	<p>The percentage of persons 18 years of age and older who have a new episode of opioid use that puts them at risk for continued opioid use. Two rates are reported:</p> <ol style="list-style-type: none"> <li>1. The percentage of persons with at least 15 days of prescription opioids in a 30-day period.</li> <li>2. The percentage of persons with at least 31 days of prescription opioids in a 62-day period.</li> </ol>		
<b>Measurement period</b>	January 1–December 31.		
<b>Copyright and disclaimer notice</b>	<p><i>*Adapted with financial support from the Centers for Medicare &amp; Medicaid Services and with permission from the measure developer, Minnesota Department of Human Services.</i></p> <p>Refer to the complete copyright and disclaimer information at the front of this publication.</p> <p>NCQA website: <a href="http://www.ncqa.org">www.ncqa.org</a>.</p> <p>Submit policy clarification support questions via My NCQA (<a href="https://my.ncqa.org">https://my.ncqa.org</a>).</p>		
<b>Clinical recommendation statement/ rationale</b>	<p>Literature suggests that long-term opioid use often begins with the treatment of acute pain, and a relationship exists between early prescribing patterns and long-term use of opioids (Shah et al. 2017b). The Centers for Disease Control and Prevention (CDC) Guideline for Prescribing Opioids for Chronic Pain recommends minimizing opioid supply to “no greater quantity than needed for the expected duration of pain severe enough to require opioids” (CDC, 2022).</p> <p>Continued opioid use for noncancer pain is associated with increased risk of opioid use disorder, opioid-related overdose, hospitalization and opioid overdose-related mortality (Edlund et al. 2014; Dunn et al. 2010; Deyo et al. 2016; Paulozzi et al. 2012; Shah et al. 2017a). Studies find a consistent link between increasing days supply of the first prescription with probability of continued opioid use, and the rate of opioid use at 1 year post-initial prescription increases substantially for patients with 31 or more days of opioid therapy (Shah et al. 2017a; Shah et al. 2017b).</p>		
<b>Citations</b>	<p>CDC. 2022. “CDC Clinical Practice Guideline for Prescribing Opioids for Pain —United States, 2022.” <a href="https://www.cdc.gov/mmwr/volumes/71/rr/rr7103a1.htm?s_cid=rr7103a1.htm_w">https://www.cdc.gov/mmwr/volumes/71/rr/rr7103a1.htm?s_cid=rr7103a1.htm_w</a> (Accessed April 7, 2024.)</p> <p>Deyo, R.A., S.E. Hallvik, C. Hildebran, M. Marino, E. Dexter, J.M. Irvine, N. O’Kane, J. Van Otterloo, D.A. Wright, G. Leichtling, and L.M. Millet. 2016. “Association Between Initial Opioid Prescribing Patterns and Subsequent Long-Term Use Among Opioid-Naïve Patients: A Statewide Retrospective Cohort Study.” <i>Journal of General Internal Medicine</i> 32(1): 21–7.</p>		

	<p>Dunn, K.M., K.W. Saunders, C.M. Rutter, C.J. Banta-Green, J.O. Merrill, M.D. Sullivan, M. Von Korff. 2010. "Overdose and Prescribed Opioids: Associations Among Chronic Non-Cancer Pain Patients." <i>Annals of Internal Medicine</i> 152(2): 85–92.</p> <p>Edlund, M.J., B.C. Martin, J.E. Russo, A. DeVries, J.B. Braden, and M.D. Sullivan. 2014. "The Role of Opioid Prescription in Incident Opioid Abuse and Dependence Among Individuals With Chronic Noncancer Pain: The Role of Opioid Prescription." <i>Clin J Pain</i> 30:557–64.</p> <p>Paulozzi, L.J., E.M. Kilbourne, N.G. Shah, K.B. Nolte, H.A. Desai, M.G. Landen, W. Harvey, and L.D. Loring. 2012. "A History of Being Prescribed Controlled Substances and Risk of Drug Overdose Death." <i>Pain Medicine</i> 13(1): 87–95.</p> <p>Shah, A., C.J. Hayes, and B.C. Martin. 2017a. "Characteristics of Initial Prescription Episodes and Likelihood of long-Term Opioid Use—United States, 2006–2015." <i>Morbidity and Mortality Weekly Report</i> 66(10): 265–9.</p> <p>Shah, A., C.J. Hayes, and B.C. Martin. 2017b. "Factors Influencing Long-Term Opioid Use Among Opioid Naïve Patients: An Examination of Initial Prescription Characteristics and Pain Etiologies." <i>The Journal of Pain</i> 18(11): 1374–383. DOI:10.1016/j.jpain.2017.06.010.</p>
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## Characteristics

<b>Scoring</b>	Proportion.
<b>Type</b>	Process.
<b>Product lines</b>	<ul style="list-style-type: none"> <li>Commercial.</li> <li>Medicaid.</li> <li>Medicare.</li> </ul>
<b>Stratifications</b>	<p>Age as of November 1 of the year prior to the measurement period.</p> <ul style="list-style-type: none"> <li>18–64 years.</li> <li>65 years and older.</li> </ul>
<b>Risk adjustment</b>	None.
<b>Improvement notation</b>	Decreased score indicates improvement.
<b>Guidance</b>	<p><b>Data collection methodology:</b> Administrative. Refer to <a href="#">General Guideline: Data Collection Methods</a> for additional information.</p> <p><b>Date specificity:</b> Dates must be specific enough to determine the event occurred in the period being measured.</p> <p><b>Which services count?</b></p> <ul style="list-style-type: none"> <li>Do not include denied claims when identifying initial population and numerator events; only include claims the organization paid for or expects to pay for (i.e., claims incurred but not paid).</li> </ul>

	<ul style="list-style-type: none"> <li>Include all paid, suspended, pending and denied claims to identify the denominator exclusions.</li> </ul> <p><b>Supplemental data exceptions:</b> Supplemental data may not be used for this measure, except for denominator exclusions.</p> <p><b>Medication list:</b></p> <ul style="list-style-type: none"> <li>If an organization uses both pharmacy data (NDC codes) and clinical data (RxNorm codes) for reporting, and there are both NDC and RxNorm codes on the same date of service, use only one data source for the date of service.</li> <li>This measure does not include the following opioid medications: <ul style="list-style-type: none"> <li>Injectables.</li> <li>Cough and cold products that contain opioids.</li> <li>Single-agent and combination buprenorphine products used as part of medication-assisted treatment of opioid use disorder (buprenorphine sublingual tablets, buprenorphine subcutaneous implant and all buprenorphine/haloxone combination products).</li> <li>Ionsys® (fentanyl transdermal patch). This is for inpatient use only, and is available only through a restricted program under a Risk Evaluation and Mitigation Strategy.</li> <li>Methadone for the treatment of opioid use disorder.</li> </ul> </li> </ul>
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## Definitions

<b>Calculating number of days covered for the numerator</b>	<p>Use the following steps to identify and calculate covered days for the numerator.</p> <p><b>Step 1.</b> Identify dispensing events where multiple prescriptions for the same medication were dispensed with overlapping days supply (i.e., dispensed on the same day or dispensed on different days with overlapping days supply). Sum the days supply for these dispensing events.</p> <p>Identify the start and end dates. The start date is the date of service of the earliest dispensing event and the end date is the start date plus the summed days supply, minus 1. The start date through the end date are considered covered days.</p> <ul style="list-style-type: none"> <li><i>For example:</i> <ul style="list-style-type: none"> <li>If there are three 7 days supply dispensing events for the same medication on January 1, the start date is January 1 and the end date is January 21. Covered days include January 1–21.</li> <li>If there are two 7 days supply dispensing events for the same medication on January 1 and January 5, the start date is January 1 and the end date is January 14. Covered days include January 1–14.</li> <li>If there are three 7 days supply dispensing events for the same medication on January 1, a 7 days supply dispensing event on January 20, and a 7 days supply dispensing event on January 28, the start date is January 1 and the end date is February 4. Covered days include January 1–February 4.</li> </ul> </li> </ul>
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	<p><b>Note:</b> This step assumes taking one prescription at a time (and starting the next prescription after exhausting the previous prescription).</p> <p><b>Step 2.</b> For all other dispensing events (multiple prescriptions for the same medication on different days without overlap, multiple prescriptions for different medications on the same or different days, with or without overlap), identify the start and end dates for each dispensing event individually. The start date through the end date are considered covered days.</p> <p><b>Note:</b> This step assumes taking different medications concurrently.</p> <p><b>Step 3.</b> Count the covered days. Consider each calendar day covered by one or more medications to be 1 covered day.</p>
<b>Identifying same or different drugs</b>	Use the medication lists specified in the Opioid Medications table. Drugs in different medication lists are considered different drugs. For example, a dispensing event from the <u>Acetaminophen Codeine Medications List</u> is considered a different drug than a dispensing event from the <u>Codeine Sulfate Medications List</u> .
<b>Intake period</b>	November 1 of the year prior to the measurement period to October 31 of the measurement period.
<b>IPSD</b>	Index prescription start date. Earliest prescription dispensing date for opioid medication during the intake period.
<b>Negative medication history</b>	A period of 180 days prior to the IPSD when the person had no pharmacy claims for either new or refill prescriptions for an opioid medication.
<b>Initial population</b>	<p><i>Measure item count:</i> Person.</p> <p><i>Attribution basis:</i> Enrollment.</p> <ul style="list-style-type: none"> <li>• <i>Benefits:</i> Medical and pharmacy.</li> <li>• <i>Continuous enrollment:</i> 180 days prior to the IPSD through 61 days after the IPSD.</li> <li>• <i>Allowable gap:</i> None.</li> </ul> <p><i>Ages:</i> 18 years of age and older as of November 1 of the year prior to the measurement period.</p> <p><i>Event:</i> New episode of opioid use.</p> <p><b>Step 1.</b> Determine the IPSD. Identify the date of the earliest dispensing event for an opioid medication (<u>Opioid Medications List</u>) during the intake period.</p> <p><b>Step 2.</b> Test for negative medication history. Remove persons who were dispensed an opioid medication within 180 days prior to the IPSD.</p> <p><b>Step 3.</b> Calculate continuous enrollment.</p>
<b>Denominator exclusions</b>	<b>Persons with a date of death.</b> Death in the measurement period, identified using data sources determined by the organization. Method and data sources are subject to review during the HEDIS audit.

	<p><b>Persons in hospice or using hospice services.</b> Persons who use hospice services (<u>Hospice Encounter Value Set</u>; <u>Hospice Intervention Value Set</u>) or elect to use a hospice benefit any time during the measurement period. Organizations that use the Monthly Membership Detail Data File to identify these persons must use only the run date of the file.</p> <p><b>Persons receiving palliative care.</b> Persons receiving palliative care (<u>Palliative Care Assessment Value Set</u>; <u>Palliative Care Encounter Value Set</u>; <u>Palliative Care Intervention Value Set</u>) or who had an encounter for palliative care (ICD-10-CM code Z51.5*) at any time during the 365 days prior to the IPSD through 61 days after the IPSD.</p> <p><b>Cancer or sickle cell disease.</b> Persons with cancer (<u>Malignant Neoplasms Value Set*</u>) or sickle cell disease (<u>Sickle Cell Anemia and HB S Disease Value Set*</u>) any time during the 365 days prior to the IPSD through 61 days after the IPSD.</p> <p><b>Coding Guidance</b> *Do not include laboratory claims (claims with POS code 81).</p>														
<b>Denominator</b>	The initial population minus denominator exclusions.														
<b>Numerator</b>	<p><b>Numerator 1: ≥15 days covered.</b> Persons with 15 or more calendar days covered by an opioid medication during the 30-day period beginning on the IPSD through 29 days after the IPSD.</p> <p><b>Numerator 2: ≥31 days covered.</b> Persons with 31 or more calendar days covered by an opioid medication during the 62-day period beginning on the IPSD through 61 days after the IPSD.</p> <p>Use all the medication lists below to identify opioid medication dispensing events. Calculate covered days using the instruction in the definitions section.</p> <p><b>Opioid Medications</b></p> <table border="1"> <thead> <tr> <th>Medication Lists</th></tr> </thead> <tbody> <tr> <td><a href="#">Acetaminophen Benzhydrocodone Medications List</a></td></tr> <tr> <td><a href="#">Buprenorphine Medications List</a></td></tr> <tr> <td><a href="#">Butorphanol Medications List</a></td></tr> <tr> <td><a href="#">Acetaminophen Butalbital Caffeine Codeine Medications List</a></td></tr> <tr> <td><a href="#">Acetaminophen Codeine Medications List</a></td></tr> <tr> <td><a href="#">Aspirin Butalbital Caffeine Codeine Medications List</a></td></tr> <tr> <td><a href="#">Aspirin Carisoprodol Codeine Medications List</a></td></tr> <tr> <td><a href="#">Codeine Sulfate Medications List</a></td></tr> <tr> <td><a href="#">Acetaminophen Caffeine Dihydrocodeine Medications List</a></td></tr> <tr> <td><a href="#">Fentanyl Medications List</a></td></tr> <tr> <td><a href="#">Acetaminophen Hydrocodone Medications List</a></td></tr> <tr> <td><a href="#">Hydrocodone Medications List</a></td></tr> <tr> <td><a href="#">Hydrocodone Ibuprofen Medications List</a></td></tr> </tbody> </table>	Medication Lists	<a href="#">Acetaminophen Benzhydrocodone Medications List</a>	<a href="#">Buprenorphine Medications List</a>	<a href="#">Butorphanol Medications List</a>	<a href="#">Acetaminophen Butalbital Caffeine Codeine Medications List</a>	<a href="#">Acetaminophen Codeine Medications List</a>	<a href="#">Aspirin Butalbital Caffeine Codeine Medications List</a>	<a href="#">Aspirin Carisoprodol Codeine Medications List</a>	<a href="#">Codeine Sulfate Medications List</a>	<a href="#">Acetaminophen Caffeine Dihydrocodeine Medications List</a>	<a href="#">Fentanyl Medications List</a>	<a href="#">Acetaminophen Hydrocodone Medications List</a>	<a href="#">Hydrocodone Medications List</a>	<a href="#">Hydrocodone Ibuprofen Medications List</a>
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	<p><b>ADJUSTMENTS ALLOWED</b></p> <ul style="list-style-type: none"><li>• <i>Product lines.</i> Organizations are not required to use product line criteria; product lines may be combined, and all (or no) product line criteria may be used.</li><li>• <i>Attribution.</i> Organizations are not required to use enrollment criteria.</li><li>• <i>Benefits.</i> Organizations are not required to use a benefit.</li><li>• <i>Ages.</i> The denominator age range may be expanded. The age determination dates may be changed (e.g., select, “age as of June 30”).</li><li>• <i>Other.</i> Organizations may use additional initial population criteria to focus on an area of interest defined by gender, race, ethnicity, socioeconomic or sociodemographic characteristics, geographic region or another characteristic.</li><li>• <i>Measurement period adjustments.</i> Organizations may adjust the measurement period.</li><li>• <i>Exclusions.</i> The hospice, deceased person and palliative care exclusions are not required.</li><li>• <i>Telehealth.</i> Services/events that allow the use of synchronous telehealth visits, telephone visits and asynchronous telehealth (e-visits, virtual check-ins) may be stratified to identify services performed via telehealth. This adjustment is not allowed for events, numerators and exclusions that do not allow the use of telehealth.</li><li>• <i>Supplemental data.</i> Supplemental data may be used to identify initial population, denominator, exclusion and numerator events.</li></ul> <p><b>ADJUSTMENTS ALLOWED WITH LIMITS</b></p> <ul style="list-style-type: none"><li>• <i>Initial population:</i> Event. Organizations may include denied claims to calculate the denominator. Only medications that contain (or map to) codes in the medication lists may be used to identify opioid use. Medication lists and logic may not be changed.</li><li>• <i>Numerator.</i> Organizations may include denied claims to calculate the numerator. Medication lists and logic may not be changed.</li></ul> <p><b>ADJUSTMENTS NOT ALLOWED</b></p> <ul style="list-style-type: none"><li>• <i>Exclusions.</i> The cancer and sickle cell disease exclusions must be applied. The value sets and logic may not be changed.</li></ul>
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# **Measures Collected Through the Medicare Health Outcomes Survey**

## **Medicare Health Outcomes Survey (HOS)**

Detailed specifications and summary of changes are contained in *HEDIS Volume 6: Specifications for the Medicare Health Outcomes Survey*.

*HEDIS MY 2025 Volume 6: Specifications for the Medicare Health Outcomes Survey* will be published prior to survey administration in February 2026.

### **Description**

This measure provides a general indication of how well a Medicare Advantage Organization (MAO) manages the physical and mental health of its members. The survey measures physical and mental health status at the beginning of a 2-year period and again at the end of the 2-year period, when a change score is calculated. Each member's health status is categorized as "better than expected," "the same as expected" or "worse than expected," accounting for death and risk-adjustment factors. MAO-specific results are assigned as percentages of members whose health status was better, the same or worse than expected.

## Fall Risk Management (FRM)

This measure is collected using the Medicare Health Outcomes Survey (HOS). Detailed specifications and summary of changes are contained in *HEDIS Volume 6: Specifications for the Medicare Health Outcomes Survey*.

*HEDIS MY 2025 Volume 6: Specifications for the Medicare Health Outcomes Survey* will be published prior to survey administration in February 2026.

### Description

The two components of this measure assess different facets of fall risk management.

- *Discussing Fall Risk.* The percentage of Medicare members 65 years of age and older who were seen by a practitioner in the past 12 months and who discussed falls or problems with balance or walking with their current practitioner.
- *Managing Fall Risk.* The percentage of Medicare members 65 years of age and older who had a fall or had problems with balance or walking in the past 12 months, who were seen by a practitioner in the past 12 months and who received a recommendation for how to prevent falls or treat problems with balance or walking from their current practitioner.

### Eligible Population

<b>Product lines</b>	Medicare.
<b>Age</b>	65 and older as of December 31 of the measurement year.
<b>Exclusion</b>	Evidence from CMS administrative records of a hospice start date.

### Protocol and Survey Instrument

<b>Medicare</b>	Collected using the HOS. Refer to <i>HEDIS Volume 6: Specifications for the Medicare Health Outcomes Survey</i> for the HOS questionnaires and data collection protocols.
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## **Management of Urinary Incontinence in Older Adults (MUI)**

This measure is collected using the HOS. Detailed specifications and summary of changes are contained in *HEDIS Volume 6: Specifications for the Medicare Health Outcomes Survey*.

*HEDIS MY 2025 Volume 6: Specifications for the Medicare Health Outcomes Survey* will be published prior to survey administration in February 2026.

### **Description**

The following components of this measure assess the management of urinary incontinence in older adults:

- *Discussing Urinary Incontinence.* The percentage of Medicare members 65 years of age and older who reported having urine leakage in the past 6 months and who discussed their urinary leakage problem with a health care provider.
- *Discussing Treatment of Urinary Incontinence.* The percentage of Medicare members 65 years of age and older who reported having urine leakage in the past 6 months and who discussed treatment options for their urinary incontinence with a health care provider.
- *Impact of Urinary Incontinence.* The percentage of Medicare members 65 years of age and older who reported having urine leakage in the past 6 months and who reported that urine leakage made them change their daily activities or interfered with their sleep a lot.

**Note:** A lower rate indicates better performance for this indicator.

### **Eligible Population**

<b>Product lines</b>	Medicare.
<b>Age</b>	65 and older as of December 31 of the measurement year.
<b>Exclusion</b>	Evidence from CMS administrative records of a hospice start date.

### **Protocol and Survey Instrument**

<b>Medicare</b>	Collected using the HOS. Refer to <i>HEDIS Volume 6: Specifications for the Medicare Health Outcomes Survey</i> for the HOS questionnaires and data collection protocols.
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## Physical Activity in Older Adults (PAO)

This measure is collected using the HOS. Detailed specifications and summary of changes are contained in *HEDIS Volume 6: Specifications for the Medicare Health Outcomes Survey*.

*HEDIS MY 2025 Volume 6: Specifications for the Medicare Health Outcomes Survey* will be published prior to survey administration in February 2026.

### Description

The two components of this measure assess different facets of promoting physical activity in older adults:

- *Discussing Physical Activity.* The percentage of Medicare members 65 years of age and older who had a doctor's visit in the past 12 months and who spoke with a doctor or other health provider about their level of exercise or physical activity.
- *Advising Physical Activity.* The percentage of Medicare members 65 years of age and older who had a doctor's visit in the past 12 months and who received advice to start, increase or maintain their level exercise or physical activity.

### Eligible Population

<b>Product lines</b>	Medicare.
<b>Age</b>	65 and older as of December 31 of the measurement year.
<b>Exclusion</b>	Evidence from CMS administrative records of a hospice start date.

### Protocol and Survey Instrument

<b>Medicare</b>	Collected using the HOS. Refer to <i>HEDIS Volume 6: Specifications for the Medicare Health Outcomes Survey</i> for the HOS questionnaires and data collection protocols.
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# **Access/Availability of Care Measures**

## ***Adults' Access to Preventive/Ambulatory Health Services (AAP)***

<b>Measure title</b>	Adults' Access to Preventive/Ambulatory Health Services	<b>Measure ID</b>	AAP
<b>Description</b>	<p>The percentage of persons 20 years of age and older who had an ambulatory or preventive care visit. The organization reports three separate percentages for each product line.</p> <ul style="list-style-type: none"> <li>• Persons enrolled in Medicaid and Medicare who had an ambulatory or preventive care visit during the measurement period.</li> <li>• Persons enrolled in a commercial product who had an ambulatory or preventive care visit during the measurement period or the 2 years prior to the measurement period.</li> </ul>		
<b>Measurement period</b>	January 1–December 31.		
<b>Copyright and disclaimer notice</b>	<p>Refer to the complete copyright and disclaimer information at the front of this publication.</p> <p>NCQA website: <a href="http://www.ncqa.org">www.ncqa.org</a>.</p> <p>Submit policy clarification support questions via My NCQA (<a href="https://my.ncqa.org">https://my.ncqa.org</a>).</p>		
<b>Clinical recommendation statement/ rationale</b>	<p>This measure assesses how people access basic and important services offered by their organization. Access refers to an individual's ability to get the services they require from a health care system.</p> <p>Health plans accept a premium for persons enrolled in their product. This measure reinforces the concept that plans are responsible for providing care to all enrolled individuals. People without access to preventive health care are more likely to develop advanced or preventable disease, at higher personal and financial cost. Although individuals have a responsibility to take care of themselves, health plans need to take an active role in education about the importance of routine care and in reminders about when routine care is needed.</p> <p>Maintaining access to care requires more than making providers and services available—it involves analysis and systematic removal of barriers to care.</p>		
<b>Citations</b>	<p>DeVoe, J. E., G.E. Fryer, R. Phillips, &amp; L. Green. 2003. "Receipt of Preventive Care Among Adults: Insurance Status and Usual Source of Care." <i>American Journal of Public Health</i>, 93(5), 786–91. <a href="https://doi.org/10.2105/AJPH.93.5.786">https://doi.org/10.2105/AJPH.93.5.786</a></p> <p>Agency for Healthcare Research and Quality. May 2014. <i>The Guide to Clinical Preventive Services: Recommendations of the U.S. Preventive Services Task Force</i> (Report No. 14-05158). Rockville, MD.</p>		

Characteristics	
<b>Scoring</b>	Proportion.
<b>Type</b>	Process.
<b>Product lines</b>	<ul style="list-style-type: none"> <li>• Commercial.</li> <li>• Medicaid.</li> <li>• Medicare.</li> </ul>
<b>Stratifications</b>	<p>Age as of the last day of the measurement period.</p> <ul style="list-style-type: none"> <li>• 20–44 years.</li> <li>• 45–64 years.</li> <li>• 65 years and older.</li> </ul>
<b>Risk adjustment</b>	None.
<b>Improvement notation</b>	Increased score indicates improvement.
<b>Guidance</b>	<p><b>Data collection methodology:</b> Administrative. Refer to <a href="#">General Guideline: Data Collection Methods</a> for additional information.</p> <p><b>Date specificity:</b> Dates must be specific enough to determine the event occurred in the period being measured.</p> <p><b>Which services count?</b> When using claims, include all paid, suspended, pending and denied claims.</p>
<b>Initial population</b>	<p><b>Measure item count:</b> Person.</p> <p><b>Attribution basis:</b> Enrollment.</p> <ul style="list-style-type: none"> <li>• <b>Benefits:</b> Medical.</li> <li>• <b>Continuous enrollment:</b> <ul style="list-style-type: none"> <li>– <b>Medicaid and Medicare:</b> The measurement period.</li> <li>– <b>Commercial:</b> The measurement period and 730 days prior to the measurement period.</li> </ul> </li> <li>• <b>Allowable gap:</b> No more than one gap of ≤45 days during each year of the continuous enrollment period. No gaps on the last day of the measurement period.</li> </ul> <p><b>Ages:</b> 20 years of age and older as of the last day of the measurement period.</p> <p><b>Event:</b> None.</p>
<b>Denominator exclusions</b>	<p><b>Persons with a date of death.</b></p> <p>Death in the measurement period, identified using data sources determined by the organization. Method and data sources are subject to review during the HEDIS audit.</p>

	<p><b>Persons in hospice or using hospice services.</b> Persons who use hospice services (<u>Hospice Encounter Value Set</u>; <u>Hospice Intervention Value Set</u>) or elect to use a hospice benefit any time during the measurement period. Organizations that use the Monthly Membership Detail Data File to identify these persons must use only the run date of the file.</p>																				
<b>Denominator</b>	The initial population minus denominator exclusions.																				
<b>Numerator</b>	<p><b>Medicaid and Medicare:</b> One or more ambulatory or preventive visits during the measurement period.</p> <p><b>Commercial:</b> One or more ambulatory or preventive visits during the measurement period or the 2 years prior to the measurement period.</p> <p>Identify ambulatory or preventive care visits (<u>Ambulatory Visits Value Set</u>, <u>Reason for Ambulatory Visit Value Set*</u>).</p> <p><b>Coding Guidance</b> *Do not include laboratory claims (claims with POS code 81).</p>																				
<b>Summary of changes</b>	<ul style="list-style-type: none"> <li>No changes to this measure.</li> </ul>																				
<b>Data element tables</b>	<p>Organizations that submit HEDIS data to NCQA must provide the following data elements.</p> <p><b>Table AAP-1/2/3: Data Elements for Adults' Access to Preventive/Ambulatory Health Services</b></p> <table border="1"> <thead> <tr> <th>Metric</th> <th>Age</th> <th>Data Element</th> <th>Reporting Instructions</th> </tr> </thead> <tbody> <tr> <td rowspan="5">AdultAccessAmbulatoryCare</td> <td>20-44</td> <td>InitialPopulation</td> <td>For each Stratification</td> </tr> <tr> <td>45-64</td> <td>Exclusions</td> <td>For each Stratification</td> </tr> <tr> <td>65+</td> <td>Denominator</td> <td>For each Stratification</td> </tr> <tr> <td>Total</td> <td>NumeratorByAdmin</td> <td>For each Stratification</td> </tr> <tr> <td></td> <td>Rate</td> <td>(Percent)</td> </tr> </tbody> </table>	Metric	Age	Data Element	Reporting Instructions	AdultAccessAmbulatoryCare	20-44	InitialPopulation	For each Stratification	45-64	Exclusions	For each Stratification	65+	Denominator	For each Stratification	Total	NumeratorByAdmin	For each Stratification		Rate	(Percent)
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- **Ages.** The denominator age range may be expanded. The age determination dates may be changed (e.g., select, "age as of June 30").
- **Other.** Organizations may use additional initial population criteria to focus on an area of interest defined by gender, race, ethnicity, socioeconomic or sociodemographic characteristics, geographic region or another characteristic.
- **Measurement period adjustments.** Organizations may adjust the measurement period.
- **Exclusions.** The hospice and deceased person exclusions are not required.
- **Telehealth.** Services/events that allow the use of synchronous telehealth visits, telephone visits and asynchronous telehealth (e-visits, virtual check-ins) may be stratified to identify services performed via telehealth. This adjustment is not allowed for events, numerators and exclusions that do not allow the use of telehealth.
- **Supplemental data.** Supplemental data may be used to identify initial population, denominator, exclusion and numerator events.

**ADJUSTMENTS NOT ALLOWED**

- **Numerator.** Value sets and logic may not be changed.

## ***Initiation and Engagement of Substance Use Disorder Treatment (IET)***

<b>Measure title</b>	Initiation and Engagement of Substance Use Disorder Treatment	<b>Measure ID</b>	IET
<b>Description</b>	<p>The percentage of new substance use disorder (SUD) episodes that result in treatment initiation and engagement. Two rates are reported:</p> <ul style="list-style-type: none"> <li>• <i>Initiation of SUD Treatment.</i> The percentage of new SUD episodes that result in treatment initiation through an inpatient SUD admission, outpatient visit, intensive outpatient encounter, partial hospitalization, telehealth visit or medication treatment within 14 days.</li> <li>• <i>Engagement of SUD Treatment.</i> The percentage of new SUD episodes that have evidence of treatment engagement within 34 days of initiation.</li> </ul>		
<b>Measurement period</b>	January 1–December 31.		
<b>Copyright and disclaimer notice</b>	<p>Refer to the complete copyright and disclaimer information at the front of this publication.</p> <p>NCQA website: <a href="http://www.ncqa.org">www.ncqa.org</a>.</p> <p>Submit policy clarification support questions via My NCQA (<a href="https://my.ncqa.org">https://my.ncqa.org</a>).</p>		
<b>Clinical recommendation statement/ rationale</b>	<p>Evidence-based treatment for SUD involves both psychosocial supports and medication (Department of Veteran Affairs, 2015, Kampman et al. 2020, Michigan Quality Improvement Consortium 2015, Reus et al. 2018). Individuals who receive timely follow-up care may be more likely to complete treatment or receive more days of treatment than those who leave care prematurely (Proctor &amp; Herschman, 2014). Benefits of SUD treatment typically extend beyond reduction of substance misuse to reduced crime, reduced risk of infectious diseases and improved patient function (Pew, 2016).</p> <p>Early treatment engagement is a critical step between accessing care and completing a full course of treatment. Individuals who engage in early SUD treatment have been found to have decreased odds of negative outcomes, including mortality (Paddock et al. 2017; Watkins et al. 2016).</p>		
<b>Citations</b>	<p>Department of Veteran Affairs, Department of Defense. 2015. <i>VA/DoD Clinical Practice Guideline for the Management of Substance Use Disorders</i>. Washington DC: Department of Veterans Affairs, Department of Defense.</p> <p>Kampman, K., K. Freedman. 2020. “American Society of Addiction Medicine (ASAM) National Practice Guideline for the Treatment of Opioid Use Disorder: 2020 Focused Update.” <i>Journal of Addiction Medicine</i> 14, no. 2S: 1–91, <a href="https://doi.org/10.1097/ADM.0000000000000633">https://doi.org/10.1097/ADM.0000000000000633</a></p> <p>Michigan Quality Improvement Consortium. August 2015. <i>Screening, Diagnosis and Referral for Substance Use Disorders</i>. Southfield (MI): Michigan Quality Improvement Consortium. 1 p.</p>		

	<p>Paddock, S.M., K.A. Hepner, T. Hudson, et al. 2017. "Association Between Process-Based Quality Indicators and Mortality for Patients with Substance Use Disorders." <i>J Stud Alcohol Drugs</i> 78:588–96.</p> <p>Pew. 2016. <i>Medication-Assisted Treatment Improves Outcomes for Patient with Opioid Use Disorder</i>. <a href="https://www.pewtrusts.org/en/research-and-analysis/fact-sheets/2016/11/medication-assisted-treatment-improves-outcomes-for-patients-with-opioid-use-disorder#1-background">https://www.pewtrusts.org/en/research-and-analysis/fact-sheets/2016/11/medication-assisted-treatment-improves-outcomes-for-patients-with-opioid-use-disorder#1-background</a></p> <p>Proctor, S.L., P.L. Herschman. 2014. "The Continuing Care Model of Substance Use Treatment: What Works, and When Is "Enough," "Enough?" <i>Psychiatry Journal</i>, vol. 2014, Article ID 692423. <a href="https://doi.org/10.1155/2014/692423">https://doi.org/10.1155/2014/692423</a></p> <p>Reus, V., et al. 2018. "Practice Guideline for the Pharmacological Treatment of Patients with Alcohol Use Disorder." <i>American Journal of Psychiatry</i> 175(1), 86–90. doi:10.1176/appi.ajp.2017.1750101</p>
<b>Characteristics</b>	
<b>Scoring</b>	Proportion.
<b>Type</b>	Process.
<b>Product lines</b>	<ul style="list-style-type: none"> <li>• Commercial.</li> <li>• Medicaid.</li> <li>• Medicare.</li> </ul>
<b>Stratifications</b>	<p>Age as of the SUD episode date.</p> <ul style="list-style-type: none"> <li>• 13–17 years.</li> <li>• 18–64 years.</li> <li>• 65+ years.</li> </ul> <p>SUD diagnosis cohort.</p> <ul style="list-style-type: none"> <li>• Alcohol use disorder.</li> <li>• Opioid use disorder.</li> <li>• Other substance use disorder.</li> </ul> <p>Race. (Refer to <a href="#">General Guideline: Race and Ethnicity Stratification</a>.)</p> <ul style="list-style-type: none"> <li>• American Indian or Alaska Native.</li> <li>• Asian.</li> <li>• Black or African American.</li> <li>• Middle Eastern or North African.</li> <li>• Native Hawaiian or Pacific Islander.</li> <li>• White.</li> <li>• Some Other Race.</li> <li>• Two or More Races.</li> <li>• Asked But No Answer.</li> </ul>

	<ul style="list-style-type: none"> <li>• Unknown.</li> </ul> <p>Ethnicity. (Refer to <a href="#">General Guideline: Race and Ethnicity Stratification</a>.)</p> <ul style="list-style-type: none"> <li>• Hispanic or Latino.</li> <li>• Not Hispanic or Latino.</li> <li>• Asked But No Answer.</li> <li>• Unknown.</li> </ul>
<b>Risk adjustment</b>	None.
<b>Improvement notation</b>	Increased score indicates improvement.
<b>Guidance</b>	<p><b>Data collection methodology:</b> Administrative. Refer to <a href="#">General Guideline: Data Collection Methods</a> for additional information.</p> <p><b>Date specificity:</b> Dates must be specific enough to determine the event occurred in the period being measured.</p> <p><b>What services count?</b></p> <ul style="list-style-type: none"> <li>• When using claims, include all paid, suspended, pending and denied claims.</li> <li>• Organizations may have different methods for billing intensive outpatient visits and partial hospitalizations. Some methods may be comparable to outpatient billing, with separate claims for each date of service; others may be comparable to inpatient billing, with an admission date, a discharge date and units of service. Organizations whose billing methods are comparable to inpatient billing may count each unit of service as an individual visit. The unit of service must have occurred during the required time frame for the rate.</li> </ul> <p><b>Medication lists:</b></p> <ul style="list-style-type: none"> <li>• Methadone is not included on the medication lists for this measure. Methadone for opioid use disorder (OUD), administered or dispensed by federally certified opioid treatment programs (OTP) is billed on a medical claim. A pharmacy claim for methadone would indicate treatment for pain rather than for OUD.</li> <li>• If an organization uses both pharmacy data (NDC codes) and clinical data (RxNorm codes) for reporting, and there are both NDC and RxNorm codes on the same date of service, use only one data source for the date of service.</li> </ul> <p><b>Other guidance:</b> The measure is based on episodes; therefore, it is possible for the denominator to include multiple events for the same person.</p>

## Definitions

<b>Date of service for services billed weekly or monthly</b>	For an opioid treatment service that bills monthly or weekly ( <a href="#">OUD Weekly Non Drug Service Value Set</a> ; <a href="#">OUD Monthly Office Based Treatment Value Set</a> ; <a href="#">OUD Weekly Drug Treatment Service Value Set</a> ), if the service includes a range of dates, then use the earliest date as the date of service. Use this date for all relevant events (the SUD episode date, negative diagnosis history and numerator events).
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<b>Direct transfer</b>	<p>The discharge date from the first inpatient setting precedes the admission date to a second inpatient setting by 1 calendar day or less.</p> <ul style="list-style-type: none"> <li>• <i>For example:</i> <ul style="list-style-type: none"> <li>– An inpatient discharge on June 1, followed by an admission to another inpatient setting on June 1, <i>is a direct transfer</i>.</li> <li>– An inpatient discharge on June 1, followed by an admission to an inpatient setting on June 2, <i>is a direct transfer</i>.</li> <li>– An inpatient discharge on June 1, followed by an admission to another inpatient setting on June 3, <i>is not a direct transfer</i>; these are two distinct inpatient stays.</li> </ul> </li> </ul> <p>Use the following method to identify admissions to and discharges from inpatient settings.</p> <ol style="list-style-type: none"> <li>1. Identify all acute and nonacute inpatient stays (<u>Inpatient Stay Value Set</u>).</li> <li>2. Identify the admission and discharge dates for the stay.</li> </ol>
<b>Intake period</b>	November 15 of the year prior to the measurement period through November 14 of the measurement period. The intake period is used to capture new SUD episodes.
<b>SUD episode</b>	<p>An encounter during the intake period with a diagnosis of SUD.</p> <p>For visits that result in an inpatient stay, the inpatient discharge is the SUD episode (an SUD diagnosis is not required for the inpatient stay; use the diagnosis from the visit that resulted in the inpatient stay to determine the diagnosis cohort).</p>
<b>SUD episode date</b>	<p>The date of service for an encounter during the intake period with a diagnosis of SUD.</p> <p><i>For a visit (not resulting in an inpatient stay), the SUD episode date is the date of service.</i></p> <p><i>For an inpatient stay or for withdrawal management (i.e., detoxification) that occurred during an inpatient stay, the SUD episode date is the date of discharge.</i></p> <p><i>For withdrawal management (i.e., detoxification) that did not occur during an inpatient stay, the SUD episode date is the date of service.</i></p> <p><i>For direct transfers, the SUD episode date is the discharge date from the last admission (an SUD diagnosis is not required for the transfer; use the diagnosis from the initial admission to determine the diagnosis cohort).</i></p>
<b>Initial population</b>	<p><b>Measure item count:</b> Episode.</p> <p><b>Attribution basis:</b> Enrollment.</p> <ul style="list-style-type: none"> <li>• <b>Benefits:</b> Medical, pharmacy and chemical dependency (inpatient and outpatient).</li> </ul> <p><b>Note:</b> Withdrawal management/detoxification-only chemical dependency benefits do not meet these criteria.</p> <ul style="list-style-type: none"> <li>• <b>Continuous enrollment:</b> 194 days prior to the SUD episode date through 47 days after the SUD episode date (242 days total).</li> </ul>

	<ul style="list-style-type: none"> <li>• <i>Allowable gap:</i> None.</li> </ul> <p><b>Ages:</b> 13 years of age and older as of the SUD episode date.</p> <p><b>Event:</b> New episode of SUD during the intake period.</p> <p><b>Step 1.</b> Identify all SUD episodes. Any of the following meet criteria:</p> <ul style="list-style-type: none"> <li>• An outpatient visit (<u>Visit Setting Unspecified Value Set</u>) <b>with</b> (<u>Outpatient POS Value Set</u>) <b>with</b> one of the following: <u>Alcohol Abuse and Dependence Value Set</u>, <u>Opioid Abuse and Dependence Value Set</u>, <u>Other Drug Abuse and Dependence Value Set</u>.</li> <li>• An outpatient visit (<u>BH Outpatient Value Set</u>) <b>with</b> one of the following: <u>Alcohol Abuse and Dependence Value Set</u>, <u>Opioid Abuse and Dependence Value Set</u>, <u>Other Drug Abuse and Dependence Value Set</u>.</li> <li>• An intensive outpatient encounter or partial hospitalization (<u>Visit Setting Unspecified Value Set</u>) <b>with</b> POS code 52 <b>with</b> one of the following: <u>Alcohol Abuse and Dependence Value Set</u>, <u>Opioid Abuse and Dependence Value Set</u>, <u>Other Drug Abuse and Dependence Value Set</u>.</li> <li>• An intensive outpatient encounter or partial hospitalization (<u>Partial Hospitalization or Intensive Outpatient Value Set</u>) <b>with</b> one of the following: <u>Alcohol Abuse and Dependence Value Set</u>, <u>Opioid Abuse and Dependence Value Set</u>, <u>Other Drug Abuse and Dependence Value Set</u>.</li> <li>• A non-residential substance abuse treatment facility visit (<u>Visit Setting Unspecified Value Set</u>) <b>with</b> (<u>Nonresidential Substance Abuse Treatment Facility POS Value Set</u>) <b>with</b> one of the following: <u>Alcohol Abuse and Dependence Value Set</u>, <u>Opioid Abuse and Dependence Value Set</u>, <u>Other Drug Abuse and Dependence Value Set</u>.</li> <li>• A community mental health center visit (<u>Visit Setting Unspecified Value Set</u>) <b>with</b> POS code 53 <b>with</b> one of the following: <u>Alcohol Abuse and Dependence Value Set</u>, <u>Opioid Abuse and Dependence Value Set</u>, <u>Other Drug Abuse and Dependence Value Set</u>.</li> <li>• A telehealth visit (<u>Visit Setting Unspecified Value Set</u>) <b>with</b> (<u>Telehealth POS Value Set</u>) <b>with</b> one of the following: <u>Alcohol Abuse and Dependence Value Set</u>, <u>Opioid Abuse and Dependence Value Set</u>, <u>Other Drug Abuse and Dependence Value Set</u>.</li> <li>• A substance use disorder service (<u>Substance Use Disorder Services Value Set</u>) <b>with</b> one of the following: <u>Alcohol Abuse and Dependence Value Set</u>, <u>Opioid Abuse and Dependence Value Set</u>, <u>Other Drug Abuse and Dependence Value Set</u>.</li> <li>• Substance use disorder counseling and surveillance (<u>Substance Abuse Counseling and Surveillance Value Set*</u>) <b>with</b> one of the following: <u>Alcohol Abuse and Dependence Value Set*</u>, <u>Opioid Abuse and Dependence Value Set*</u>, <u>Other Drug Abuse and Dependence Value Set*</u>.</li> <li>• A withdrawal management event (<u>Detoxification Value Set</u>) <b>with</b> one of the following: <u>Alcohol Abuse and Dependence Value Set</u>, <u>Opioid Abuse and Dependence Value Set</u>, <u>Other Drug Abuse and Dependence Value Set</u>.</li> </ul>
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- An ED visit ([ED Value Set](#)) **with** one of the following: [Alcohol Abuse and Dependence Value Set](#), [Opioid Abuse and Dependence Value Set](#), [Other Drug Abuse and Dependence Value Set](#).
- An acute or nonacute inpatient discharge **with** one of the following on the discharge claim: [Alcohol Abuse and Dependence Value Set](#), [Opioid Abuse and Dependence Value Set](#), [Other Drug Abuse and Dependence Value Set](#). 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.
- A telephone visit ([Telephone Visits Value Set](#)) **with** one of the following: [Alcohol Abuse and Dependence Value Set](#), [Opioid Abuse and Dependence Value Set](#), [Other Drug Abuse and Dependence Value Set](#).
- An e-visit or virtual check-in ([Online Assessments Value Set](#)) **with** one of the following: [Alcohol Abuse and Dependence Value Set](#), [Opioid Abuse and Dependence Value Set](#), [Other Drug Abuse and Dependence Value Set](#).
- An opioid treatment service ([OUD Weekly Non Drug Service Value Set](#); [OUD Monthly Office Based Treatment Value Set](#); [OUD Weekly Drug Treatment Service Value Set](#)) **with** a diagnosis of opioid abuse or dependence ([Opioid Abuse and Dependence Value Set](#)).

**Step 2.** Test for negative SUD diagnosis history.

Remove SUD episodes if the person had a SUD diagnosis ([Alcohol Abuse and Dependence Value Set\\*](#), [Opioid Abuse and Dependence Value Set\\*](#), [Other Drug Abuse and Dependence Value Set\\*](#)) during the 194 days prior to the SUD episode date. Do not include ED visits ([ED Value Set](#)) or withdrawal management events ([Detoxification Value Set](#)).

If the SUD episode was an inpatient stay, use the admission date to determine negative SUD history.

*For visits with an SUD diagnosis that resulted in an inpatient stay* (where the inpatient stay becomes the SUD episode), use the earliest date of service to determine the negative SUD diagnosis history (so that the visit that resulted in the inpatient stay is not considered a positive diagnosis history).

*For direct transfers*, use the first admission date to determine the negative SUD diagnosis history.

**Step 3.** Test for negative SUD medication history. Remove SUD episodes if any of the following occurred during the 194 days prior to the SUD episode date:

- An SUD medication treatment dispensing event ([Alcohol Use Disorder Treatment Medications List](#); [Naltrexone Injection Medications List](#); [Buprenorphine Oral Medications List](#); [Buprenorphine Injection Medications List](#); [Buprenorphine Implant Medications List](#); [Buprenorphine Naloxone Medications List](#)).

	<ul style="list-style-type: none"> <li>An SUD medication administration event (<a href="#">Naltrexone Injection Value Set</a>; <a href="#">Buprenorphine Oral Value Set</a>; <a href="#">Buprenorphine Oral Weekly Value Set</a>; <a href="#">Buprenorphine Injection Value Set</a>; <a href="#">Buprenorphine Naloxone Value Set</a>; <a href="#">Buprenorphine Implant Value Set</a>; <a href="#">Methadone Oral Value Set</a>; <a href="#">Methadone Oral Weekly Value Set</a>).</li> </ul> <p><b>Step 4.</b> Remove SUD episodes that do not meet continuous enrollment criteria.</p> <p><b>Step 5.</b> Deduplicate eligible episodes. If a person has more than one eligible episode on the same day, include only one eligible episode. For example, if a person has two eligible episodes on January 1, only one eligible episode would be included; then, if applicable, include the next eligible episode that occurs after January 1.</p> <p><b>Note:</b> All eligible episodes that were not removed or deduplicated remain in the denominator.</p> <p><b>Step 6.</b> Identify the SUD diagnosis cohort for each SUD episode.</p> <ul style="list-style-type: none"> <li>If the SUD episode has a diagnosis of alcohol use disorder (<a href="#">Alcohol Abuse and Dependence Value Set</a>), include the episode in the <i>alcohol use disorder cohort</i>.</li> <li>If the SUD episode has a diagnosis of opioid use disorder (<a href="#">Opioid Abuse and Dependence Value Set</a>), include the episode in the <i>opioid use disorder cohort</i>.</li> <li>If the SUD episode has a diagnosis of SUD that is neither for opioid nor alcohol (<a href="#">Other Drug Abuse and Dependence Value Set</a>), include the person in the <i>other substance use disorder cohort</i>.</li> </ul> <p>Include SUD episodes in all SUD diagnosis cohorts for which they meet criteria.</p> <ul style="list-style-type: none"> <li>For example, if the SUD episode has a diagnosis of alcohol use disorder and opioid use disorder, include the episode in the alcohol use disorder and opioid use disorder cohorts.</li> </ul> <p><b>Coding Guidance</b> *Do not include laboratory claims (claims with POS code 81).</p>
<b>Denominator exclusions</b>	<p><b>Persons with a date of death.</b> Death in the measurement period, identified using data sources determined by the organization. Method and data sources are subject to review during the HEDIS audit.</p> <p><b>Persons in hospice or using hospice services.</b> Persons who use hospice services (<a href="#">Hospice Encounter Value Set</a>; <a href="#">Hospice Intervention Value Set</a>) or elect to use a hospice benefit any time during the measurement period. Organizations that use the Monthly Membership Detail Data File to identify these persons must use only the run date of the file.</p>
<b>Denominator</b>	The initial population minus denominator exclusions.
<b>Numerator</b>	<p><b>Numerator 1: Initiation of SUD treatment.</b> Initiation of SUD treatment within 14 days of the SUD episode date. Follow the steps below to identify numerator compliance.</p>

**Step 1.** If the SUD episode was an inpatient discharge, the inpatient stay is considered initiation of treatment and the SUD episode is compliant.

**Step 2.** If the SUD episode was an opioid treatment service that bills monthly (OUD Monthly Office Based Treatment Value Set), the opioid treatment service is considered initiation of treatment and the SUD episode is compliant.

**Step 3.** For remaining SUD episodes (those not compliant after steps 1–2), identify episodes with at least one of the following on the SUD episode date or during the 13 days after the SUD episode date (14 total days):

- An acute or nonacute inpatient admission **with** a diagnosis (on the discharge claim) of one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set. To identify acute and nonacute inpatient admissions:
  1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
  2. Identify the admission date for the stay.
- An outpatient visit (Visit Setting Unspecified Value Set) **with** (Outpatient POS Value Set) **with** one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- An outpatient visit (BH Outpatient Value Set) **with** one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- An intensive outpatient encounter or partial hospitalization (Visit Setting Unspecified Value Set) **with** POS code 52 **with** one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- An intensive outpatient encounter or partial hospitalization (Partial Hospitalization or Intensive Outpatient Value Set) **with** one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- A non-residential substance abuse treatment facility visit (Visit Setting Unspecified Value Set) **with** (Nonresidential Substance Abuse Treatment Facility POS Value Set) **with** one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- A community mental health center visit (Visit Setting Unspecified Value Set) **with** POS code 53 **with** one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- A telehealth visit (Visit Setting Unspecified Value Set) **with** (Telehealth POS Value Set) **with** one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.

- A substance use disorder service (Substance Use Disorder Services Value Set) **with** one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- Substance use disorder counseling and surveillance (Substance Abuse Counseling and Surveillance Value Set\*) **with** one of the following: Alcohol Abuse and Dependence Value Set\*, Opioid Abuse and Dependence Value Set\*, Other Drug Abuse and Dependence Value Set\*).
- A telephone visit (Telephone Visits Value Set) **with** one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- An e-visit or virtual check-in (Online Assessments Value Set) **with** one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- A weekly or monthly opioid treatment service (OUD Weekly Non Drug Service Value Set; OUD Monthly Office Based Treatment Value Set; OUD Weekly Drug Treatment Service Value Set).
- For SUD episodes in the alcohol use disorder cohort, an alcohol use disorder medication treatment dispensing event (Alcohol Use Disorder Treatment Medications List) or a medication administration event (Naltrexone Injection Value Set).
- For SUD episodes in the opioid use disorder cohort, an opioid use disorder medication treatment dispensing event (Naltrexone Oral Medications List; Naltrexone Injection Medications List; Buprenorphine Oral Medications List; Buprenorphine Injection Medications List; Buprenorphine Implant Medications List; Buprenorphine Naloxone Medications List) or a medication administration event (Naltrexone Injection Value Set, Buprenorphine Oral Value Set, Buprenorphine Oral Weekly Value Set, Buprenorphine Injection Value Set, Buprenorphine Implant Value Set, Buprenorphine Naloxone Value Set, Methadone Oral Value Set, Methadone Oral Weekly Value Set).

For all initiation events except medication treatment dispensing events and medication administration events, initiation on the same day as the SUD episode date must be with different providers in order to count.

Remove the person from the denominator for numerators 1 and 2 (Initiation of SUD Treatment and Engagement of SUD Treatment) if the initiation of treatment event is an inpatient stay with a discharge date after November 27 of the measurement period.

#### **Numerator 2: Engagement of SUD treatment.**

Follow the steps below to identify numerator compliance.

If the initiation of SUD treatment event from numerator 1 was an inpatient admission, the 34-day period for engagement begins the day after discharge.

**Step 1.** Identify all SUD episodes compliant for Numerator 1: Initiation of SUD Treatment. SUD episodes that are not compliant for Numerator 1: Initiation of SUD Treatment are not compliant for Numerator 2: Engagement of SUD Treatment.

**Step 2.** Identify SUD episodes that had at least one weekly or monthly opioid treatment service with medication administration (OUD Monthly Office Based Treatment Value Set; OUD Weekly Drug Treatment Service Value Set) on the day after the initiation encounter through 34 days after the initiation event. The opioid treatment service is considered engagement of treatment and the SUD episode is compliant.

**Step 3.** Identify SUD episodes with long-acting SUD medication administration events on the day after the initiation encounter through 34 days after the initiation event. The long-acting SUD medication administration event is considered engagement of treatment, and the SUD episode is compliant. Any of the following meet criteria:

- *For SUD episodes in the alcohol use disorder cohort*, an alcohol use disorder medication treatment dispensing event (Naltrexone Injection Medications List) or a medication administration event (Naltrexone Injection Value Set).
- *For SUD episodes in the opioid use disorder cohort*, an opioid use disorder medication treatment dispensing event (Naltrexone Injection Medications List; Buprenorphine Injection Medications List; Buprenorphine Implant Medications List) or a medication administration event (Naltrexone Injection Value Set; Buprenorphine Injection Value Set; Buprenorphine Implant Value Set).

**Step 4.** For remaining SUD episodes, identify episodes with at least two of the following (any combination) on the day after the initiation encounter through 34 days after the initiation event:

- Engagement visit.
- Engagement medication treatment event.

Two engagement visits may be on the same date of service, but must be with different providers to count as two events. An engagement visit on the same date of service as an engagement medication treatment event meets criteria (they are not required to be with different providers).

Refer to the descriptions below to identify engagement visits and engagement medication treatment events.

*Engagement visit.* Any of the following meet criteria for an engagement visit:

- An acute or nonacute inpatient admission **with** a diagnosis (on the discharge claim) of one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set. To identify acute or nonacute inpatient admissions:
  1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
  2. Identify the admission date for the stay.

- An outpatient visit (Visit Setting Unspecified Value Set) **with** (Outpatient POS Value Set) **with** one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- An outpatient visit (BH Outpatient Value Set) **with** one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- An intensive outpatient encounter or partial hospitalization (Visit Setting Unspecified Value Set) **with** POS code 52 **with** one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- An intensive outpatient encounter or partial hospitalization (Partial Hospitalization or Intensive Outpatient Value Set) **with** one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- A non-residential substance abuse treatment facility visit (Visit Setting Unspecified Value Set) **with** (Nonresidential Substance Abuse Treatment Facility POS Value Set) **with** one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- A community mental health center visit (Visit Setting Unspecified Value Set) **with** POS code 53 **with** one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- A telehealth visit (Visit Setting Unspecified Value Set) **with** (Telehealth POS Value Set) **with** one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- A substance use disorder service (Substance Use Disorder Services Value Set) **with** one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- Substance use disorder counseling and surveillance (Substance Abuse Counseling and Surveillance Value Set\*) **with** one of the following: Alcohol Abuse and Dependence Value Set\*, Opioid Abuse and Dependence Value Set\*, Other Drug Abuse and Dependence Value Set\*).
- A telephone visit (Telephone Visits Value Set) **with** one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- An e-visit or virtual check-in (Online Assessments Value Set) **with** one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- An opioid treatment service (OUD Weekly Non Drug Service Value Set).

	<p><i>Engagement medication treatment events.</i> Either of the following meets criteria for a medication treatment event:</p> <ul style="list-style-type: none"> <li>• For SUD episodes in the alcohol use disorder cohort, an alcohol use disorder medication treatment dispensing event (<a href="#">Alcohol Use Disorder Treatment Medications List</a>).</li> <li>• For SUD episodes in the opioid use disorder cohort, an opioid use disorder medication treatment dispensing event (<a href="#">Naltrexone Oral Medications List</a>; <a href="#">Buprenorphine Oral Medications List</a>; <a href="#">Buprenorphine Naloxone Medications List</a>) or a medication administration event (<a href="#">Buprenorphine Oral Value Set</a>; <a href="#">Buprenorphine Oral Weekly Value Set</a>; <a href="#">Buprenorphine Naloxone Value Set</a>; <a href="#">Methadone Oral Value Set</a>; <a href="#">Methadone Oral Weekly Value Set</a>).</li> </ul> <p><b>Coding Guidance</b> *Do not include laboratory claims (claims with POS code 81).</p>																																																											
<b>Summary of changes</b>	<ul style="list-style-type: none"> <li>• Updated the race and ethnicity stratification categories to align with OMB SPD 15 2024.</li> <li>• Added instructions on allowable adjustments to the race and ethnicity stratification.</li> </ul>																																																											
<b>Data element table</b>	<p>Organizations that submit HEDIS data to NCQA must provide the following data elements.</p> <p><b>Table IET-A-1/2/3: Data Elements for Initiation and Engagement of Substance Use Disorder Treatment</b></p> <table border="1"> <thead> <tr> <th>Metric</th><th>Diagnosis</th><th>Age</th><th>Data Element</th><th>Reporting Instructions</th></tr> </thead> <tbody> <tr> <td>Initiation</td><td>Alcohol</td><td>13-17</td><td>Benefit</td><td>Metadata</td></tr> <tr> <td>Engagement</td><td>Opioid</td><td>18-64</td><td>InitialPopulation</td><td>For each Stratification, repeat per Metric</td></tr> <tr> <td></td><td>Other</td><td>65+</td><td>Exclusions</td><td>For each Stratification, repeat per Metric</td></tr> <tr> <td></td><td>Total</td><td>Total</td><td>Denominator</td><td>For each Stratification, repeat per Metric</td></tr> <tr> <td></td><td></td><td></td><td>NumeratorByAdmin</td><td>For each Metric and Stratification</td></tr> <tr> <td></td><td></td><td></td><td>Rate</td><td>(Percent)</td></tr> </tbody> </table> <p><b>Table IET-B-1/2/3: Data Elements for Initiation and Engagement of Substance Use Disorder Treatment: Stratifications by Race</b></p> <table border="1"> <thead> <tr> <th>Metric</th><th>Race</th><th>Data Element</th><th>Reporting Instructions</th></tr> </thead> <tbody> <tr> <td>Initiation</td><td>AmericanIndianOrAlaskaNative</td><td>Denominator</td><td>For each Stratification, repeat per Metric</td></tr> <tr> <td>Engagement</td><td>Asian</td><td>Numerator</td><td>For each Metric and Stratification</td></tr> <tr> <td></td><td>BlackOrAfricanAmerican</td><td>Rate</td><td>(Percent)</td></tr> <tr> <td></td><td>MiddleEasternOrNorthAfrican</td><td></td><td></td></tr> <tr> <td></td><td>NativeHawaiianOrPacificIslander</td><td></td><td></td></tr> </tbody> </table>	Metric	Diagnosis	Age	Data Element	Reporting Instructions	Initiation	Alcohol	13-17	Benefit	Metadata	Engagement	Opioid	18-64	InitialPopulation	For each Stratification, repeat per Metric		Other	65+	Exclusions	For each Stratification, repeat per Metric		Total	Total	Denominator	For each Stratification, repeat per Metric				NumeratorByAdmin	For each Metric and Stratification				Rate	(Percent)	Metric	Race	Data Element	Reporting Instructions	Initiation	AmericanIndianOrAlaskaNative	Denominator	For each Stratification, repeat per Metric	Engagement	Asian	Numerator	For each Metric and Stratification		BlackOrAfricanAmerican	Rate	(Percent)		MiddleEasternOrNorthAfrican				NativeHawaiianOrPacificIslander		
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Metric	Race	Data Element	Reporting Instructions																																																									
Initiation	AmericanIndianOrAlaskaNative	Denominator	For each Stratification, repeat per Metric																																																									
Engagement	Asian	Numerator	For each Metric and Stratification																																																									
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	MiddleEasternOrNorthAfrican																																																											
	NativeHawaiianOrPacificIslander																																																											

Metric	Race	Data Element	Reporting Instructions
	White		
	SomeOtherRace		
	TwoOrMoreRaces		
	AskedButNoAnswer		
	Unknown		

Metric	Ethnicity	Data Element	Reporting Instructions
Initiation	HispanicOrLatino	Denominator	For each Stratification, repeat per Metric
Engagement	NotHispanicOrLatino	Numerator	For each Metric and Stratification
	AskedButNoAnswer	Rate	(Percent)
	Unknown		

Rules for Allowable Adjustments	<p><b>Copyright and use:</b> The “Rules for Allowable Adjustments of HEDIS” (the “Rules”) describe how NCQA’s HEDIS measure specifications can be adjusted for other populations, if applicable. The Rules, reviewed and approved by NCQA measure experts, provide for expanded use of HEDIS measures without changing their clinical intent.</p> <p><b>Adjusted HEDIS measures may not be used for HEDIS health plan reporting.</b></p> <p><b>ADJUSTMENTS ALLOWED</b></p> <ul style="list-style-type: none"> <li>• <b>Product lines.</b> Organizations are not required to use product line criteria; product lines may be combined, and all (or no) product line criteria may be used.</li> <li>• <b>Attribution.</b> Organizations are not required to use enrollment criteria.</li> <li>• <b>Benefits.</b> Organizations are not required to use a benefit.</li> <li>• <b>Ages.</b> The denominator age range may be expanded. Age determination dates may be changed (e.g., select, “age as of June 30”).</li> <li>• <b>Other.</b> Organizations may use additional initial population criteria to focus on an area of interest defined by gender, race, ethnicity, socioeconomic or sociodemographic characteristics, geographic region or another characteristic.</li> <li>• <b>Measurement period adjustments.</b> Organizations may adjust the measurement period.</li> <li>• <b>Stratifications:</b> Race and ethnicity stratification. The race and ethnicity stratification is not required. Organizations may adjust this stratification as needed.</li> <li>• <b>Exclusions.</b> The hospice and deceased person exclusions are not required.</li> </ul>
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- *Telehealth.* Services/events that allow the use of synchronous telehealth visits, telephone visits and asynchronous telehealth (e-visits, virtual check-ins) may be stratified to identify services performed via telehealth. This adjustment is not allowed for events, numerators and exclusions that do not allow the use of telehealth.
- *Supplemental data.* Supplemental data may be used to identify initial population, denominator, exclusion and numerator events.

**ADJUSTMENTS ALLOWED WITH LIMITS**

- *SUD diagnosis cohorts.* Reporting each stratum or combined strata is allowed. The value sets used to identify these cohorts may not be changed.

**ADJUSTMENTS NOT ALLOWED**

- *Initial population:* Event. The value sets, medication lists and logic may not be changed.
- *Numerator.* The medication lists, value sets and logic may not be changed.

## Prenatal and Postpartum Care (PPC)

Measure title	Prenatal and Postpartum Care	Measure ID	PPC
<b>Description</b>	<p>The percentage of deliveries of live births on or between October 8 of the year prior to the measurement period and October 7 of the measurement period. For these persons, the measure assesses the following facets of prenatal and postpartum care:</p> <ul style="list-style-type: none"> <li>• <i>Timeliness of Prenatal Care.</i> The percentage of deliveries that received a prenatal care visit in the first trimester on or before the enrollment start date or within 42 days of enrollment in the organization.</li> <li>• <i>Postpartum Care.</i> The percentage of deliveries that had a postpartum visit on or between 7 and 84 days after delivery.</li> </ul>		
<b>Measurement period</b>	January 1–December 31.		
<b>Copyright and disclaimer notice</b>	<p>Refer to the complete copyright and disclaimer information at the front of this publication.</p> <p>NCQA website: <a href="http://www.ncqa.org">www.ncqa.org</a>.</p> <p>Submit policy clarification support questions via My NCQA (<a href="https://my.ncqa.org">https://my.ncqa.org</a>).</p>		
<b>Clinical recommendation statement/ rationale</b>	<p>According to the National Institutes of Health (NIH), prenatal care can minimize the risk of pregnancy complications and negative birth outcomes. Similarly, comprehensive postpartum care is critical for setting the stage for the long-term health and well-being of new mothers and their infants. Common issues after birth include lack of sleep, fatigue, pain, stress, breastfeeding difficulties, mental health disorders and pre-existing health and social concerns. In addition, more than half of maternal deaths occur after birth.</p> <p>Joint guidelines published by ACOG and the American Academy of Pediatrics (AAP) recommend a prenatal visit in the first trimester of pregnancy. In May 2018, ACOG published a committee opinion recommending that all women have an initial assessment with a maternal care provider within 21 days after birth to address acute postpartum issues. The initial assessment should then be followed by ongoing care as needed and conclude with a comprehensive visit within 12 weeks after birth.</p> <p>The Department of Defense, Veteran's Administration (DoD/VA) clinical practice guidelines recommend a postpartum visit within 6 weeks, and no later than 8 weeks, after delivery.</p>		
<b>Citations</b>	<p>National Institutes of Health (NIH). 2012. Eunice Kennedy Shriver National Institute of Child Health and Human Development. What Is Prenatal Care &amp; Why Is It Important? <a href="http://www.nichd.nih.gov/health/topics/pregnancy/conditioninfo/Pages/prenatal-care.aspx">www.nichd.nih.gov/health/topics/pregnancy/conditioninfo/Pages/prenatal-care.aspx</a></p>		

	<p>American College of Obstetricians and Gynecologists (ACOG). 2018. "Optimizing Postpartum Care." ACOG Committee Opinion No. 736. <i>Obstet Gynecol</i> 131:140–50.</p> <p>Kassebaum, N., A. Bertozzi-Villa, M. Coggeshall, K. Shackelford, C. Steiner, K. Heuton, and D. Gonzalez-Medina. 2015. "Global, Regional, and National Levels and Causes of Maternal Mortality During 1990–2013." <i>Obstetric Anesthesia Digest</i> 35(4), 196–7. doi:10.1097/01.aoa.0000472714.57328.86.</p> <p>American Academy of Pediatrics, American College of Obstetricians and Gynecologists. 2017. Guidelines for Perinatal Care. 8th Ed. Elk Grove Village, Ill. American Academy of Pediatrics, and Washington, DC.</p> <p>Department of Veteran's Affairs. Department of Defense. 2018. VA/DoD Clinical Practice Guideline for Management of Pregnancy. <a href="https://www.healthquality.va.gov/guidelines/WH/up/VADoDPregnancyCPG4102018.pdf">https://www.healthquality.va.gov/guidelines/WH/up/VADoDPregnancyCPG4102018.pdf</a></p>
<b>Characteristics</b>	
<b>Scoring</b>	Proportion.
<b>Type</b>	Process.
<b>Product lines</b>	<ul style="list-style-type: none"> <li>• Commercial.</li> <li>• Medicaid.</li> </ul>
<b>Stratifications</b>	<p>Race. (Refer to <a href="#">General Guideline: Race and Ethnicity Stratification</a>.)</p> <ul style="list-style-type: none"> <li>• American Indian or Alaska Native.</li> <li>• Asian.</li> <li>• Black or African American.</li> <li>• Middle Eastern or North African.</li> <li>• Native Hawaiian or Pacific Islander.</li> <li>• White.</li> <li>• Some Other Race.</li> <li>• Two or More Races.</li> <li>• Asked But No Answer.</li> <li>• Unknown.</li> </ul> <p>Ethnicity. (Refer to <a href="#">General Guideline: Race and Ethnicity Stratification</a>.)</p> <ul style="list-style-type: none"> <li>• Hispanic or Latino.</li> <li>• Not Hispanic or Latino.</li> <li>• Asked But No Answer.</li> <li>• Unknown.</li> </ul>
<b>Risk adjustment</b>	None.
<b>Improvement notation</b>	Increased score indicates improvement.

<b>Guidance</b>	<p><b>Data collection methodology:</b> Administrative and hybrid. Refer to <a href="#">General Guideline: Data Collection Methods</a> for additional information.</p> <p><b>Date specificity:</b> Dates must be specific enough to determine the event occurred in the period being measured.</p> <p><b>What services count?</b></p> <ul style="list-style-type: none"> <li>• When using claims, include all paid, suspended, pending and denied claims.</li> <li>• Services that occur over multiple visits count toward this measure if all services are within the time frame established in the measure. Ultrasound and lab results alone are not considered a visit; they must be combined with an office visit with an appropriate practitioner in order to count for this measure.</li> </ul> <p><b>Other guidance:</b></p> <ul style="list-style-type: none"> <li>• Criteria for identifying prenatal care for persons who were not enrolled during the first trimester allow more flexibility than criteria for persons who were enrolled. <ul style="list-style-type: none"> <li>– <i>For persons who were enrolled at least 219 days before delivery</i>, the organization has sufficient opportunity to provide prenatal care by the end of the first trimester.</li> <li>– <i>For persons who were not enrolled at least 219 days before delivery</i>, the organization has sufficient opportunity to provide prenatal care within 42 days after enrollment.</li> </ul> </li> <li>• Refer to <a href="#">Appendix 1</a> for the definition of PCP and OB/GYN and other prenatal care practitioner.</li> <li>• Ancillary services (lab, ultrasound) may be delivered by an ancillary provider. Nonancillary services (e.g., fetal heart tone, prenatal risk assessment) must be delivered by the required provider type.</li> <li>• For both rates and for both Administrative and Hybrid data collection methods, services provided during a telephone visit, e-visit or virtual check-in are eligible for use in reporting.</li> <li>• For each person, the organization must use one date (date of delivery or estimated delivery date [EDD]) to define the start and end of the first trimester. If multiple EDDs are documented, the organization must define a method to determine which EDD to use, and use that date consistently. If the organization elects to use EDD, and the EDD is not on or between October 8 of the year prior to the measurement period and October 7 of the measurement period, the person is removed as a valid data error and replaced by the next person in the oversample. The LMP may not be used to determine the first trimester.</li> <li>• The EDD may be used to identify the first trimester for the Timeliness of Prenatal Care rate and use the date of delivery for the Postpartum Care rate.</li> <li>• The measure is based on deliveries; therefore, it is possible for denominator to include multiple deliveries for the same person.</li> </ul>
<b>Definitions</b>	
<b>First trimester</b>	280–176 days prior to delivery (or estimated delivery date [EDD]).

<b>Initial population</b>	<p><b>Measure item count:</b> Episode.</p> <p><b>Attribution basis:</b> Enrollment.</p> <ul style="list-style-type: none"> <li>• <b>Benefits:</b> Medical.</li> <li>• <b>Continuous enrollment:</b> 43 days prior to delivery through 60 days after delivery.</li> <li>• <b>Allowable gap:</b> None.</li> </ul> <p><b>Ages:</b> None.</p> <p><b>Event: Deliveries.</b> Live birth deliveries in any setting on or between October 8 of the year prior to the measurement period and October 7 of the measurement period.</p> <p><b>Step 1.</b> Identify all persons with a delivery (<u>Deliveries Value Set</u>) on or between October 8 of the year prior to the measurement period and October 7 of the measurement period.</p> <p><b>Note:</b> <i>The intent is to identify the date of delivery (the date of the “procedure”). If the date of delivery cannot be interpreted on the claim, use the date of service or, for inpatient claims, the date of discharge.</i></p> <p><b>Step 2.</b> Remove non-live births (<u>Non Live Births Value Set</u>).</p> <p><b>Step 3.</b> Identify continuous enrollment. Determine if enrollment was continuous 43 days prior to delivery through 60 days after delivery, with no gaps.</p> <p><b>Step 4.</b> Remove multiple deliveries in a 180-day period. If a person has more than one delivery in a 180-day period, include only the first eligible delivery. Then, if applicable, include the next delivery that occurs after the 180-day period. Identify deliveries chronologically, including only one per 180-day period.</p> <p><b>Note:</b> <i>The initial population for this measure is based on deliveries, not on persons. All eligible deliveries that were not removed in steps 1–4 remain in the initial population.</i></p>
<b>Denominator exclusions</b>	<p><b>Persons with a date of death.</b> Death in the measurement period, identified using data sources determined by the organization. Method and data sources are subject to review during the HEDIS audit.</p> <p><b>Persons in hospice or using hospice services.</b> Persons who use hospice services (<u>Hospice Encounter Value Set</u>; <u>Hospice Intervention Value Set</u>) or elect to use a hospice benefit any time during the measurement period. Organizations that use the Monthly Membership Detail Data File to identify these persons must use only the run date of the file.</p>
<b>Denominator</b>	<p><b>ADMINISTRATIVE</b> The initial population minus denominator exclusions.</p> <p><b>HYBRID</b> A systematic sample drawn from the administrative denominator.</p>

	<p>Organizations may reduce the sample size using the current year's administrative rate or the prior year's audited, product line-specific rate for the lower of the two indicators.</p> <p>Refer to the <a href="#">Guidelines for Calculations and Sampling</a> for information on reducing the sample size.</p>
Numerator	<p><b>ADMINISTRATIVE</b></p> <p><b>Numerator 1: Timeliness of prenatal care.</b></p> <p>A prenatal visit during the required time frame. Follow the steps below to identify numerator compliance.</p> <p><b>Step 1.</b> Identify persons who were continuously enrolled (with no gaps) from at least 219 days before delivery (or EDD) through 60 days after delivery.</p> <p>These persons must have a prenatal visit during the first trimester.</p> <p><b>Step 2.</b> Identify persons who were not continuously enrolled from at least 219 days before delivery (or EDD) through 60 days after delivery.</p> <p>These persons must have a prenatal visit any time during the period that begins 280 days prior to delivery and ends 42 days after the enrollment start date.</p> <p>Do not count visits that occur on or after the date of delivery. Visits that occur prior to the person's enrollment start date during the pregnancy meet criteria.</p> <p><b>Step 3.</b> Identify prenatal visits that occurred during the required time frame (the time frame identified in step 1 or 2). Any of the following, where the practitioner type is an OB/GYN or other prenatal care practitioner or PCP, meet criteria for a prenatal visit:</p> <ul style="list-style-type: none"> <li>• A bundled service (<a href="#">Prenatal Bundled Services Value Set</a>) where the organization can identify the date when prenatal care was initiated (because bundled service codes are used on the date of delivery, these codes may be used only if the claim form indicates when prenatal care was initiated).</li> <li>• A visit for prenatal care (<a href="#">Stand Alone Prenatal Visits Value Set†</a>).</li> <li>• A prenatal visit (<a href="#">Prenatal Visits Value Set</a>) <b>with</b> a pregnancy-related diagnosis code (<a href="#">Pregnancy Diagnosis Value Set</a>).</li> </ul> <p><b>Numerator 2: Postpartum care.</b></p> <p>A postpartum visit on or between 7 and 84 days after delivery. Any of the following meet criteria:</p> <ul style="list-style-type: none"> <li>• A postpartum visit (<a href="#">Postpartum Care Value Set†</a>).</li> <li>• An encounter for postpartum care (<a href="#">Encounter for Postpartum Care Value Set‡*</a>).</li> <li>• Cervical cytology (<a href="#">Cervical Cytology Lab Test Value Set</a>; <a href="#">Cervical Cytology Result or Finding Value Set</a>).</li> <li>• A bundled service (<a href="#">Postpartum Bundled Services Value Set</a>) where the organization can identify the date when postpartum care was rendered (because bundled service codes are used on the date of delivery, not on the date of the postpartum visit, these codes may be used only if the claim form indicates when postpartum care was rendered).</li> </ul>

	<p>Exclude services provided in an acute inpatient setting (<u>Acute Inpatient Value Set; Acute Inpatient POS Value Set</u>).</p> <p><b>Note:</b> The practitioner requirement only applies to the Hybrid Specification. The organization is not required to identify practitioner type in administrative data.</p> <p><b>Coding Guidance</b></p> <p>*Do not include laboratory claims (claims with POS code 81).</p> <p>†Do not use codes with a modifier (<u>CPT CAT II Modifier Value Set</u>).</p> <p><b>HYBRID</b></p> <p><i>Administrative:</i> Refer to administrative specifications to identify positive numerator hits from administrative data.</p> <p><b>Numerator 1: Timeliness of prenatal care.</b></p> <p>A prenatal visit during the required time frame. Refer to <i>Administrative Specification</i> to identify the required time frame for each person based on the date of enrollment in the organization and the gaps in enrollment during the pregnancy.</p> <p><i>Medical record:</i> Prenatal care visit to an OB/GYN or other prenatal care practitioner, or PCP. For visits to a PCP, a diagnosis of pregnancy must be present. Documentation in the medical record must include a note indicating the date when the prenatal care visit occurred and evidence of one of the following.</p> <ul style="list-style-type: none"> <li>• Documentation indicating the person is pregnant or references to the pregnancy.</li> </ul> <p><i>For example:</i></p> <ul style="list-style-type: none"> <li>– Documentation in a standardized prenatal flow sheet, <b>or</b></li> <li>– Documentation of last menstrual period (LMP), EDD or gestational age, <b>or</b></li> <li>– A positive pregnancy test result, <b>or</b></li> <li>– Documentation of gravidity and parity, <b>or</b></li> <li>– Documentation of complete obstetrical history, <b>or</b></li> <li>– Documentation of prenatal risk assessment and counseling/education.</li> <li>• A basic physical obstetrical examination that includes auscultation for fetal heart tone, <b>or</b> pelvic exam with obstetric observations, <b>or</b> measurement of fundus height (a standardized prenatal flow sheet may be used).</li> <li>• Evidence that a prenatal care procedure was performed, such as: <ul style="list-style-type: none"> <li>– Screening test in the form of an obstetric panel (must include all of the following: hematocrit, differential WBC count, platelet count, hepatitis B surface antigen, rubella antibody, syphilis test, RBC antibody screen, Rh and ABO blood typing), <b>or</b></li> <li>– TORCH antibody panel alone, <b>or</b></li> <li>– A rubella antibody test/titer with an Rh incompatibility (ABO/Rh) blood typing, <b>or</b></li> <li>– Ultrasound of a pregnant uterus.</li> </ul> </li> </ul>
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	<p><b>Numerator 2: Postpartum care.</b></p> <p>A postpartum visit on or between 7 and 84 days after delivery, as documented through either administrative data or medical record review.</p> <p><i>Medical record:</i> Postpartum visit to an OB/GYN or other prenatal care practitioner, or PCP on or between 7 and 84 days after delivery. Do not include postpartum care provided in an acute inpatient setting.</p> <p>Documentation in the medical record must include a note indicating the date when a postpartum visit occurred and <i>one</i> of the following:</p> <ul style="list-style-type: none"> <li>• Pelvic exam.</li> <li>• Evaluation of weight, BP, breasts and abdomen. <ul style="list-style-type: none"> <li>– Notation of “breastfeeding” is acceptable for the “evaluation of breasts” component.</li> </ul> </li> <li>• Notation of postpartum care, including, but not limited to: <ul style="list-style-type: none"> <li>– Notation of “postpartum care,” “PP care,” “PP check,” “6-week check.”</li> <li>– A preprinted “Postpartum Care” form in which information was documented during the visit.</li> </ul> </li> <li>• Perineal or cesarean incision/wound check.</li> <li>• Screening for depression, anxiety, tobacco use, substance use disorder or preexisting mental health disorders.</li> <li>• Glucose screening, for persons with gestational diabetes.</li> <li>• Documentation of any of the following topics: <ul style="list-style-type: none"> <li>– Infant care or breastfeeding.</li> <li>– Resumption of intercourse, birth spacing or family planning.</li> <li>– Sleep/fatigue.</li> <li>– Resumption of physical activity.</li> <li>– Attainment of healthy weight.</li> </ul> </li> </ul> <p><b>Note</b></p> <ul style="list-style-type: none"> <li>• A Pap test does not count as a prenatal care visit for the administrative and hybrid specification of the Timeliness of Prenatal Care rate but is acceptable for the Postpartum Care rate as evidence of a pelvic exam. A colposcopy alone is not numerator compliant for either rate.</li> <li>• Services that occur over multiple visits count toward this measure if all services are within the time frame established in the measure. Ultrasound and lab results alone are not considered a visit; they must be combined with an office visit with an appropriate practitioner in order to count for this measure.</li> <li>• The intent is to assess whether prenatal and preventive care was rendered on a routine, outpatient basis rather than assessing treatment for emergent events.</li> </ul>
<b>Summary of changes</b>	<ul style="list-style-type: none"> <li>• Updated the race and ethnicity stratification categories to align with OMB SPD 15 2024.</li> <li>• Added instructions on allowable adjustments to the race and ethnicity stratifications.</li> <li>• Updated the allowable adjustments for the Numerator: Timeliness of Prenatal Care to allow visits any time during the pregnancy.</li> </ul>

<b>Data element tables</b>	<p>Organizations that submit HEDIS data to NCQA must provide the following data elements.</p> <p><b>Table PPC-A-1/2: Data Elements for Prenatal and Postpartum Care</b></p> <table border="1"> <thead> <tr> <th>Metric</th><th>Data Element</th><th>Reporting Instructions</th><th>A</th></tr> </thead> <tbody> <tr> <td>TimelinessPrenatalCare</td><td>CollectionMethod</td><td>For each Metric</td><td>✓</td></tr> <tr> <td>PostpartumCare</td><td>InitialPopulation*</td><td>For each Metric</td><td>✓</td></tr> <tr> <td></td><td>Exclusions*</td><td>For each Metric</td><td>✓</td></tr> <tr> <td></td><td>Denominator*</td><td>Repeat per Metric</td><td>✓</td></tr> <tr> <td></td><td>NumeratorByAdminDenom</td><td>For each Metric</td><td></td></tr> <tr> <td></td><td>CYAR</td><td>(Percent)</td><td></td></tr> <tr> <td></td><td>MinReqSampleSize</td><td>Repeat per Metric</td><td></td></tr> <tr> <td></td><td>OversampleRate</td><td>Repeat per Metric</td><td></td></tr> <tr> <td></td><td>OversampleRecordsNumber</td><td>(Count)</td><td></td></tr> <tr> <td></td><td>ExclusionValidDataErrors</td><td>Repeat per Metric</td><td></td></tr> <tr> <td></td><td>ExclusionEmployeeOrDep</td><td>Repeat per Metric</td><td></td></tr> <tr> <td></td><td>OversampleRecsAdded</td><td>Repeat per Metric</td><td></td></tr> <tr> <td></td><td>NumeratorByAdmin</td><td>For each Metric</td><td>✓</td></tr> <tr> <td></td><td>NumeratorByMedicalRecords</td><td>For each Metric</td><td></td></tr> <tr> <td></td><td>Rate</td><td>(Percent)</td><td>✓</td></tr> </tbody> </table> <p><b>Table PPC-B-1/2: Data Elements for Prenatal and Postpartum Care: Stratifications by Race</b></p> <table border="1"> <thead> <tr> <th>Metric</th></tr> </thead> <tbody> <tr> <td>TimelinessPrenatalCare</td></tr> <tr> <td>PostpartumCare</td></tr> </tbody> </table> <table border="1"> <thead> <tr> <th>Race</th><th>Data Element</th><th>Reporting Instructions</th><th>A</th></tr> </thead> <tbody> <tr> <td>AmericanIndianOrAlaskaNative</td><td>CollectionMethod</td><td>For each Metric, repeat per Stratification</td><td>✓</td></tr> <tr> <td>Asian</td><td>Denominator*</td><td>For each Stratification, repeat per Metric</td><td>✓</td></tr> <tr> <td>BlackOrAfricanAmerican</td><td>Numerator</td><td>For each Metric and Stratification</td><td>✓</td></tr> <tr> <td>MiddleEasternOrNorthAfrican</td><td>Rate</td><td>(Percent)</td><td>✓</td></tr> <tr> <td>NativeHawaiianOrPacificIslander</td><td></td><td></td><td></td></tr> <tr> <td>White</td><td></td><td></td><td></td></tr> <tr> <td>SomeOtherRace</td><td></td><td></td><td></td></tr> </tbody> </table>	Metric	Data Element	Reporting Instructions	A	TimelinessPrenatalCare	CollectionMethod	For each Metric	✓	PostpartumCare	InitialPopulation*	For each Metric	✓		Exclusions*	For each Metric	✓		Denominator*	Repeat per Metric	✓		NumeratorByAdminDenom	For each Metric			CYAR	(Percent)			MinReqSampleSize	Repeat per Metric			OversampleRate	Repeat per Metric			OversampleRecordsNumber	(Count)			ExclusionValidDataErrors	Repeat per Metric			ExclusionEmployeeOrDep	Repeat per Metric			OversampleRecsAdded	Repeat per Metric			NumeratorByAdmin	For each Metric	✓		NumeratorByMedicalRecords	For each Metric			Rate	(Percent)	✓	Metric	TimelinessPrenatalCare	PostpartumCare	Race	Data Element	Reporting Instructions	A	AmericanIndianOrAlaskaNative	CollectionMethod	For each Metric, repeat per Stratification	✓	Asian	Denominator*	For each Stratification, repeat per Metric	✓	BlackOrAfricanAmerican	Numerator	For each Metric and Stratification	✓	MiddleEasternOrNorthAfrican	Rate	(Percent)	✓	NativeHawaiianOrPacificIslander				White				SomeOtherRace			
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Race	Data Element	Reporting Instructions	A
TwoOrMoreRaces			
AskedButNoAnswer			
Unknown			

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

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

\*Repeat the InitialPopulation, Exclusions and Denominator values for metrics using the Administrative Method.

### Rules for Allowable Adjustments

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

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

**The Rules do not apply to the hybrid portion of the measure; only the administrative sections may be changed.**

#### ADJUSTMENTS ALLOWED

- **Product lines.** Organizations are not required to use product line criteria; product lines may be combined, and all (or no) product line criteria may be used.
- **Ages.** There are no ages specified for this measure.
- **Attribution.** Organizations are not required to use enrollment criteria.
- **Benefits.** Organizations are not required to use a benefit.
- **Other.** Organizations may use additional initial population criteria to focus on an area of interest defined by gender, race, ethnicity, socioeconomic or sociodemographic characteristics, geographic region or another characteristic.
- **Measurement period adjustments.** Organizations may adjust the measurement period.

- *Stratifications:* Race and ethnicity stratification. The race and ethnicity stratification is not required. Organizations may adjust this stratification as needed.
- *Exclusions.* The hospice and deceased person exclusions are not required.
- *Telehealth.* Services/events that allow the use of synchronous telehealth visits, telephone visits and asynchronous telehealth (e-visits, virtual check-ins) may be stratified to identify services performed via telehealth. This adjustment is not allowed for events, numerators and exclusions that do not allow the use of telehealth.
- *Supplemental data.* Supplemental data may be used to identify initial population, denominator, exclusion and numerator events.

#### **ADJUSTMENTS ALLOWED WITH LIMITS**

- *Initial population:* Event. Organizations may not change the logic, but may change the delivery date and account for the impact on other date-dependent events. Organizations may assess at the person level (vs. discharge level) by applying measure logic appropriately (i.e., percentage of persons with deliveries). Only events that contain (or map to) codes in the value sets may be used to identify visits. The value sets and logic may not be changed.
- *Numerator:* Timeliness of prenatal care. Organizations may remove the continuous enrollment criteria in steps 1 and 2 and assess for a prenatal care visit that occurs any time during the pregnancy. Value sets may not be changed. If the delivery-date range is changed, all numerator events must be measured in relation to the new range.

**Note:** Use caution when making adjustments to the timeliness of the prenatal visit. Assessing for visits outside of the first trimester should be used to assess gaps in care for the patient.

#### **ADJUSTMENTS NOT ALLOWED**

- *Numerator:* Postpartum care. Value sets and logic may not be changed. If the delivery-date range is changed, all numerator events must be measured in relation to the new range.

## ***Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)***

Measure title	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics*	Measure ID	APP
<b>Description</b>	The percentage of persons 1–17 years of age who had a new prescription for an antipsychotic medication and had documentation of psychosocial care as first-line treatment.		
<b>Measurement period</b>	January 1–December 31.		
<b>Copyright and disclaimer notice</b>	<p>*Developed with financial support from the Agency for Healthcare Research and Quality (AHRQ) and CMS under the CHIPRA Pediatric Quality Measures Program Centers of Excellence grant number U18HS020503, from a measure developed by MedNet Medical Solutions.</p> <p>Refer to the complete copyright and disclaimer information at the front of this publication.</p> <p>NCQA website: <a href="http://www.ncqa.org">www.ncqa.org</a>.</p> <p>Submit policy clarification support questions via My NCQA (<a href="https://my.ncqa.org">https://my.ncqa.org</a>).</p>		
<b>Clinical recommendation statement/ rationale</b>	<p>Antipsychotic medications are associated with a number of potential adverse impacts, including weight gain and diabetes, which can have serious implications for future health outcomes. Children without primary indication for an antipsychotic, and who are not given the benefit of a trial of psychosocial treatment first, may unnecessarily incur the risks associated with antipsychotic medications. To the extent that psychosocial interventions are associated with better outcomes, underuse of these therapies may lead to poorer mental and physical health outcomes.</p> <p>Guidelines recommend that psychosocial treatments be provided prior to initiating an antipsychotic. Treatment guidelines for management of aggression and disruptive behavior disorders all endorse psychosocial interventions as first-line treatment.</p>		
<b>Citations</b>	<p>Bobo, W.V., W.O. Cooper, C.M. Stein, et al. October 1, 2013. "Antipsychotics and the Risk of Type 2 Diabetes Mellitus in Children and Youth." <i>JAMA Psychiatry</i> 70(10):1067–75.</p> <p>Correll, C.U. 2008. "Antipsychotic Use in Children and Adolescents: Minimizing Adverse Effects to Maximize Outcomes." <i>FOCUS: The Journal of Lifelong Learning in Psychiatry</i> 6(3):368–78.</p> <p>Substance Abuse and Mental Health Services Administration. May 3, 2007. <i>The NSDUH Report: Depression and the Initiation of Alcohol and Other Drug Use Among Youths Aged 12 to 17</i>. Rockville, MD.</p> <p>Eyberg, S.M., M.M. Nelson, S.R. Boggs. January 2008. "Evidence-Based Psychosocial Treatments for Children and Adolescents with Disruptive Behavior." <i>Journal of Clinical Child and Adolescent Psychology</i> 37(1):215–37.</p>		

Characteristics	
<b>Scoring</b>	Proportion.
<b>Type</b>	Process.
<b>Product lines</b>	<ul style="list-style-type: none"> <li>• Commercial.</li> <li>• Medicaid.</li> </ul>
<b>Stratifications</b>	<p>Age as of the last day of the measurement period.</p> <ul style="list-style-type: none"> <li>• 1–11 years.</li> <li>• 12–17 years.</li> </ul>
<b>Risk adjustment</b>	None.
<b>Improvement notation</b>	Increased score indicates improvement.
<b>Guidance</b>	<p><b>Data collection methodology:</b> Administrative. Refer to <a href="#">General Guideline: Data Collection Methods</a> for additional information.</p> <p><b>Date specificity:</b> Dates must be specific enough to determine the event occurred in the period being measured.</p> <p><b>Which services count?</b> When using claims, include all paid, suspended, pending and denied claims.</p>
Definitions	
<b>Intake period</b>	January 1 through December 1 of the measurement period.
<b>IPSD</b>	Index prescription start date. The earliest prescription dispensing date for an antipsychotic medication where the date is in the intake period and there is a negative medication history.
<b>Negative medication history</b>	A period of 120 days prior to the IPSD when the person had no antipsychotic medications dispensed for either new or refill prescriptions.
<b>Initial population</b>	<p><b>Measure item count:</b> Person.</p> <p><b>Attribution basis:</b> Enrollment.</p> <ul style="list-style-type: none"> <li>• <b>Benefits:</b> Medical, mental health, pharmacy.</li> <li>• <b>Continuous enrollment:</b> 120 days prior to the IPSD through 30 days after the IPSD.</li> <li>• <b>Allowable gap:</b> None.</li> </ul> <p><b>Ages:</b> 1–17 years of age as of the last day of the measurement period.</p> <p><b>Event:</b> Persons with a new prescription for antipsychotics.</p> <p><b>Step 1.</b> Identify all persons who were dispensed an antipsychotic medication (<a href="#">Antipsychotic Medications List</a>, <a href="#">Antipsychotic Combination Medications List</a>) during the intake period.</p>

	<p><b>Step 2.</b> Test for negative medication history. For each person identified in step 1, identify the PSD and test each antipsychotic prescription for negative medication history.</p> <p><b>Step 3.</b> Calculate continuous enrollment.</p>																												
<b>Denominator exclusions</b>	<p><b>Persons with a date of death.</b> Death in the measurement period, identified using data sources determined by the organization. Method and data sources are subject to review during the HEDIS audit.</p> <p><b>Persons in hospice or using hospice services.</b> Persons who use hospice services (<u>Hospice Encounter Value Set</u>; <u>Hospice Intervention Value Set</u>) or elect to use a hospice benefit any time during the measurement period. Organizations that use the Monthly Membership Detail Data File to identify these persons must use only the run date of the file.</p> <p><b>Persons for whom first-line antipsychotic medications may be clinically appropriate.</b> Persons with a diagnosis of schizophrenia, schizoaffective disorder, bipolar disorder, other psychotic disorder, autism or other developmental disorder (<u>Schizophrenia Value Set*</u>, <u>Bipolar Disorder Value Set*</u>, <u>Other Psychotic and Developmental Disorders Value Set*</u>) on at least two different dates of service during the measurement period.</p> <p><b>Coding Guidance</b> *Do not include laboratory claims (claims with POS code 81).</p>																												
<b>Denominator</b>	The initial population minus denominator exclusions.																												
<b>Numerator</b>	<p><b>Persons who received psychosocial care or residential behavioral health treatment.</b> Persons who received psychosocial care (<u>Psychosocial Care Value Set</u>) or residential behavioral health treatment (<u>Residential Behavioral Health Treatment Value Set</u>) in the 121-day period from 90 days prior to the PSD through 30 days after the PSD.</p>																												
<b>Summary of changes</b>	<ul style="list-style-type: none"> <li>No changes to this measure.</li> </ul>																												
<b>Data element tables</b>	<p>Organizations that submit HEDIS data to NCQA must provide the following data elements.</p> <p><b>Table APP-1/2: Data Elements Access to Psychosocial Care for Children and Adolescents on Antipsychotics</b></p> <table border="1"> <thead> <tr> <th>Metric</th> <th>Age</th> <th>Data Element</th> <th>Reporting Instructions</th> </tr> </thead> <tbody> <tr> <td>PsychosocialCareAntipsychotics</td> <td>1-11</td> <td>Benefit</td> <td>Metadata</td> </tr> <tr> <td></td> <td>12-17</td> <td>InitialPopulation</td> <td>For each Stratification</td> </tr> <tr> <td></td> <td>Total</td> <td>Exclusions</td> <td>For each Stratification</td> </tr> <tr> <td></td> <td></td> <td>Denominator</td> <td>For each Stratification</td> </tr> <tr> <td></td> <td></td> <td>NumeratorByAdmin</td> <td>For each Stratification</td> </tr> <tr> <td></td> <td></td> <td>Rate</td> <td>(Percent)</td> </tr> </tbody> </table>	Metric	Age	Data Element	Reporting Instructions	PsychosocialCareAntipsychotics	1-11	Benefit	Metadata		12-17	InitialPopulation	For each Stratification		Total	Exclusions	For each Stratification			Denominator	For each Stratification			NumeratorByAdmin	For each Stratification			Rate	(Percent)
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<b>Rules for Allowable Adjustments</b>	<p><b>Copyright and use:</b> The “Rules for Allowable Adjustments of HEDIS” (the “Rules”) describe how NCQA’s HEDIS measure specifications can be adjusted for other populations, if applicable. The Rules, reviewed and approved by NCQA measure experts, provide for expanded use of HEDIS measures without changing their clinical intent.</p> <p><b>Adjusted HEDIS measures may not be used for HEDIS health plan reporting.</b></p> <p><b>ADJUSTMENTS ALLOWED</b></p> <ul style="list-style-type: none"> <li>• <i>Product lines.</i> Organizations are not required to use product line criteria; product lines may be combined, and all (or no) product line criteria may be used.</li> <li>• <i>Ages.</i> The age determination dates may be changed (e.g., select, “age as of June 30”). Changing the denominator age range is allowed.</li> <li>• <i>Attribution.</i> Organizations are not required to use enrollment criteria.</li> <li>• <i>Benefits.</i> Organizations are not required to use a benefit.</li> <li>• <i>Other.</i> Organizations may use additional initial population criteria to focus on an area of interest defined by gender, race, ethnicity, socioeconomic or sociodemographic characteristics, geographic region or another characteristic.</li> <li>• <i>Measurement period adjustments.</i> Organizations may adjust the measurement period.</li> <li>• <i>Exclusions.</i> Hospice and deceased persons exclusions are not required.</li> <li>• <i>Telehealth.</i> Services/events that allow the use of synchronous telehealth visits, telephone visits and asynchronous telehealth (e-visits, virtual check-ins) may be stratified to identify services performed via telehealth. This adjustment is not allowed for events/diagnoses, numerators and exclusions that do not allow the use of telehealth.</li> <li>• <i>Supplemental data.</i> Supplemental data may be used to identify initial population, denominator, exclusion and numerator events.</li> </ul> <p><b>ADJUSTMENTS NOT ALLOWED</b></p> <ul style="list-style-type: none"> <li>• <i>Initial population:</i> Event. Medication lists, value sets and logic may not be changed.</li> <li>• <i>Exclusions.</i> The persons for whom first-line antipsychotic medications may be clinically appropriate exclusions must be applied. Value sets and logic may not be changed.</li> <li>• <i>Numerator.</i> Value sets and logic may not be changed.</li> </ul>
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# **Experience of Care Measures**

## CAHPS Health Plan Survey 5.1H, Adult Version (CPA)

This measure is collected using survey methodology. Refer to *HEDIS Volume 3: Specifications for Survey Measures* for the measure specifications and data collection protocols.

### Description

This measure provides information on the experiences of commercial and Medicaid members with the organization and gives a general indication of how well the organization meets members' expectations. Results summarize member experiences through ratings, composites and question summary rates.

Four global rating questions reflect overall satisfaction:

1. Rating of All Health Care.
2. Rating of Health Plan.
3. Rating of Personal Doctor.
4. Rating of Specialist Seen Most Often.

Five composite scores summarize responses in key areas:

1. Claims Processing (commercial only).
2. Customer Service.
3. Getting Care Quickly.
4. Getting Needed Care.
5. How Well Doctors Communicate.

Item-specific question summary rates are reported for the rating questions and each composite question. Question Summary Rates are also reported individually for one item summarizing the following concept:

1. Coordination of Care.

**Note:** Medicare member experience with the organization is assessed through the Medicare CAHPS survey. Medicare CAHPS is not a HEDIS measure, Medicare CAHPS is maintained and administered by the Centers for Medicare & Medicaid Services (CMS) on behalf of Medicare Advantage (MA) plans.

## CAHPS Health Plan Survey 5.1H, Child Version (CPC)

This measure is collected using survey methodology. Refer to *HEDIS Volume 3: Specifications for Survey Measures* for the measure specifications and data collection protocols.

### Description

This measure provides information on parents' experience with their child's Medicaid organization. Results summarize member experiences through ratings, composites and individual question summary rates.

Four global rating questions reflect overall satisfaction:

1. Rating of All Health Care.
2. Rating of Health Plan.
3. Rating of Personal Doctor.
4. Rating of Specialist Seen Most Often.

Four composite scores summarize responses in key areas:

1. Customer Service.
2. Getting Care Quickly.
3. Getting Needed Care.
4. How Well Doctors Communicate.

Item-specific question summary rates are reported for the rating questions and each composite question. Question Summary Rates are also reported individually for one item summarizing the following concept:

1. Coordination of Care.

## **Children With Chronic Conditions (CCC)**

This measure is collected using survey methodology. Refer to *HEDIS Volume 3: Specifications for Survey Measures* for the measure specifications and data collection protocols.

### **Description**

This measure provides information on parents' experience with their child's Medicaid organization for the population of children with chronic conditions. Three composites summarize satisfaction with basic components of care essential for successful treatment, management and support of children with chronic conditions:

1. Access to Specialized Services.
2. Family Centered Care: Personal Doctor Who Knows Child.
3. Coordination of Care for Children With Chronic Conditions.

Item-specific question summary rates are reported for each composite question. Question summary rates are also reported individually for two items summarizing the following concepts:

1. Access to Prescription Medicines.
2. Family Centered Care: Getting Needed Information.

# **Utilization Measures**

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

Measure title	Well-Child Visits in the First 30 Months of Life	Measure ID	W30
<b>Description</b>	<p>The percentage of persons who had the following number of well-child visits with a PCP during the last 15 months. The following rates are reported:</p> <ol style="list-style-type: none"> <li>1. <i>Well-Child Visits in the First 15 Months.</i> Persons who turned 15 months old during the measurement period: Six or more well-child visits.</li> <li>2. <i>Well-Child Visits for Age 15 Months–30 Months.</i> Persons who turned 30 months old during the measurement period: Two or more well-child visits.</li> </ol>		
<b>Measurement period</b>	January 1–December 31.		
<b>Copyright and disclaimer notice</b>	<p>Refer to the complete copyright and disclaimer information at the front of this publication.  NCQA website: <a href="http://www.ncqa.org">www.ncqa.org</a>.  Submit policy clarification support questions via My NCQA (<a href="https://my.ncqa.org">https://my.ncqa.org</a>).</p>		
<b>Clinical recommendation statement/rationale</b>	<p>This measure is based on the American Academy of Pediatrics Bright Futures guidelines for Health Supervision of Infants, Children and Adolescents. In addition to the Bright Futures Guidelines, the AAP publishes a recommended schedule of screenings and assessments, known as the periodicity schedule, that outlines what to do at every visit, from infancy to adolescence. Bright Futures recommends more frequent well-child visits in the first years of life and one or more annual well-child visits from age 3–21. They recommend that the well-child visits include, but are not limited to, an initial/interval medical history, physical exam, developmental assessment, immunization and anticipatory guidance.</p> <p>The AAP/Bright Futures guidelines also recommend two or more visits between 15 months and 30 months, an important period for early assessment and screenings. Early identification of developmental disorders is critical to the well-being of children and their families. It is an integral function of the primary care medical home and an appropriate responsibility of all pediatric health care professionals. Research shows that early intervention treatment services can greatly improve a child's development. Early intervention services help children from birth through 3 years of age (36 months) learn important skills.</p>		
<b>Citations</b>	<p>Hagan, J.F., J.S. Shaw, and P.M. Duncan, eds. 2017. <i>Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents</i>. Fourth edition. Elk Grove Village, IL: Bright Futures/American Academy of Pediatrics.</p> <p>Bright Futures &amp; American Academy of Pediatrics. 2025. <i>Periodicity Schedule—Recommendations for Preventive Pediatric Health Care</i>. <a href="https://downloads.aap.org/AAP/PDF/periodicity_schedule.pdf">https://downloads.aap.org/AAP/PDF/periodicity_schedule.pdf</a></p>		

Characteristics	
<b>Scoring</b>	Proportion.
<b>Type</b>	Process.
<b>Product lines</b>	<ul style="list-style-type: none"> <li>• Commercial.</li> <li>• Medicaid.</li> </ul>
<b>Stratifications</b>	<p>Race. (Refer to <a href="#">General Guideline: Race and Ethnicity Stratification</a>.)</p> <ul style="list-style-type: none"> <li>• American Indian or Alaska Native.</li> <li>• Asian.</li> <li>• Black or African American.</li> <li>• Middle Eastern or North African.</li> <li>• Native Hawaiian or Pacific Islander.</li> <li>• White.</li> <li>• Some Other Race.</li> <li>• Two or More Races.</li> <li>• Asked But No Answer.</li> <li>• Unknown.</li> </ul> <p>Ethnicity. (Refer to <a href="#">General Guideline: Race and Ethnicity Stratification</a>.)</p> <ul style="list-style-type: none"> <li>• Hispanic or Latino.</li> <li>• Not Hispanic or Latino.</li> <li>• Asked But No Answer.</li> <li>• Unknown.</li> </ul>
<b>Risk adjustment</b>	None.
<b>Improvement notation</b>	Increased score indicates improvement.
<b>Guidance</b>	<p><b>Data collection methodology:</b> Administrative. Refer to <a href="#">General Guideline: Data Collection Methods</a> for additional information.</p> <p><b>Date specificity:</b> Dates must be specific enough to determine the event occurred in the period being measured.</p> <p><b>Which services count?</b> When using claims, include all paid, suspended, pending and denied claims.</p> <p><b>Other guidance:</b></p> <ul style="list-style-type: none"> <li>• Refer to <a href="#">Appendix 1</a> for the definition of PCP.</li> <li>• The well-child visit must occur with a PCP, but the PCP does not have to be the practitioner assigned to the child.</li> </ul>

<b>Initial population</b>	<p><b>Measure item count:</b> Person.</p> <p><b>Attribution basis:</b> Enrollment.</p> <ul style="list-style-type: none"> <li>• <b>Benefits:</b> Medical.</li> <li>• <b>Continuous enrollment:</b> <ul style="list-style-type: none"> <li>– <i>Initial population 1:</i> 31 days through 15 months of age. Calculate 31 days of age by adding 31 days to the date of birth.</li> <li>– <i>Initial population 2:</i> 15 months plus 1 day through 30 months of age. Calculate the 15-month birthday plus 1 day as the first birthday plus 91 days.</li> </ul> </li> <li>• <b>Allowable gap:</b> <ul style="list-style-type: none"> <li>– <i>Initial population 1:</i> No more than one gap of ≤45 days during the continuous enrollment period. No gaps on the 15-month birthday.</li> <li>– <i>Initial population 2:</i> No more than one gap of ≤45 days during the continuous enrollment period. No gaps on the 30-month birthday.</li> </ul> </li> </ul> <p><b>Ages:</b></p> <ul style="list-style-type: none"> <li>• <i>Initial population 1:</i> Persons who turn 15 months old during the measurement period. Calculate the 15-month birthday as the first birthday plus 90 days.</li> <li>• <i>Initial population 2:</i> Persons who turn 30 months old during the measurement period. Calculate the 30-month birthday as the second birthday plus 180 days.</li> </ul> <p><b>Event:</b> None.</p>
<b>Denominator exclusions</b>	<p><b>Persons with a date of death.</b> Death in the measurement period, identified using data sources determined by the organization. Method and data sources are subject to review during the HEDIS audit.</p> <p><b>Persons in hospice or using hospice services.</b> Persons who use hospice services (<u>Hospice Encounter Value Set</u>; <u>Hospice Intervention Value Set</u>) or elect to use a hospice benefit any time during the measurement period. Organizations that use the Monthly Membership Detail Data File to identify these persons must use only the run date of the file.</p>
<b>Denominator</b>	<p><b>Denominator 1: Well-child visits in the first 15 months.</b> The initial population 1 minus denominator exclusions.</p> <p><b>Denominator 2: Well-child visits for 15 months–30 months of age.</b> The initial population 2 minus denominator exclusions.</p>
<b>Numerator</b>	<p><b>Numerator 1: Well-child visits in the first 15 months.</b> Persons with six or more well-child visits on different dates of service with a PCP on or before the 15-month birthday. Either of the following meet criteria:</p> <ul style="list-style-type: none"> <li>• A well-care visit (<u>Well Care Visit Value Set</u>).</li> <li>• An encounter for well-care (<u>Encounter for Well Care Value Set*</u>).</li> </ul> <p>Do not include telehealth visits (visits billed with a code that indicates telehealth: <u>Telehealth POS Value Set</u>; <u>Online Assessments Value Set</u>; <u>Telephone Visits Value Set</u>).</p>

	<p><b>Numerator 2: Well-child visits for age 15 months–30 months</b></p> <p>Two or more well-child visits on different dates of service with a PCP between the child's 15-month birthday plus 1 day and the 30-month birthday. Either of the following meets criteria:</p> <ul style="list-style-type: none"> <li>• A well-care visit (<a href="#">Well Care Visit Value Set</a>).</li> <li>• An encounter for well-care (<a href="#">Encounter for Well Care Value Set*</a>).</li> </ul> <p>Do not include telehealth visits (visits billed with a code that indicates telehealth: <a href="#">Telehealth POS Value Set</a>; <a href="#">Online Assessments Value Set</a>; <a href="#">Telephone Visits Value Set</a>).</p> <p><b>Coding Guidance</b></p> <p>*Do not include laboratory claims (claims with POS code 81).</p>																																																																	
<b>Summary of changes</b>	<ul style="list-style-type: none"> <li>• Updated the race and ethnicity stratification categories to align with OMB SPD 15 2024.</li> <li>• Added instructions on allowable adjustments to the race and ethnicity stratifications.</li> </ul>																																																																	
<b>Data element tables</b>	<p>Organizations that submit HEDIS data to NCQA must provide the following data elements.</p> <p><b>Table W30-A-1/2: Data Elements for Well-Child Visits in the First 30 Months of Life</b></p> <table border="1"> <thead> <tr> <th>Metric</th> <th>Data Element</th> <th>Reporting Instructions</th> </tr> </thead> <tbody> <tr> <td>Age15Months</td> <td>InitialPopulation</td> <td>For each Metric</td> </tr> <tr> <td>Age15To30Months</td> <td>Exclusions</td> <td>For each Metric</td> </tr> <tr> <td></td> <td>Denominator</td> <td>For each Metric</td> </tr> <tr> <td></td> <td>NumeratorByAdmin</td> <td>For each Metric</td> </tr> <tr> <td></td> <td>NumeratorBySupplemental</td> <td>For each Metric</td> </tr> <tr> <td></td> <td>Rate</td> <td>(Percent)</td> </tr> </tbody> </table> <p><b>Table W30-B-1/2: Data Elements for Well-Child Visits in the First 30 Months of Life: Stratifications by Race</b></p> <table border="1"> <thead> <tr> <th>Metric</th> <th>Race</th> <th>Data Element</th> <th>Reporting Instructions</th> </tr> </thead> <tbody> <tr> <td>Age15Months</td> <td>AmericanIndianOrAlaskaNative</td> <td>Denominator</td> <td>For each Metric and Stratification</td> </tr> <tr> <td>Age15To30Months</td> <td>Asian</td> <td>Numerator</td> <td>For each Metric and Stratification</td> </tr> <tr> <td></td> <td>BlackOrAfricanAmerican</td> <td>Rate</td> <td>(Percent)</td> </tr> <tr> <td></td> <td>MiddleEasternOrNorthAfrican</td> <td></td> <td></td> </tr> <tr> <td></td> <td>NativeHawaiianOrPacificIslander</td> <td></td> <td></td> </tr> <tr> <td></td> <td>White</td> <td></td> <td></td> </tr> <tr> <td></td> <td>SomeOtherRace</td> <td></td> <td></td> </tr> <tr> <td></td> <td>TwoOrMoreRaces</td> <td></td> <td></td> </tr> <tr> <td></td> <td>AskedButNoAnswer</td> <td></td> <td></td> </tr> <tr> <td></td> <td>Unknown</td> <td></td> <td></td> </tr> </tbody> </table>	Metric	Data Element	Reporting Instructions	Age15Months	InitialPopulation	For each Metric	Age15To30Months	Exclusions	For each Metric		Denominator	For each Metric		NumeratorByAdmin	For each Metric		NumeratorBySupplemental	For each Metric		Rate	(Percent)	Metric	Race	Data Element	Reporting Instructions	Age15Months	AmericanIndianOrAlaskaNative	Denominator	For each Metric and Stratification	Age15To30Months	Asian	Numerator	For each Metric and Stratification		BlackOrAfricanAmerican	Rate	(Percent)		MiddleEasternOrNorthAfrican				NativeHawaiianOrPacificIslander				White				SomeOtherRace				TwoOrMoreRaces				AskedButNoAnswer				Unknown		
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Metric	Race	Data Element	Reporting Instructions																																																															
Age15Months	AmericanIndianOrAlaskaNative	Denominator	For each Metric and Stratification																																																															
Age15To30Months	Asian	Numerator	For each Metric and Stratification																																																															
	BlackOrAfricanAmerican	Rate	(Percent)																																																															
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	Unknown																																																																	

<b>Table W30-C-1/2: Data Elements for Well-Child Visits in the First 30 Months of Life: Stratifications by Ethnicity</b>			
Metric	Ethnicity	Data Element	Reporting Instructions
Age15Months	HispanicOrLatino	Denominator	For each Metric and Stratification
Age15To30Months	NotHispanicOrLatino	Numerator	For each Metric and Stratification
	AskedButNoAnswer	Rate	(Percent)
	Unknown		

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| **Rules for Allowable Adjustments** | **Copyright and use:** The “Rules for Allowable Adjustments of HEDIS” (the “Rules”) describe how NCQA’s HEDIS measure specifications can be adjusted for other populations, if applicable. The Rules, reviewed and approved by NCQA measure experts, provide for expanded use of HEDIS measures without changing their clinical intent.  **Adjusted HEDIS measures may not be used for HEDIS health plan reporting.**  **ADJUSTMENTS ALLOWED**   - *Product lines.* Organizations are not required to use product line criteria; product lines may be combined, and all (or no) product line criteria may be used. - *Attribution.* Organizations are not required to use enrollment criteria. - *Benefits.* Organizations are not required to use a benefit. - *Other.* Organizations may use additional initial population criteria to focus on an area of interest defined by gender, race, ethnicity, socio-economic or sociodemographic characteristics, geographic region or another characteristic. - *Measurement period adjustments.* Organizations may adjust the measurement period. - *Stratifications:* Race and ethnicity stratification. The race and ethnicity stratification is not required. Organizations may adjust this stratification as needed. - *Exclusions.* The hospice and deceased person exclusions are not required. - *Supplemental data.* Supplemental data may be used to identify initial population, denominator, exclusion and numerator events.   **ADJUSTMENTS ALLOWED WITH LIMITS**   - *Ages.* The age determination dates may be changed (e.g., select, “age 15 months as of June 30”). The denominator age may not be expanded. - *Stratifications.* Organizations may stratify the count of visits for the numerator of both rates. Value sets and logic may not be changed.   **ADJUSTMENTS NOT ALLOWED**   - *Numerator.* Value sets and logic may not be changed. - *Telehealth.* Organizations may not include telehealth services for this measure. |

## ***Child and Adolescent Well-Care Visits (WCV)***

<b>Measure title</b>	Child and Adolescent Well-Care Visits	<b>Measure ID</b>	WCV
<b>Description</b>	The percentage of persons 3–21 years of age who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement period.		
<b>Measurement period</b>	January 1–December 31.		
<b>Copyright and disclaimer notice</b>	Refer to the complete copyright and disclaimer information at the front of this publication. NCQA website: <a href="http://www.ncqa.org">www.ncqa.org</a> . Submit policy clarification support questions via My NCQA ( <a href="https://my.ncqa.org">https://my.ncqa.org</a> ).		
<b>Clinical recommendation statement/ rationale</b>	This measure is based on the American Academy of Pediatrics Bright Futures guidelines for Health Supervision of Infants, Children and Adolescents. Bright Futures recommends one or more well care visits from age 3–21.		
<b>Citations</b>	Bright Futures & American Academy of Pediatrics. “Periodicity Schedule — Recommendations for Preventive Pediatric Health Care.” 2025. <a href="https://downloads.aap.org/AAP/PDF/periodicity_schedule.pdf">https://downloads.aap.org/AAP/PDF/periodicity_schedule.pdf</a>		
<b>Characteristics</b>			
<b>Scoring</b>	Proportion.		
<b>Type</b>	Process.		
<b>Product lines</b>	<ul style="list-style-type: none"> <li>• Commercial.</li> <li>• Medicaid.</li> </ul>		
<b>Stratifications</b>	<p>Age as of the last day of the measurement period.</p> <ul style="list-style-type: none"> <li>• 3–11 years.</li> <li>• 12–17 years.</li> <li>• 18–21 years.</li> </ul> <p>Race. (Refer to <a href="#">General Guideline: Race and Ethnicity Stratification</a>.)</p> <ul style="list-style-type: none"> <li>• American Indian or Alaska Native.</li> <li>• Asian.</li> <li>• Black or African American.</li> <li>• Middle Eastern or North African.</li> <li>• Native Hawaiian or Pacific Islander.</li> <li>• White.</li> <li>• Some Other Race.</li> </ul>		

	<ul style="list-style-type: none"> <li>• Two or More Races.</li> <li>• Asked But No Answer.</li> <li>• Unknown.</li> </ul> <p>Ethnicity. (Refer to <a href="#">General Guideline: Race and Ethnicity Stratification</a>.)</p> <ul style="list-style-type: none"> <li>• Hispanic or Latino.</li> <li>• Not Hispanic or Latino.</li> <li>• Asked But No Answer.</li> <li>• Unknown.</li> </ul>
<b>Risk adjustment</b>	None.
<b>Improvement notation</b>	Increased score indicates improvement.
<b>Guidance</b>	<p><b>Data collection methodology:</b> Administrative. Refer to <a href="#">General Guideline: Data Collection Methods</a> for additional information.</p> <p><b>Date specificity:</b> Dates must be specific enough to determine the event occurred in the period being measured.</p> <p><b>Which services count?</b> When using claims, include all paid, suspended, pending and denied claims.</p> <p><b>Other guidance:</b></p> <ul style="list-style-type: none"> <li>• Refer to <a href="#">Appendix 1</a> for the definition of PCP and OB/GYN and other prenatal care practitioner.</li> <li>• The well-care visit must occur with a PCP or an OB/GYN practitioner, but the practitioner does not have to be the practitioner assigned to the child/adolescent.</li> </ul>

## Definitions

<b>Initial population</b>	<p><b>Measure item count:</b> Person.</p> <p><b>Attribution basis:</b> Enrollment.</p> <ul style="list-style-type: none"> <li>• <b>Benefits:</b> Medical.</li> <li>• <b>Continuous enrollment:</b> The measurement period.</li> <li>• <b>Allowable gap:</b> No more than one gap of ≤45 days during the measurement period. No gaps on the last day of the measurement period.</li> </ul> <p><b>Ages:</b> 3–21 years of age as of the last day of the measurement period.</p> <p><b>Event:</b> None.</p>
<b>Denominator exclusions</b>	<p><b>Persons with a date of death.</b></p> <p>Death in the measurement period, identified using data sources determined by the organization. Method and data sources are subject to review during the HEDIS audit.</p>

	<p><b>Persons in hospice or using hospice services.</b> Persons who use hospice services (<a href="#">Hospice Encounter Value Set</a>; <a href="#">Hospice Intervention Value Set</a>) or elect to use a hospice benefit any time during the measurement period. Organizations that use the Monthly Membership Detail Data File to identify these persons must use only the run date of the file.</p>																												
<b>Denominator</b>	The initial population minus denominator exclusions.																												
<b>Numerator</b>	<p><b>Persons who had one or more well-care visits during the measurement period with a PCP or OB/GYN practitioner.</b> Either of the following meet criteria:</p> <ul style="list-style-type: none"> <li>• A well-care visit (<a href="#">Well Care Visit Value Set</a>).</li> <li>• An encounter for well-care (<a href="#">Encounter for Well Care Value Set*</a>).</li> </ul> <p>Do not include telehealth visits (visits billed with a code that indicates telehealth: <a href="#">Telehealth POS Value Set</a>; <a href="#">Online Assessments Value Set</a>; <a href="#">Telephone Visits Value Set</a>).</p> <p><b>Coding Guidance</b> *Do not include laboratory claims (claims with POS code 81).</p>																												
<b>Summary of changes</b>	<ul style="list-style-type: none"> <li>• Updated the race and ethnicity stratification categories to align with OMB SPD 15 2024.</li> <li>• Added instructions on allowable adjustments to the race and ethnicity stratifications.</li> </ul>																												
<b>Data element tables</b>	<p>Organizations that submit HEDIS data to NCQA must provide the following data elements.</p> <p><b>Table WCV-A-1/2: Data Elements for Child and Adolescent Well-Care Visits</b></p> <table border="1"> <thead> <tr> <th>Metric</th> <th>Age</th> <th>Data Element</th> <th>Reporting Instructions</th> </tr> </thead> <tbody> <tr> <td>ChildAdolescentWellVisits</td> <td>3-11</td> <td>InitialPopulation</td> <td>For each Stratification</td> </tr> <tr> <td></td> <td>12-17</td> <td>Exclusions</td> <td>For each Stratification</td> </tr> <tr> <td></td> <td>18-21</td> <td>Denominator</td> <td>For each Stratification</td> </tr> <tr> <td></td> <td>Total</td> <td>NumeratorByAdmin</td> <td>For each Stratification</td> </tr> <tr> <td></td> <td></td> <td>NumeratorBySupplemental</td> <td>For each Stratification</td> </tr> <tr> <td></td> <td></td> <td>Rate</td> <td>(Percent)</td> </tr> </tbody> </table>	Metric	Age	Data Element	Reporting Instructions	ChildAdolescentWellVisits	3-11	InitialPopulation	For each Stratification		12-17	Exclusions	For each Stratification		18-21	Denominator	For each Stratification		Total	NumeratorByAdmin	For each Stratification			NumeratorBySupplemental	For each Stratification			Rate	(Percent)
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	Total	NumeratorByAdmin	For each Stratification																										
		NumeratorBySupplemental	For each Stratification																										
		Rate	(Percent)																										

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

Metric	Race	Data Element	Reporting Instructions
ChildAdolescentWellVisits	AmericanIndianOrAlaskaNative	Denominator	For each Stratification
	Asian	Numerator	For each Stratification
	BlackOrAfricanAmerican	Rate	(Percent)
	MiddleEasternOrNorthAfrican		
	NativeHawaiianOrPacificIslander		
	White		
	SomeOtherRace		
	TwoOrMoreRaces		
	AskedButNoAnswer		
	Unknown		

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

Metric	Ethnicity	Data Element	Reporting Instructions
ChildAdolescentWellVisits	HispanicOrLatino	Denominator	For each Stratification
	NotHispanicOrLatino	Numerator	For each Stratification
	AskedButNoAnswer	Rate	(Percent)
	Unknown		

#### Rules for Allowable Adjustments

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

#### ADJUSTMENTS ALLOWED

- **Product lines.** Organizations are not required to use product line criteria; product lines may be combined, and all (or no) product line criteria may be used.
- **Attribution.** Organizations are not required to use enrollment criteria.
- **Benefits.** Organizations are not required to use a benefit.

- *Other.* Organizations may use additional initial population criteria to focus on an area of interest defined by gender, race, ethnicity, socio-economic or sociodemographic characteristics, geographic region or another characteristic.
- *Measurement period adjustments.* Organizations may adjust the measurement period.
- *Stratifications:* Race and ethnicity stratification. The race and ethnicity stratification is not required. Organizations may adjust this stratification as needed.
- *Exclusions.* The hospice and deceased person exclusions are not required.
- *Supplemental data.* Supplemental data may be used to identify initial population, denominator, exclusion and numerator events.

**ADJUSTMENTS ALLOWED WITH LIMITS**

- *Ages.* The age determination dates may be changed (e.g., select, "age 15 months as of June 30"). The denominator age may be changed if the range is within the specified age range (3–21 years). Organizations must consult American Academy of Pediatrics guidelines when considering whether to expand the age ranges outside the current thresholds.

**ADJUSTMENTS NOT ALLOWED**

- *Numerator.* Value sets and logic may not be changed.
- *Telehealth.* Organizations may not include telehealth services for this measure.

## ***Antibiotic Utilization for Respiratory Conditions (AXR)***

<b>Measure title</b>	Antibiotic Utilization for Respiratory Conditions	<b>Measure ID</b>	AXR
<b>Description</b>	The percentage of episodes for persons 3 months of age and older with a diagnosis of a respiratory condition that resulted in an antibiotic dispensing event.		
<b>Measurement period</b>	January 1–December 31.		
<b>Copyright and disclaimer notice</b>	<p>Refer to the complete copyright and disclaimer information at the front of this publication.</p> <p>NCQA website: <a href="http://www.ncqa.org">www.ncqa.org</a>.</p> <p>Submit policy clarification support questions via My NCQA (<a href="https://my.ncqa.org">https://my.ncqa.org</a>).</p>		
<b>Clinical recommendation statement/ rationale</b>	<p>While antibiotic medications are indicated interventions for conditions caused by bacterial infections, recent studies demonstrate that approximately 30% of antibiotics prescribed in outpatient settings did not align with clinical guidelines. Non-indicated antibiotic use (i.e., for viral respiratory infections) can drive increases in prevalence of antibiotic-resistant bacteria, negative clinical outcomes and high health care costs. Monitoring antibiotic use for respiratory conditions might encourage prescribing practices that align with clinical guidelines for respiratory care.</p>		
<b>Citations</b>	<p><i>Antibiotic Use and Stewardship in the United States, 2024 Update: Progress and Opportunities.</i> Centers for Disease Control and Prevention. Updated November 20, 2024. Accessed April 7, 2025. <a href="https://www.cdc.gov/antibiotic-use/hcp/data-research/stewardship-report.html">https://www.cdc.gov/antibiotic-use/hcp/data-research/stewardship-report.html</a></p> <p>Sur, D.K.C., &amp; M.L. Plesa. 2022. “Antibiotic Use in Acute Upper Respiratory Tract Infections.” <i>Am Fam Physician</i> 106(6):628–36.</p>		
<b>Characteristics</b>			
<b>Scoring</b>	Proportion.		
<b>Type</b>	Process.		
<b>Product lines</b>	<ul style="list-style-type: none"> <li>• Commercial.</li> <li>• Medicaid.</li> <li>• Medicare.</li> </ul>		
<b>Stratifications</b>	<p>Age as of the episode date.</p> <ul style="list-style-type: none"> <li>• 3 months–17 years.</li> <li>• 18–64 years.</li> <li>• 65 years and older.</li> </ul>		
<b>Risk adjustment</b>	None.		

<b>Guidance</b>	<p><b>Data collection methodology:</b> Administrative. Refer to <a href="#">General Guideline: Data Collection Methods</a> for additional information.</p> <p><b>Date specificity:</b> Dates must be specific enough to determine the event occurred in the period being measured.</p> <p><b>Which services count?</b></p> <ul style="list-style-type: none"> <li>• Do not include denied claims when identifying initial population and numerator events; only include claims the organization paid for or expects to pay for (i.e., claims incurred but not paid).</li> <li>• Include all paid, suspended, pending and denied claims to identify the denominator exclusions.</li> <li>• If a person is enrolled retroactively, count all services for which the organization paid or expects to pay.</li> <li>• When confirming that an ED visit does not result in an inpatient stay, all inpatient stays must be considered, regardless of payment status (paid, suspended, pending, denied).           <ul style="list-style-type: none"> <li>– <i>For example</i>, if an ED visit is paid, but an inpatient stay is denied, the ED visit resulted in an inpatient stay and is not included in the measure.</li> </ul> </li> </ul> <p><b>Supplemental data exceptions:</b> Supplemental data for this measure may be used only for denominator exclusions.</p> <p><b>Improvement notation:</b> This measure is designed to capture the frequency of antibiotic utilization for respiratory conditions. Organizations should use this information for internal evaluation only. NCQA does not view higher or lower service counts as indicating better or worse performance.</p> <p><b>Other guidance:</b> The measure is based on episodes; therefore, it is possible for the denominator to include multiple events for the same person.</p>
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<b>Definitions</b>	
<b>Episode date</b>	The date of service for any outpatient, telephone or ED visit, e-visit or virtual check-in during the intake period with a diagnosis of a respiratory condition.
<b>Intake period</b>	July 1 of the year prior to the measurement period to June 30 of the measurement period. The intake period captures eligible episodes of treatment.
<b>Negative comorbid condition history</b>	A period of 365 days prior to and including the episode date when the person had no claims/encounters with any diagnosis for a comorbid condition (366 days total).
<b>Negative competing diagnosis</b>	The episode date and 3 days following the episode date when the person had no claims/encounters with a competing diagnosis.
<b>Negative medication history</b>	To qualify for negative medication history, the following criteria must be met: <ul style="list-style-type: none"> <li>• A period of 30 days prior to the episode date when the person had no pharmacy claims for either new or refill prescriptions for a listed antibiotic drug.</li> </ul>

	<ul style="list-style-type: none"> <li>• No prescriptions dispensed more than 30 days prior to the episode date that are active on the episode date.             <ul style="list-style-type: none"> <li>– A prescription is considered active if the “days supply” indicated on the date when the person was dispensed the prescription is the number of days or more between that date and the relevant service date. The 30-day look-back period for pharmacy data includes the 30 days prior to the intake period.</li> </ul> </li> </ul>
<b>Initial population</b>	<p><i>Measure item count:</i> Episode.</p> <p><i>Attribution basis:</i> Enrollment.</p> <ul style="list-style-type: none"> <li>• <b>Benefits:</b> Medical and pharmacy.</li> <li>• <b>Continuous enrollment:</b> 30 days prior to the episode date through 3 days after the episode date (34 total days).</li> <li>• <b>Allowable gap:</b> None.</li> </ul> <p><i>Ages:</i> At least 3 months of age as of the episode date.</p> <p><b>Event: Diagnosis of a respiratory condition.</b></p> <p><b>Step 1.</b> Identify all persons who had an outpatient, ED, telephone visit, e-visit or virtual check-in visit (<u>Outpatient, ED and Telehealth Value Set</u>) during the intake period with a diagnosis of a respiratory condition (<u>Respiratory Conditions and Symptoms Value Set</u>).</p> <p><b>Step 2.</b> For each person identified in step 1, determine all respiratory condition episode dates. Do not include visits that result in an inpatient stay (<u>Inpatient Stay Value Set</u>).</p> <p><b>Step 3.</b> Test for negative comorbid condition history. Remove episode dates where the person had a claim/encounter with any diagnosis for a comorbid condition (<u>Comorbid Conditions Value Set*</u>) during the 365 days prior to or on the episode date (366 days total).</p> <p><b>Step 4.</b> Test for negative medication history. Remove episode dates where a new or refill prescription for an antibiotic medication (<u>AXR Antibiotic Medications List</u>) was dispensed 30 days prior to the episode date or was active on the episode date.</p> <p><b>Step 5.</b> Test for negative competing diagnoses. Remove episode dates where the person had a claim/encounter with a competing diagnosis (<u>AXR Competing Diagnosis Value Set*</u>) on or 3 days after the episode date.</p> <p><b>Step 6.</b> Calculate continuous enrollment.</p> <p><b>Step 7.</b> Deduplicate eligible episodes. Identify visits chronologically, including only one per 31-day period. If a person has more than one eligible episode in a 31-day period, include only the first eligible episode.</p> <ul style="list-style-type: none"> <li>• <i>For example</i>, if a person has an eligible episode on January 1, include the January 1 visit and do not include eligible episodes that occur on or between January 2 and January 31. Then, if applicable, include the next eligible episode that occurs on or after February 1.</li> </ul> <p><b>Coding Guidance</b></p> <p>*Do not include laboratory claims (claims with POS code 81).</p>

<b>Denominator exclusions</b>	<p><b>Persons with a date of death.</b> Death in the measurement period, identified using data sources determined by the organization. Method and data sources are subject to review during the HEDIS audit.</p> <p><b>Persons in hospice or using hospice services.</b> Persons who use hospice services (<u>Hospice Encounter Value Set</u>; <u>Hospice Intervention Value Set</u>) or elect to use a hospice benefit any time during the measurement period. Organizations that use the Monthly Membership Detail Data File to identify these persons must use only the run date of the file.</p>																												
<b>Denominator</b>	The initial population minus denominator exclusions.																												
<b>Numerator</b>	<p><b>Antibiotic medication prescription.</b> Dispensed a prescription for an antibiotic medication (<u>AXR Antibiotic Medications List</u>) on or 3 days after the episode date.</p>																												
<b>Summary of changes</b>	<ul style="list-style-type: none"> <li>Added a death exclusion to the <i>Denominator exclusions</i> section.</li> </ul>																												
<b>Data element tables</b>	<p>Organizations that submit HEDIS data to NCQA must provide the following data elements.</p> <p><b>Table AXR-1/2/3: Data Elements for Antibiotic Utilization</b></p> <table border="1"> <thead> <tr> <th>Metric</th> <th>Age</th> <th>Data Element</th> <th>Reporting Instructions</th> </tr> </thead> <tbody> <tr> <td>AntibioticUtilizationRespiratoryConditions</td> <td>3m-17</td> <td>Benefit</td> <td>Metadata</td> </tr> <tr> <td></td> <td>18-64</td> <td>InitialPopulation</td> <td>For each Stratification</td> </tr> <tr> <td></td> <td>65+</td> <td>Exclusions</td> <td>For each Stratification</td> </tr> <tr> <td></td> <td>Total</td> <td>Denominator</td> <td>For each Stratification</td> </tr> <tr> <td></td> <td></td> <td>NumeratorByAdmin</td> <td>For each Stratification</td> </tr> <tr> <td></td> <td></td> <td>Rate</td> <td>(Percent)</td> </tr> </tbody> </table>	Metric	Age	Data Element	Reporting Instructions	AntibioticUtilizationRespiratoryConditions	3m-17	Benefit	Metadata		18-64	InitialPopulation	For each Stratification		65+	Exclusions	For each Stratification		Total	Denominator	For each Stratification			NumeratorByAdmin	For each Stratification			Rate	(Percent)
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<b>Rules for Allowable Adjustments</b>	<p><b>Copyright and use:</b> The “Rules for Allowable Adjustments of HEDIS” (the “Rules”) describe how NCQA’s HEDIS measure specifications can be adjusted for other populations, if applicable. The Rules, reviewed and approved by NCQA measure experts, provide for expanded use of HEDIS measures without changing their clinical intent.</p> <p><b>Adjusted HEDIS measures may not be used for HEDIS health plan reporting.</b></p> <p><b>ADJUSTMENTS ALLOWED</b></p> <ul style="list-style-type: none"> <li><i>Product lines.</i> Organizations are not required to use product line criteria; product lines may be combined, and all (or no) product line criteria may be used.</li> </ul>																												

- *Attribution.* Organizations are not required to use enrollment criteria.
- *Benefits.* Organizations are not required to use a benefit.
- *Other.* Organizations may use additional initial population criteria to focus on an area of interest defined by gender, race, ethnicity, socioeconomic or sociodemographic characteristics, geographic region or another characteristic.
- *Measurement period adjustments.* Organizations may adjust the measurement period.

**Note:** Changes to these criteria can affect how the event will be calculated using the intake period, episode date, negative comorbid condition, negative medication history, negative competing diagnosis.

- *Exclusions.* The hospice and deceased person exclusions are not required.
- *Telehealth.* Services/events that allow the use of synchronous telehealth visits, telephone visits and asynchronous telehealth (e-visits, virtual check-ins) may be stratified to identify services performed via telehealth. This adjustment is not allowed for events/diagnoses, numerators and exclusions that do not allow the use of telehealth.
- *Supplemental data.* Supplemental data may be used to identify initial population, denominator, exclusion and numerator events.

#### **ADJUSTMENTS ALLOWED WITH LIMITS**

- *Ages.* Age determination dates may be changed (e.g., select "age as of January 1"). The denominator age may be changed if the range is within the specified age range. The denominator age may not be expanded.
- *Initial population:* Event. Only events that contain (or map to) codes in the medication lists and value sets may be used to identify visits, diagnoses and medication history. Medication lists, value sets and logic may not be changed. Organizations may include denied claims to calculate the denominator.
- *Numerator.* Medications lists and logic may not be changed. Organizations may include denied claims to calculate inpatient services.

# **Risk Adjusted Utilization Measures**

## Plan All-Cause Readmissions (PCR)

Measure title	Plan All-Cause Readmissions	Measure ID	PCR
<b>Description</b>	For persons 18 years of age and older, the risk-adjusted ratio of observed-to-expected unplanned acute readmissions (inpatient and observation stays) for any diagnosis within 30 days of an acute hospitalization (inpatient and observation stays).		
<b>Measurement period</b>	January 1–December 31.		
<b>Copyright and disclaimer notice</b>	<p>Refer to the complete copyright and disclaimer information at the front of the publication.</p> <p>NCQA website: <a href="http://www.ncqa.org">www.ncqa.org</a>.</p> <p>Submit policy clarification support questions via My NCQA (<a href="https://my.ncqa.org">https://my.ncqa.org</a>).</p>		
<b>Clinical recommendation statement/ rationale</b>	<p>Readmission to the hospital within 30 days of discharge is frequently avoidable and can lead to adverse outcomes for patients. Any preventable hospitalization can have a negative impact on health outcomes, particularly for older adults and adults with multiple chronic conditions. Health risks associated with hospitalization include infection, adverse drug events, loss of function, isolation, lower quality of life and readmission.</p>		
<b>Citations</b>	<p>Medicare Payment Advisory Commission. “Data Book: Health Care Spending and the Medicare Program.” Baltimore, MD: MedPAC, 2015. Available at <a href="http://medpac.gov/documents/reports/june-2015-report-to-the-congress-medicare-and-the-health-care-delivery-system.pdf?sfvrsn=0">http://medpac.gov/documents/reports/june-2015-report-to-the-congress-medicare-and-the-health-care-delivery-system.pdf?sfvrsn=0</a></p> <p>Burke, R.E., E.A. Whitfield, D. Hittle, S.J. Min, C. Levy, A.V. Prochazka, E.A. Coleman, R. Schwartz, A.A. Ginde. 2016. “Hospital Readmission from Post-Acute Care Facilities: Risk Factors, Timing, and Outcomes.” <i>J Am Med Dir Assoc</i> 17(3):249–55. doi: 10.1016/j.jamda.2015.11.005</p> <p>Hakkarainen, T.W., S. Arbabi, M.M. Willis, G.H. Davidson, D.R. Flum. 2016. “Outcomes of Patients Discharged to Skilled Nursing Facilities After Acute Care Hospitalizations.” <i>Ann Surg</i> 263(2):280–5. doi:10.1097/SLA.0000000000001367.</p>		
<b>Characteristics</b>			
<b>Scoring</b>	Ratio.		
<b>Product lines</b>	<ul style="list-style-type: none"> <li>• Commercial.</li> <li>• Medicaid.</li> <li>• Medicare.</li> </ul>		

<b>Stratifications</b>	<p>Age as of the index discharge date for commercial and Medicaid.</p> <ul style="list-style-type: none"> <li>• 18–44 years.</li> <li>• 45–54 years.</li> <li>• 55–64 years.</li> </ul> <p>Age as of the index discharge date for Medicare.</p> <ul style="list-style-type: none"> <li>• 18–44 years.</li> <li>• 45–54 years.</li> <li>• 55–64 years.</li> <li>• 65–74 years.</li> <li>• 75–84 years.</li> <li>• 18–64 years.</li> <li>• 85+ years.</li> </ul> <p>Skilled nursing facility. Age as of the index discharge date (Medicare only).</p> <ul style="list-style-type: none"> <li>• 65–74 years.</li> <li>• 75–84 years.</li> <li>• 85+ years.</li> </ul> <p>SES as of the end of the continuous enrollment period for each Medicare discharge (Medicare IHS only). (Refer to <a href="#">General Guideline: Medicare Socioeconomic Status Stratification</a>.)</p> <ul style="list-style-type: none"> <li>• Non-LIS/DE, Nondisability.</li> <li>• LIS/DE.</li> <li>• Disability.</li> <li>• LIS/DE and Disability.</li> <li>• Other.</li> <li>• Unknown.</li> </ul>
<b>Guidance</b>	<p><b>Programming Guidance</b></p> <p><b>Dual enrollment:</b> Persons with dual commercial/Medicaid enrollment may only be reported in the commercial product line. Persons with dual Medicaid and Medicare enrollment may only be reported in the Medicare product line. Dual enrollment is assessed after the continuous enrollment criteria are applied. To meet criteria for dual enrollment, persons must have dual enrollment at the end of the continuous enrollment period.</p> <p><b>Facilities:</b> The measure includes acute discharges from any type of facility (including behavioral health care facilities).</p> <p><b>Risk Adjustment Measure-Specific Guidance</b></p> <p><b>Observation stays:</b> For observation stays (<u>Observation Stay Value Set</u>) that do not have a recorded admission or discharge date, set the admission date to the earliest date of service on the claim and set the discharge date to the last date of service on the claim.</p>

<p><b>Which services count?</b></p> <ul style="list-style-type: none"> <li>• Use all paid, suspended, pending, and denied claims when applying risk adjustment comorbidity category determination and the hospice exclusion.</li> <li>• Do not include denied claims when identifying all other events (e.g., the IHS in the PCR measure or observed events in the other risk adjusted utilization measures); only report claims the organization paid for or expects to pay for (i.e., claims incurred but not paid).</li> </ul> <p><b>Supplemental data exceptions:</b> Supplemental data may only be used for the hospice exclusion.</p> <p><b>Transfers:</b></p> <ul style="list-style-type: none"> <li>• Treat transfers <i>between</i> institutions as separate admissions.</li> <li>• Base transfer reports <i>within</i> an institution on the type and level of services provided.</li> <li>• Report separate admissions when the transfer is between acute and nonacute levels of service or between mental health/chemical dependency services and non-mental health/chemical dependency services.</li> <li>• Count only one admission when the transfer takes place within the same service category, but to a different level of care (e.g., from intensive care to a lesser level of care; from a lesser level of care to intensive care).</li> </ul> <p><b>Risk adjustment:</b> Organizations may not use risk assessment protocols to supplement diagnoses for calculation of the risk adjustment scores for these measures. The measurement model was developed and tested using only claims-based diagnoses; diagnoses from additional data sources would affect the validity of the models as they are currently implemented in the specification.</p> <p><b>General Rules</b></p> <p><b>Data collection methodology:</b> Administrative. Refer to <a href="#">General Guideline: Data Collection Methods</a> for additional information.</p> <p><b>Date specificity:</b> Dates must be specific enough to determine the event occurred in the period being measured.</p> <p><b>Other guidance:</b> The measure is based on episodes; therefore, it is possible for the denominator to include multiple events for the same person.</p> <p><b>Improvement notation:</b> To interpret the rate as better or worse than expected, the rate must be calibrated. Organizations can calibrate rates by dividing individual organization rates or national percentiles by the national average rate. Organizations may be more successful at achieving fewer readmissions than expected, given the types of cases treated by the organization (calibrated rate with a value &lt;1.0), or may be less successful (calibrated rate with a value &gt;1.0).</p>
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<b>Definitions</b>	
<b>Direct transfer</b>	When the discharge date from the initial stay precedes the admission date to a subsequent stay by 1 calendar day or less. <ul style="list-style-type: none"> <li>• <i>For example:</i> <ul style="list-style-type: none"> <li>– A discharge on June 1, followed by a subsequent admission on June 1 or June 2, <i>is a direct transfer</i>.</li> <li>– A discharge on June 1, followed by a subsequent admission on June 3, <i>is not a direct transfer</i>; these are two distinct stays.</li> <li>– A discharge on June 1, followed by a subsequent admission on June 2 (with discharge on June 3), followed by a subsequent admission on June 4, <i>is a direct transfer</i>.</li> </ul> </li> </ul> <p>Direct transfers may occur between different facilities, and between acute inpatient and observation.</p>
<b>IHS</b>	Index hospital stay. An acute inpatient or observation stay with a discharge on or between January 1 and December 1 of the measurement period, as identified in the denominator.
<b>Index admission date</b>	The IHS admission date.
<b>Index discharge date</b>	The IHS discharge date. The index discharge date must occur on or between January 1 and December 1 of the measurement period.
<b>Index readmission stay</b>	An acute inpatient or observation stay for any diagnosis with an admission date within 30 days of a previous index discharge date.
<b>Index readmission date</b>	The admission date associated with the index readmission stay.
<b>Planned hospital stay</b>	A hospital stay is considered planned if it meets criteria as described in step 3 (exclusions) of the numerator.
<b>Plan population</b>	Persons in the initial population prior to exclusion of outliers. The plan population is only used as a denominator for the outlier rate.  Persons must be 18 years and older as of the earliest index discharge date.  The plan population is based on persons, not on discharges. Count persons only once in the plan population.  Assign persons to the product/product line in which they are enrolled at the start of the continuous enrollment period of their earliest IHS. If there is a gap at the beginning of this continuous enrollment period, assign the person to the product/product line in which they were enrolled as of their first enrollment segment during this continuous enrollment period.
<b>Outlier</b>	Enrollees in Medicaid and Medicare in the initial population with four or more IHS between January 1 and December 1 of the measurement period.  Commercial enrollees in the initial population with three or more IHS between January 1 and December 1 of the measurement period.

<b>Nonoutlier</b>  <b>Skilled nursing care discharge</b>	<p>When assigning outlier status, assign enrollees to the product/product line in which they are enrolled at the start of the continuous enrollment period of their earliest IHS. If there is a gap at the beginning of the continuous enrollment period, assign enrollees to the product/product line in which they were enrolled as of their first enrollment segment during the continuous enrollment period.</p> <p>Medicaid and Medicare enrollees in the eligible population with three or fewer IHS between January 1 and December 1 of the measurement period.</p> <p>Commercial enrollees in the eligible population with two or fewer IHS between January 1 and December 1 of the measurement period.</p> <p><b>Step 1.</b> For Medicare nonoutlier enrollees 65 years of age and older, determine if the IHS was discharged or transferred to skilled nursing care (<u>Skilled Nursing Stay Value Set</u>).</p> <p>An index stay is discharged or transferred to skilled nursing care when the discharge date from the acute inpatient or observation stay precedes the admission date for skilled nursing care by 1 calendar day or less.</p> <ul style="list-style-type: none"> <li>• <i>For example:</i> <ul style="list-style-type: none"> <li>– An index stay discharge on June 1, followed by an admission to a skilled nursing setting on June 1 or June 2, <i>is an IHS</i> discharged or transferred to skilled nursing care.</li> <li>– An index stay discharge on June 1, followed by an admission to a skilled nursing setting on June 3, <i>is not an IHS</i> discharged or transferred to skilled nursing care.</li> </ul> </li> </ul> <p><b>Step 2.</b> Report Medicare discharges for each IHS discharged or transferred to skilled nursing care to an age group in Table PCR-C-3.</p>
<b>Initial population</b>	<p><b>Measure item count:</b> Episode.</p> <p><b>Attribution basis:</b> Enrollment.</p> <ul style="list-style-type: none"> <li>• <b>Benefits:</b> Medical.</li> <li>• <b>Continuous enrollment:</b> 365 days prior to the index discharge date through 30 days after the index discharge date.</li> <li>• <b>Allowable gap:</b> <ul style="list-style-type: none"> <li>– <i>365 days to 1 day prior to the index discharge date:</i> No more than one gap of ≤45 days.</li> <li>– <i>Index discharge date and 30 days following the index discharge date:</i> None.</li> </ul> </li> </ul> <p><b>Ages:</b></p> <ul style="list-style-type: none"> <li>• <i>Commercial and Medicaid:</i> 18–64 years as of the index discharge date.</li> <li>• <i>Medicare:</i> 18 years and older as of the index discharge date.</li> </ul> <p><b>Gender/Sex criteria:</b></p> <ul style="list-style-type: none"> <li>• Administrative Gender of Female (AdministrativeGender code female).</li> <li>• Administrative Gender of Male (AdministrativeGender code male).</li> </ul>

	<p><b>Exclusion: Persons in hospice or using hospice services.</b></p> <p>Persons who use hospice services (<a href="#">Hospice Encounter Value Set</a>; <a href="#">Hospice Intervention Value Set</a>) or elect to use a hospice benefit any time during the measurement period. Organizations that use the Monthly Membership Detail Data File to identify these persons must use only the run date of the file.</p>
<b>Denominator</b>	<p><b>Acute inpatient or observation stay discharges.</b></p> <p><b>Step 1.</b> Identify all acute inpatient and observation stay discharges on or between January 1 and December 1 of the measurement period. To identify acute inpatient and observation stay discharges:</p> <ol style="list-style-type: none"> <li>1. Identify all acute and nonacute inpatient stays (<a href="#">Inpatient Stay Value Set</a>) and observation stays (<a href="#">Observation Stay Value Set</a>).</li> <li>2. Exclude nonacute inpatient stays (<a href="#">Nonacute Inpatient Stay Value Set</a>).</li> <li>3. Identify the discharge date for the stay.</li> </ol> <p>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.</p> <p><b>Step 2.</b> For discharges with one or more direct transfers, use the last discharge.</p> <p>Using the discharges identified in step 1, identify direct transfers between acute inpatient and observation using the definition of "direct transfer." Exclude the hospital stay if the direct transfer's discharge date occurs after December 1 of the measurement period.</p> <p><b>Step 3.</b> Exclude hospital stays where the index admission date is the same as the index discharge date.</p> <p><b>Step 4.</b> Exclude hospital stays for any of the following reasons:</p> <ul style="list-style-type: none"> <li>• The person died during the stay.</li> <li>• A principal diagnosis of pregnancy (<a href="#">Pregnancy Value Set</a>) or a condition originating in the perinatal period (<a href="#">Perinatal Conditions Value Set</a>) on the discharge claim.</li> </ul> <p><b>Note:</b> 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.</p> <p><b>Step 5.</b> Calculate continuous enrollment.</p> <p><b>Step 6.</b> Remove hospital stays for outliers and report these persons as outliers in Tables PCR-A-1/2 and PCR-A-3.</p> <p><b>Note:</b> Count discharges with one or more direct transfers (identified in step 2) as one discharge when identifying outliers.</p> <p><b>Step 7.</b> Assign each remaining acute inpatient or observation stay to an age and stratification category using the reporting instructions below.</p>

<b>Risk adjustment factors</b>	<p><b>Risk Adjustment Determination</b></p> <p>For each IHS among nonoutliers, identify risk adjustment weights based on observation stay status at discharge, surgeries, discharge condition, COVID-19 discharge, comorbidity, age and gender. Weights are specific to product line (Medicare Under 65, Medicare 65+, commercial, Medicaid). Refer to the reporting indicator column in the risk adjustment tables to ensure that weights are linked appropriately.</p> <p><b>Observation stay:</b> Determine if the IHS at discharge was an observation stay (<u>Observation Stay Value Set</u>). For direct transfers, determine the hospitalization status using the last discharge.</p> <p><b>Surgeries:</b> Determine if the person underwent surgery during the stay. Consider an IHS to include a surgery if at least one procedure code (<u>Surgery Procedure Value Set</u>) is present from any provider between the admission and discharge dates.</p> <p><b>Discharge condition:</b> Assign a discharge Clinical Condition (CC) category code or codes to the IHS based on its principal discharge diagnosis, using Table CC—Mapping. For direct transfers, use the principal discharge diagnosis from the last discharge.</p> <p>Exclude diagnoses that cannot be mapped to Table CC—Mapping.</p> <p><b>COVID-19 discharge:</b> Assign a COVID-19 discharge code to the IHS if its principal discharge diagnosis was COVID-19 (ICD-10-CM code U07.1). For direct transfers, use the principal discharge diagnosis from the last discharge.</p> <p><b>Comorbidities:</b></p> <p><b>Step 1.</b> Identify all diagnoses for encounters during the 365 days prior to and on the date of the index discharge date. Exclude the principal discharge diagnosis on the IHS. Include the following when identifying encounters:</p> <ul style="list-style-type: none"> <li>• Outpatient visits, ED visits, telephone visits, nonacute inpatient encounters and acute inpatient encounters (<u>Outpatient, ED, Telephone, Acute Inpatient and Nonacute Inpatient Value Set</u>) with a date of service in the period from 365 days before the index discharge date to (and including) the index discharge date.</li> <li>• Acute and nonacute inpatient discharges (<u>Inpatient Stay Value Set</u>) with a discharge date in the period from 365 days before the index discharge date to (and including) the index discharge date.</li> </ul> <p><b>Step 2.</b> Assign each diagnosis to one or more comorbid Clinical Condition (CC) category using Table CC—Mapping in the Risk Adjustment Shared Tables. If the code appears more than once in Table CC—Mapping, it is assigned to multiple CCs.</p> <p>Exclude all diagnoses that cannot be assigned to a comorbid CC category. For denominator units with no qualifying diagnoses from face-to-face encounters, skip to <i>Risk Adjustment Calculation</i>.</p> <p>All digits must match exactly when mapping diagnosis codes to the comorbid CCs.</p> <p><b>Step 3.</b> Determine HCCs for each comorbid CC identified. Refer to Table HCC—Rank.</p>
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For each denominator unit's comorbid CC list, match the comorbid CC code to the comorbid CC code in the table, and assign:

- The ranking group.
- The rank.
- The HCC.

For comorbid CCs that do not match to Table HCC—Rank, use the comorbid CC as the HCC and assign a rank of 1. One comorbid CC can map to multiple HCCs; each HCC can have one or more comorbid CCs.

**Step 4.** Assess each ranking group separately and select only the highest ranked HCC in each ranking group using the “Rank” column (1 is the highest rank possible).

Drop all other HCCs in each ranking group, and de-duplicate the HCC list if necessary.

- *For example*, assume a denominator unit with the following comorbid CCs: CC-85, CC-17 and CC-19 (assume no other CCs).
  - CC-85 does not have a map to the ranking table and becomes HCC-85.
  - HCC-17 and HCC-19 are part of Diabetes Ranking Group 1. Because CC-17 is ranked higher than CC-19 in Ranking Group Diabetes 1, the comorbidity is assigned as HCC-17 for Ranking Group 1.

The final comorbidities for this denominator unit are HCC-17 and HCC-85.

**Table HCC—Rank**

Ranking Group	CC	Description	Rank	HCC
NA	CC-85	Congestive Heart Failure	NA	HCC-85
Diabetes 1	CC-17	Diabetes With Acute Complications	1	HCC-17
	CC-18	Diabetes With Chronic Complications	2	HCC-18
	CC-19	Diabetes Without Complications	3	HCC-19

**Step 5.** Identify combination HCCs listed in Table HCC—Comb.

Some combinations suggest a greater amount of risk when observed together.

- *For example*, when diabetes and CHF are present, an increased amount of risk is evident. Additional HCCs are selected to account for these relationships.

Compare each denominator unit's list of unique HCCs to those in the *Comorbid HCC* columns in Table HCC—Comb and assign any additional HCC conditions.

*If there are overlapping combinations, use both sets of combinations.* Based on the combinations, a denominator unit can have none, one or more of these added HCCs.

- *For example*, for a denominator unit with comorbidities HCC-17 and HCC-85 (assume no other HCCs), assign HCC-901 in addition to HCC-17 and HCC-85. This *does not* replace HCC-17 and HCC-85.

<b>Table HCC—Comb</b>					
	Comorbid HCC 1	Comorbid HCC 2	Comorbid HCC 3	HCC-Combination	HCC-Comb Description
HCC-17	HCC-85	NA		HCC-901	Combination: Diabetes and CHF
HCC-18	HCC-85	NA		HCC-901	Combination: Diabetes and CHF
HCC-19	HCC-85	NA		HCC-901	Combination: Diabetes and CHF

<b>Risk adjustment</b>	<p><b>Risk Adjustment Calculation</b></p> <p>For each IHS among nonoutliers, use the following steps to identify risk adjustment weights based on observation stays status at discharge, surgeries, discharge condition, COVID-19, comorbidity, age and gender.</p> <p><b>Note:</b> For Medicare product lines, IHS that are discharged or transferred to skilled nursing care should be assigned two sets of risk adjustment weights: the skilled nursing care risk weights for reporting in Table PCR-C-3 and the standard set of risk weights for reporting in Table PCR-A-3 and Table PCR-B-3.</p> <p>For reporting IHS that are discharged or transferred to skilled nursing care, do not assign the skilled nursing care risk weights for the stays when reporting in Table PCR-A-3 and Table PCR-B-3 and do not assign the standard set of risk weights for the stays when reporting in Table PCR-C-3.</p> <p><b>Step 1.</b> For each IHS discharge that is an observation stay, link the observation stay IHS weight.</p> <p><b>Step 2.</b> For each IHS with a surgery, link the surgery weight.</p> <p><b>Step 3.</b> For each IHS with a discharge CC category, link the primary discharge weights.</p> <p><b>Step 4.</b> For each IHS with a comorbidity HCC category, link the comorbidity weights.</p> <p><b>Step 5.</b> For each IHS with a COVID-19 discharge, link the COVID-19 discharge weight.</p> <p><b>Step 6.</b> Link the age and gender weights for each IHS.</p> <p><b>Step 7.</b> Sum all weights (observation stay, presence of surgery, principal discharge diagnosis, comorbidities, COVID-19 discharge, age and gender) associated with the IHS and use the formula below to calculate the estimated readmission risk for each IHS:</p> $\text{Estimated Readmission Risk} = \frac{e^{(\sum \text{WeightsForIHS})}}{1+e^{(\sum \text{WeightsForIHS})}}$ <p><b>OR</b></p> <p>Estimated Readmission Risk = [exp (sum of weights for IHS)] / [ 1 + exp (sum of weights for IHS)]</p> <p><b>Note:</b> "Exp" refers to the exponential or antilog function.</p>
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	<p>Truncate the estimated readmission risk for each IHS to 10 decimal places. Do not truncate or round in previous steps.</p> <p><b>Step 8.</b> Calculate the count of expected readmissions for each age and stratification category. The count of expected readmissions is the sum of the estimated readmission risk calculated in step 7 for each IHS in each age and stratification category.</p> $\text{Count of Expected Readmissions} = \sum (\text{Estimated Readmission Risk})$ <p><b>Step 9.</b> Use the formula below and the estimated readmission risk calculated in step 7 to calculate the variance for each IHS.</p> <p>Variance = Estimated Readmission Risk x (1 – Estimated Readmission Risk)</p> <p>Truncate the variance <i>for each IHS</i> to 10 decimal places.</p> <ul style="list-style-type: none"> <li>• <i>For example:</i> If the estimated readmission risk is 0.1518450741 for an IHS, then the variance for this IHS is 0.1518450741 x 0.8481549259 = 0.1287881475.</li> </ul> <p><b>Note:</b> Organizations must sum the variances for each stratification and age when populating the Variance cells in the reporting tables. When reporting, round the variance to 4 decimal places using the .5 rule.</p>
Numerator	<p><b>At least one acute readmission for any diagnosis within 30 days of the index discharge date.</b></p> <p><b>Step 1.</b> Identify all acute inpatient and observation stays with an admission date on or between January 3 and December 31 of the measurement period:</p> <ol style="list-style-type: none"> <li>1. Identify all acute and nonacute inpatient stays (<u>Inpatient Stay Value Set</u>) and observation stays (<u>Observation Stay Value Set</u>).</li> <li>2. Exclude nonacute inpatient stays (<u>Nonacute Inpatient Stay Value Set</u>).</li> <li>3. Identify the admission date for the stay.</li> </ol> <p><b>Step 2.</b> 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 using the definition of direct transfer.</p> <p><b>Step 3.</b> Exclude acute hospitalizations with any of the following criteria on the discharge claim:</p> <ul style="list-style-type: none"> <li>• A principal diagnosis of pregnancy (<u>Pregnancy Value Set</u>) or a condition originating in the perinatal period (<u>Perinatal Conditions Value Set</u>).</li> <li>• A planned hospital stay using any of the following: <ul style="list-style-type: none"> <li>– A principal diagnosis of maintenance chemotherapy (<u>Chemotherapy Encounter Value Set</u>).</li> <li>– A principal diagnosis of rehabilitation (<u>Rehabilitation Value Set</u>).</li> <li>– An organ transplant (<u>Kidney Transplant Value Set</u>, <u>Bone Marrow Transplant Value Set</u>, <u>Organ Transplant Other Than Kidney Value Set</u>, <u>Introduction of Autologous Pancreatic Cells Value Set</u>).</li> <li>– A potentially planned procedure (<u>Potentially Planned Procedures Value Set</u>) without a principal acute diagnosis (<u>Acute Condition Value Set</u>).</li> </ul> </li> </ul>

	<p><b>Note:</b> 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.</p> <p><b>Step 4.</b> For each IHS identified in the denominator, determine if any of the acute inpatient and observation stays identified in the numerator have an admission date within 30 days after the index discharge date.</p> <p><b>Note</b></p> <ul style="list-style-type: none"> <li>Count each acute hospitalization only once toward the numerator for the last denominator event.</li> </ul> <p>If a single numerator event meets criteria for multiple denominator events, only count the last denominator event.</p> <p>For example, consider the following events:</p> <ul style="list-style-type: none"> <li>Acute inpatient stay 1: May 1–10.</li> <li>Acute inpatient stay 2: May 15–25 (principal diagnosis of maintenance chemotherapy).</li> <li>Acute inpatient stay 3: May 30–June 5.</li> </ul> <p>All three acute inpatient stays are included as denominator events. Stay 2 is excluded from the numerator because it is a planned hospitalization. Stay 3 is within 30 days of stay 1 and stay 2. Count stay 3 as a numerator event only toward the last denominator event (stay 2, May 15–25).</p>
<b>Summary of changes</b>	<ul style="list-style-type: none"> <li>Updated the measure description.</li> <li>Integrated the Risk Adjustment General Guidelines into the <i>Guidance</i> section.</li> <li>Moved the instructions regarding facility type from step 1 of the denominator to the <i>Guidance</i> section.</li> <li>Moved the <i>Skilled nursing care stratification</i> reporting instructions to the <i>Definitions</i> section.</li> <li>Moved the definition of “classification period” to the <i>Risk adjustment comorbidity category determination</i> section.</li> <li>Added “direct transfer” to the <i>Definitions</i> section.</li> <li>Added administrative gender codes to the initial population.</li> </ul>
<b>Data element tables</b>	<p><b>Reporting: Number of persons in plan population</b></p> <p><b>Step 1.</b> Determine the person’s age as of the earliest index discharge date.</p> <p><b>Step 2.</b> Report the count of persons in the plan population for each age group as the PersonCount.</p> <p><b>Reporting: Number of outliers</b></p> <p><b>Step 1.</b> Determine the person’s age as of the earliest index discharge date.</p> <p><b>Step 2.</b> Report the count of outlier persons for each age group as the OutlierPersonCount.</p> <p><b>Calculated: Outlier rate</b></p> <p>The number of outlier persons (OutlierPersonCount) divided by the number of persons in the plan population (PersonCount), displayed as a permillage</p>

	<p>(multiplied by 1,000), for each age group and totals. Calculated by IDSS as the OutlierRate.</p> <p><b>Reporting: Denominator</b></p> <p>Count the number of IHS among nonoutlier persons for each age group. Report these values as the denominator.</p> <p><b>Reporting: SES Stratifications (Medicare only)</b></p> <p><b>Step 1.</b> Determine the persons enrolled in Medicare SES stratifications as of the end of the continuous enrollment period for each Medicare discharge:</p> <ul style="list-style-type: none"> <li>• <i>Non-LIS/DE, nondisability</i>: Person is eligible for Medicare due to age only (does not receive LIS, is not DE for Medicaid, does not have disability status).</li> <li>• <i>LIS/DE</i>: Person is eligible for Medicare due to age and receives LIS (includes persons eligible for Medicare due to DE), does not have disability status.</li> <li>• <i>Disability</i>: Person is eligible for Medicare due to disability status only.</li> <li>• <i>LIS/DE and disability</i>: Person is eligible for Medicare, receives LIS and has disability status.</li> <li>• <i>Other</i>: Person has ESRD-only status or is assigned “9—none of the above.”</li> <li>• <i>Unknown</i>: Person’s SES is unknown.</li> <li>• <i>Total Medicare</i>: Total of all categories.</li> </ul> <p><b>Step 2.</b> Report Medicare discharges based on the SES stratification assigned for each Medicare index stay in Table PCR-B-3.</p> <p><b>Reporting: Skilled nursing care stratification (Medicare 65+ only)</b></p> <p>Report Medicare discharges for each IHS discharged or transferred to skilled nursing care to an age group in Table PCR-C-3.</p> <p><b>Reporting: Numerator</b></p> <p>Count the number of observed IHS among nonoutlier persons with a readmission within 30 days of discharge for each age group and report these values as the ObservedCount.</p> <p><b>Calculated: Observed readmission rate</b></p> <p>The count of observed 30-day readmissions (ObservedCount) divided by the count of index stays (Denominator) for each age group and totals. Calculated by IDSS as the ObservedRate.</p> <p><b>Reporting: Count of expected 30-day readmissions</b></p> <p><b>Step 1.</b> Calculate the count of expected readmissions among nonoutliers for each age group.</p> <p><b>Step 2.</b> Round to 4 decimal places using the .5 rule and report these values as the ExpectedCount.</p> <p><b>Calculated: Expected readmissions rate</b></p> <p>The count of expected 30-day readmissions (ExpectedCount) divided by the count of index stays (Denominator) for each age group and totals. Calculated by IDSS as the ExpectedRate.</p>
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**Reporting: Variance**

**Step 1.** Calculate the total (sum) variance (*Risk Adjustment Calculation*, step 9) for each SES stratification (Medicare only), skilled nursing stratification (Medicare only) and age group.

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

**Calculated: O/E ratio**

The count of observed 30-day readmissions (ObservedCount) divided by the count of expected 30-day readmissions (ExpectedCount) for each age group and totals. Calculated by IDSS as the OE. The O/E ratio is not calculated for SES stratification.

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

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

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

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

Metric	Age	Data Element	Reporting Instructions
PlanAllCauseReadmissions	18-44	PersonCount	For each Stratification
	45-54	OutlierPersonCount	For each Stratification
	55-64	OutlierRate	OutlierPersonCount / PersonCount (Permilie)
	18-64	Denominator	For each Stratification
	65-74	ObservedCount	For each Stratification

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

<b>Table PCR-B-3: Data Elements for Plan All-Cause Readmissions by SES Stratifications</b>				
Metric	SES Stratifications	Age	Data Element	Reporting Instructions
PlanAllCauseReadmissions	NonLisDeNondisability	18-64	Denominator	For each Stratification
	LisDe	65+	ObservedCount	For each Stratification
	Disability		ObservedRate	ObservedCount / Denominator (Percent)
	LisDeAndDisability		ExpectedCount	For each Stratification
	Other		ExpectedRate	ExpectedCount / Denominator (Percent)
	Unknown		CountVariance	For each Stratification

<b>Table PCR-C-3: Data Elements for Plan All-Cause Readmissions for Skilled Nursing Care Stratifications</b>				
Metric	Age	Data Element	Reporting Instructions	
SkilledNursingCare	65-74	Denominator	For each Stratification	
	75-84	ObservedCount	For each Stratification	
	85+	ObservedRate	ObservedCount / Denominator (Percent)	
	65+	ExpectedCount	For each Stratification	
		ExpectedRate	ExpectedCount / Denominator (Percent)	
		CountVariance	For each Stratification	
		OE	ObservedCount / ExpectedCount	

## Rules for Allowable Adjustments

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

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

The measures under the Risk Adjusted Utilization domain allow two types of *Rules for Allowable Adjustments* sections:

1. *Rules for Allowable Adjustments for Risk-Adjusted Measurement.* This section must be followed for adjustments when calculating the full measure specifications, which includes all risk adjusted rates (expected rates, risk adjustment, O/E) and calculation components (count of index stays, observed events).
2. *Rules for Allowable Adjustments for Observed Measurement (rates without risk adjustment).* This section must be followed when adjusting the calculation of observed events only. When applying these adjustments, organizations must not include risk adjustment logic.

The intent of including two types of Rules is to allow organizations to adjust measures without compromising measure validity. Risk adjustment is based on statistical prediction models specifically calibrated to each measure.

**The following are the Rules for Allowable Adjustments for Risk-Adjusted Measurement of the Plan All-Cause Readmissions measure (count of index stays, count of observed 30-day readmissions, observed readmission rate, risk adjustment determination, risk adjustment weighting, count of expected 30-day readmissions, O/E).**

### ADJUSTMENTS ALLOWED

- *Benefits.* Organizations are not required to use a benefit.
- *Plan population.* Organizations are not required to use plan population to identify outlier rates.
- *Telehealth.* Services/events that allow the use of synchronous telehealth visits, telephone visits and asynchronous telehealth (e-visits, virtual check-ins) may be stratified to identify services performed via telehealth. This adjustment is not allowed for events, numerators and exclusions that do not allow the use of telehealth.

### ADJUSTMENTS ALLOWED WITH LIMITS

- *Other.* Organizations may only adjust the initial population criteria to focus on an area of interest defined by gender, sociodemographic characteristics or geographical region. NCQA recommends evaluating risk model performance and validity within adjusted populations. Organizations may not adjust for a clinical subpopulation (e.g., persons with a diabetes diagnosis).
- *Measurement period adjustments.* Organizations may only change the measurement period by 1 year.

- *SES stratification, skilled nursing care stratification.* Stratifications are not required, but if they are used the value sets, logic and product lines may not be changed.
- *Outlier.* Organizations may include denied claims to calculate these events. Organizations may not adjust the outlier logic.
- *Denominator.* Organizations may include denied claims to calculate denominator events. Value sets and logic may not be changed.
- *Risk adjustment determination, risk adjustment weighting, expected readmissions, variance.* Organizations may include denied claims to calculate these events. Risk adjustment determinations, weighting, expected readmissions, variance and calculations of expected events logic may not be changed.
- *Numerator.* Organizations may include denied claims to calculate the numerator. Value sets and logic may not be changed.

#### **ADJUSTMENTS NOT ALLOWED**

- *Product lines.* Organizations may not adjust product lines.
- *Attribution.* Organizations are required to use enrollment criteria.
- *Ages.* The age determination dates may not be changed.
- *Supplemental data.* Supplemental data may not be used to identify initial population, denominator and numerator events.
- *Exclusions.* The hospice exclusion must be applied. Logic may not be changed.

The following are the Rules for Allowable Adjustments for Observed Measurement of the Plan All-Cause Readmissions measure observed events (count of index stays, count of observed 30-day readmissions, observed readmission rate).

#### **ADJUSTMENTS ALLOWED**

- *Product lines.* When adjusting this measure to assess for observed events only, organizations are not required to use product line criteria; product lines may be combined, and all (or no) product line criteria may be used.
- *Ages.* The observed event age range may be expanded. Age determination dates may be changed (e.g., select, "age as of June 30").
- *Attribution.* Organizations are not required to use enrollment criteria.
- *Benefits.* Organizations are not required to use a benefit.
- *Other.* Organizations may adjust the initial population criteria to focus on an area of interest defined by gender, race, ethnicity, socioeconomic or sociodemographic characteristics, geographic region or another characteristic.
- *Measurement period adjustments.* Organizations may adjust the measurement period.
- *Exclusions.* Hospice exclusion is not required.
- *Outlier.* Organizations may adjust the outlier logic. The outlier logic is not required to be applied. The outlier thresholds may be expanded or reduced. Denied claims may be used to calculate these events.

- *Plan population.* Organizations are not required to use plan population to identify outlier rates.
- *Telehealth.* Services/events that allow the use of synchronous telehealth visits, telephone visits and asynchronous telehealth (e-visits, virtual check-ins) may be stratified to identify services performed via telehealth. This adjustment is not allowed for events, numerators and exclusions that do not allow the use of telehealth.
- *Supplemental data.* Supplemental data may be used to identify initial population, denominator, exclusion and numerator events.

#### **ADJUSTMENTS ALLOWED WITH LIMITS**

- *SES stratification, skilled nursing care stratification.* Stratifications are not required, but if they are used, the value sets, logic and product lines may not be changed.
- *Denominator.* Organizations may include denied claims to calculate denominator events. Value sets and logic may not be changed.
- *Numerator.* Organizations may include denied claims to calculate the numerator. Value sets and logic may not be changed.

## **Hospitalization Following Discharge From a Skilled Nursing Facility (HFS)**

<b>Measure title</b>	Hospitalization Following Discharge From a Skilled Nursing Facility	<b>Measure ID</b>	HFS
<b>Description</b>	For persons 65 years of age and older, the risk-adjusted ratio of observed-to-expected unplanned acute hospitalizations (inpatient and observation stays) for any diagnosis within 30 days and within 60 days following a skilled nursing facility (SNF) discharge to the community.		
<b>Measurement period</b>	January 1–December 31.		
<b>Copyright and disclaimer notice</b>	<p>Refer to the complete copyright and disclaimer information at the front of the publication.</p> <p>NCQA website: <a href="http://www.ncqa.org">www.ncqa.org</a>.</p> <p>Submit policy clarification support questions via My NCQA (<a href="https://my.ncqa.org">https://my.ncqa.org</a>).</p>		
<b>Clinical recommendation statement/ rationale</b>	Patients readmitted to a hospital from inpatient rehabilitation facilities and SNFs were found to be twice as likely to die within 30 days, and nearly four times as likely to die within 100 days, than patients without a readmission event. Health plans are accountable for a person's entire episode of care including care prior to SNF admission, during SNF stay and after SNF discharge.		
<b>Citations</b>	<p>Hakkarinen, T.W., S. Arbabi, M.M. Willis, G.H. Davidson, D.R. Flum. 2016. “Outcomes of Patients Discharged to Skilled Nursing Facilities After Acute Care Hospitalizations.” <i>Ann Surg</i> 263(2):280–5. doi:10.1097/SLA.0000000000001367.</p> <p>Mor, V., O. Intrator, Z. Feng, D.C. Grabowski. 2010. “The Revolving Door of Rehospitalization From Skilled Nursing Facilities.” <i>Health Affairs</i> 29(1): 57–64. doi: 10.1377/hlthaff.2009.0629.</p>		
<b>Characteristics</b>			
<b>Scoring</b>	Ratio.		
<b>Product lines</b>	Medicare.		
<b>Stratifications</b>	<p>Age as of the SNF discharge.</p> <ul style="list-style-type: none"> <li>• 65-74 years.</li> <li>• 75-84 years.</li> <li>• 85+ years.</li> </ul>		

Guidance	<b>Risk Adjustment Measure-Specific Guidance</b>
	<p><b>Observation stays:</b> For observation stays (<u>Observation Stay Value Set</u>) that do not have a recorded admission or discharge date, set the admission date to the earliest date of service on the claim and set the discharge date to the last date of service on the claim.</p> <p><b>Which services count?</b></p> <p>Use all paid, suspended, pending and denied claims when applying risk adjustment comorbidity category determination and the hospice exclusion.</p> <p>Do not include denied claims when identifying all other events (e.g., the SND in the HFS measure or observed events in the other risk adjusted utilization measures); only report claims the organization paid for or expects to pay for (i.e., claims incurred but not paid).</p> <p><b>Supplemental data exceptions:</b> Supplemental data may only be used for the hospice exclusion.</p> <p><b>Transfers:</b></p> <ul style="list-style-type: none"> <li>• Treat transfers <i>between</i> institutions as separate admissions.</li> <li>• Base transfer reports <i>within</i> an institution on the type and level of services provided.</li> <li>• Report separate admissions when the transfer is between acute and nonacute levels of service or between mental health/chemical dependency services and non-mental health/chemical dependency services.</li> <li>• Count only one admission when the transfer takes place within the same service category, but to a different level of care (e.g., from intensive care to a lesser level of care; from a lesser level of care to intensive care).</li> </ul> <p><b>Risk adjustment:</b> Organizations may not use risk assessment protocols to supplement diagnoses for calculation of the risk adjustment scores for these measures. The measurement model was developed and tested using only claims-based diagnoses; diagnoses from additional data sources would affect the validity of the models as they are currently implemented in the specification.</p> <p><b>General Rules</b></p> <p><b>Data collection methodology:</b> Administrative. Refer to <a href="#">General Guideline: Data Collection Methods</a> for additional information.</p> <p><b>Date specificity:</b> Dates must be specific enough to determine the event occurred in the period being measured.</p> <p><b>Other guidance:</b> The measure is based on episodes; therefore, it is possible for the denominator to include multiple events for the same person.</p> <p><b>Improvement notation:</b> To interpret the ratio as better or worse than expected, the ratio must be calibrated. Organizations can calibrate ratios by dividing individual organization ratios or national percentiles by the national average ratios. Organizations may be more successful at achieving fewer readmissions than expected, given the types of cases treated by the organization (calibrated ratio with a value &lt;1.0), or may be less successful (calibrated ratio with a value &gt;1.0).</p>

<b>Definitions</b>	
<b>Direct transfer</b>	When the discharge date from the initial stay precedes the admission date to a subsequent stay by 1 calendar day or less. <ul style="list-style-type: none"> <li>• <i>For example:</i> <ul style="list-style-type: none"> <li>– A discharge on June 1, followed by a subsequent admission on June 1 or June 2, <i>is a direct transfer</i>.</li> <li>– A discharge on June 1, followed by a subsequent admission on June 3, <i>is not a direct transfer</i>; these are two distinct stays.</li> <li>– A discharge on June 1, followed by a subsequent admission on June 2 (with discharge on June 3), followed by a subsequent admission on June 4, <i>is a direct transfer</i>.</li> </ul> </li> </ul> <p>Direct transfers may occur between different facilities, and between acute inpatient and observation.</p>
<b>SND</b>	SNF discharge. A SNF discharge on or between January 1 and November 1 of the measurement period.
<b>Planned hospital stay</b>	A hospital stay is considered planned if it meets criteria in step 3 of the numerator.
<b>Initial population</b>	<p><i>Measure item count:</i> Episode.</p> <p><i>Attribution basis:</i> Enrollment.</p> <ul style="list-style-type: none"> <li>• <i>Benefits:</i> Medical.</li> <li>• <i>Continuous enrollment:</i> 365 days prior to the SND date through 60 days after the SND date.</li> <li>• <i>Allowable gap:</i> <ul style="list-style-type: none"> <li>– <i>365 days prior to the SND date:</i> No more than one gap of ≤45 days.</li> <li>– <i>SND and 60 days following the SND date:</i> None.</li> </ul> </li> </ul> <p><i>Ages:</i> 65 years of age and older as of the SND date.</p> <p><i>Gender/sex criteria:</i></p> <ul style="list-style-type: none"> <li>• Administrative Gender of Female (AdministrativeGender code female).</li> <li>• Administrative Gender of Male (AdministrativeGender code male).</li> </ul> <p><i>Exclusions:</i></p> <p><b>Persons in hospice or using hospice services.</b> Persons who use hospice services (<u>Hospice Encounter Value Set</u>; <u>Hospice Intervention Value Set</u>) or elect to use a hospice benefit any time during the measurement period. Organizations that use the Monthly Membership Detail Data File to identify these persons must use only the run date of the file.</p> <p><b>Medicare enrollees living long-term in an institution (LTI).</b> Living long-term in an institution any time during the measurement period as identified by the LTI flag in the Monthly Membership Detail Data (MMDT) File. Use the run date of the file to determine if a member had an LTI flag during the measurement period.</p>

<b>Denominator</b>	<p><b>Skilled nursing facility discharges to the community.</b></p> <p><b>Step 1.</b> Identify all SNDs on or between January 1 and November 1 of the measurement period. To identify SNDs:</p> <ol style="list-style-type: none"> <li>1. Identify all SNF stays (<a href="#">Skilled Nursing Stay Value Set</a>).</li> <li>2. Identify the discharge date for the SNF stay.</li> </ol> <p><b>Step 2.</b> <i>Skilled nursing-to-skilled nursing direct transfers.</i> For SNF stays with one or more direct transfers from another SNF, use the last discharge. Using the discharges in step 1, identify direct transfers between SNFs using the definition of direct transfer. Exclude the SND if the direct transfer discharge date occurs after November 1 of the measurement period.</p> <p><b>Step 3.</b> Exclude SNDs where the SNF admission date is the same as the SND date.</p> <p><b>Step 4.</b> Exclude SNDs due to an acute hospital transfer. To identify acute hospital transfers from SNFs:</p> <ol style="list-style-type: none"> <li>1. Identify all acute and nonacute inpatient stays (<a href="#">Inpatient Stay Value Set</a>) and observation stays (<a href="#">Observation Stay Value Set</a>).</li> <li>2. Exclude nonacute inpatient stays (<a href="#">Nonacute Inpatient Stay Value Set</a>).</li> <li>3. Identify the admission date for the hospitalization.</li> <li>4. Exclude SNDs with an acute hospital admission date within 1 calendar day or less after the SND date. <ul style="list-style-type: none"> <li>• <i>For example:</i> <ul style="list-style-type: none"> <li>– An SND on June 1, followed by a hospitalization on June 1, <i>is excluded</i>.</li> <li>– An SND on June 1, followed by a hospitalization on June 2, <i>is excluded</i>.</li> <li>– An SND on June 1, followed by a hospitalization on June 3, <i>is included</i>.</li> </ul> </li> </ul> </li> </ol> <p><b>Step 5.</b> Calculate continuous enrollment.</p> <p><b>Step 6.</b> Assign each SND to an age stratification using the <i>Reporting: Denominator</i> section. Refer to Tables HFS-A-3 and HFS-B-3.</p>
<b>Risk adjustment factors</b>	<p><b>Risk Adjustment Determination</b></p> <p>For each SND, identify risk adjustment weights based on discharge condition, COVID-19 discharge, comorbidity, age and gender. Weights are specific to reporting rate (30-day and 60-day). Refer to the reporting indicator column in the risk adjustment tables to ensure that weights are linked appropriately.</p> <p><b>Discharge condition:</b> Assign a Clinical Condition (CC) category code or codes to the SND based on its principal discharge diagnosis, using Table CC—Mapping. For direct transfers, use the principal discharge diagnosis from the last discharge.</p> <p>Exclude diagnoses that cannot be mapped to Table CC—Mapping.</p> <p><b>COVID-19 discharge:</b> Assign a COVID-19 discharge code to the SND if its principal discharge diagnosis was COVID-19 (ICD-10-CM code U07.1). For direct transfers, use the principal discharge diagnosis from the last discharge.</p>

**Comorbidities:**

**Step 1.** Identify all diagnoses for encounters during the 365 days prior to and on the date of the SND. Exclude the primary discharge diagnosis on the SND to the community. Include the following when identifying encounters:

- Outpatient visits, ED visits, telephone visits, nonacute inpatient encounters and acute inpatient encounters (Outpatient, ED, Telephone, Acute Inpatient and Nonacute Inpatient Value Set) with a date of service in the period from 365 days before the SND to (and including) the SND.
- Acute and nonacute inpatient discharges (Inpatient Stay Value Set) with a discharge date in the period from 365 days before the SND to (and including) the SND.

**Step 2.** Assign each diagnosis to one or more comorbid Clinical Condition (CC) category using Table CC—Mapping in the Risk Adjustment Shared Tables. If the code appears more than once in Table CC—Mapping, it is assigned to multiple CCs.

Exclude all diagnoses that cannot be assigned to a comorbid CC category. For persons with no qualifying diagnoses from face-to-face encounters, skip to *Risk Adjustment Calculation*.

All digits must match exactly when mapping diagnosis codes to the comorbid CCs.

**Step 3.** Determine HCCs for each comorbid CC identified. Refer to Table HCC—Rank.

For each denominator unit's comorbid CC list, match the comorbid CC code to the comorbid CC code in the table, and assign:

- The ranking group.
- The rank.
- The HCC.

For comorbid CCs that do not match to Table HCC—Rank, use the comorbid CC as the HCC and assign a rank of 1. One comorbid CC can map to multiple HCCs; each HCC can have one or more comorbid CCs.

**Step 4.** Assess each ranking group separately and select only the highest ranked HCC in each ranking group using the “Rank” column (1 is the highest rank possible).

Drop all other HCCs in each ranking group, and de-duplicate the HCC list if necessary.

- *For example*, assume a denominator unit with the following comorbid CCs: CC-85, CC-17 and CC-19 (assume no other CCs).
  - CC-85 does not have a map to the ranking table and becomes HCC-85.
  - HCC-17 and HCC-19 are part of Diabetes Ranking Group 1. Because CC-17 is ranked higher than CC-19 in Ranking Group Diabetes 1, the comorbidity is assigned as HCC-17 for Ranking Group 1.

The final comorbidities for this denominator unit are HCC-17 and HCC-85.

**Table HCC—Rank**

Ranking Group	CC	Description	Rank	HCC
NA	CC-85	Congestive Heart Failure	NA	HCC-85
Diabetes 1	CC-17	Diabetes With Acute Complications	1	HCC-17
	CC-18	Diabetes With Chronic Complications	2	HCC-18
	CC-19	Diabetes Without Complications	3	HCC-19

**Step 5.** Identify combination HCCs listed in Table HCC—Comb.

Some combinations suggest a greater amount of risk when observed together.

- *For example*, when diabetes *and* CHF are present, an increased amount of risk is evident. Additional HCCs are selected to account for these relationships.

Compare each denominator unit's list of unique HCCs to those in the *Comorbid HCC* columns in Table HCC—Comb and assign any additional HCC conditions.

*If there are overlapping combinations, use both sets of combinations.* Based on the combinations, a denominator unit can have none, one or more of these added HCCs.

- *For example*, for a denominator unit with comorbidities HCC-17 and HCC-85 (assume no other HCCs), assign HCC-901 in addition to HCC-17 and HCC-85. This does not replace HCC-17 and HCC-85.

**Table HCC—Comb**

Comorbid HCC 1	Comorbid HCC 2	Comorbid HCC 3	HCC-Combination	HCC-Comb Description
HCC-17	HCC-85	NA	HCC-901	Combination: Diabetes and CHF
HCC-18	HCC-85	NA	HCC-901	Combination: Diabetes and CHF
HCC-19	HCC-85	NA	HCC-901	Combination: Diabetes and CHF

**Risk adjustment****Risk Adjustment Calculation**

For each SND, use the following steps to identify the 30-day and 60-day hospitalization risk adjustment weights based on discharge condition, comorbidity, age and gender.

**Step 1.** For each SND with a Discharge CC Category, link the 30-day and 60-day primary discharge weights.

**Step 2.** For each SND with a Comorbidity HCC Category, link the 30-day and 60-day weights.

**Step 3.** For each SND with a COVID-19 discharge, link the 30-day and 60-day weights.

**Step 4.** Link the 30-day and 60-day age and gender weights for each SND.

	<p><b>Step 5.</b> Sum all weights (discharge CC, comorbidities, COVID-19 discharge, age and gender) associated with each SND for each category (30-day hospitalization, 60-day hospitalization).</p> <p><b>Step 6.</b> Use the formula below to calculate the Estimated Hospitalization Risk for each SND, for each category (30-day hospitalization, 60-day hospitalization).</p> $\text{Estimated Hospitalization Risk} = \frac{e^{(\sum \text{WeightsForSND})}}{1 + e^{(\sum \text{WeightsForSND})}}$ <p><b>OR</b></p> $\text{Estimated Hospitalization Risk} = [\exp (\text{sum of weights for SND})] / [1 + \exp (\text{sum of weights for SNDs})]$ <p><b>Note:</b> "Exp" refers to the exponential or antilog function.</p> <p>Truncate the estimated hospitalization risk <i>for each SND</i> to 10 decimal places. Do not truncate or round in previous steps.</p> <p><b>Step 7.</b> Calculate the count of expected hospitalizations for each age, for each category (30-day hospitalization and 60-day hospitalization). The count of expected hospitalizations is the sum of the estimated hospitalizations risk calculated in step 6 for each SND for each age, for each category (30-day hospitalization and 60-day hospitalization).</p> $\text{Count of Expected Hospitalizations} = \sum (\text{Estimated Hospitalization Risk})$ <p><b>Step 8.</b> Use the formula below and the estimated hospitalization risk calculated in step 6 to calculate the variance for each SND, for each category (30-day hospitalization and 60-day hospitalization).</p> $\text{Variance} = \text{Estimated Hospitalization Risk} \times (1 - \text{Estimated Hospitalization Risk})$ <p>Truncate the variance <i>for each SND</i> to 10 decimal places.</p> <ul style="list-style-type: none"> <li>• <i>For example</i>, if the estimated 30-day hospitalization risk is 0.1518450741 for an SND, then the 30-day hospitalization variance for this SND is <math>0.1518450741 \times 0.8481549259 = 0.1287881475</math>.</li> </ul> <p><b>Note:</b> Organizations must sum the variances for each age when populating the variance cells in the reporting tables. When reporting, round the variance to 4 decimal places using the .5 rule.</p>
Numerator	<p><b>Acute inpatient admissions or observation stays after SND.</b></p> <p><b>Step 1.</b> For each SND, identify all acute inpatient admissions and observation stay hospitalizations with an admission date within 30 days and within 60 days after the SND date. To identify acute hospitalizations:</p> <ol style="list-style-type: none"> <li>1. Identify all acute and nonacute inpatient stays (<u>Inpatient Stay Value Set</u>) and observation stays (<u>Observation Stay Value Set</u>).</li> <li>2. Exclude nonacute inpatient stays (<u>Nonacute Inpatient Stay Value Set</u>).</li> <li>3. Identify the admission date for the hospitalization.</li> </ol>

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

Using the acute inpatient admissions or observation stays identified in step 1, identify direct transfers between acute inpatient and observation using the definition of direct transfer.

**Step 3.** Exclude planned hospitalizations with any of the following criteria on the discharge claim:

- 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](#), [Potentially Planned Post Acute Care Hospitalization Value Set](#)) without a principal acute diagnosis ([Acute Condition Value Set](#)).

#### Note

- *For hospital stays where there was a direct transfer (identified in step 2), use the original stay and any direct transfer stays to identify exclusions in this step.*
- *Count each unique acute inpatient admission or observation stay hospitalization only once toward the numerator for the last denominator event. If a single numerator event meets criteria for multiple denominator events, only count the last denominator event. For example, consider the following events:*
  - SNF stay 1: May 1–10.
  - SNF stay 2: May 15–25.
  - Acute inpatient stay: May 30–June 5.
- *The SND dates of May 10 and May 25 are included as denominator events. The acute inpatient stay counts as a numerator event only toward the last denominator event (stay 2, May 15–25).*
- *Only one inpatient admission or observation stay hospitalization may be included in the numerator for each unique SND. If there are multiple numerator events that meet criteria for a singular denominator event, only count the numerator event closest to the SND date. For example, consider the following events:*
  - SNF stay: May 1–10.
  - Observation stay: May 15–25.
  - Acute inpatient stay: May 30–June 5.

*Both the observation stay of May 15–25 and the acute inpatient stay of May 30–June 5 are within 30 days of the SND date on May 10. Only the observation stay is included in the numerator because it is the hospitalization event closest to the SND date.*

*The specifications in the second and third bullets may be applied simultaneously:*

- SNF stay 1: May 1–10.
- SNF stay 2: May 15–25.
- Acute inpatient stay 1: May 30–June 1.
- Acute inpatient stay 2: June 5–8.

	<p><i>The SND of May 10 and May 25 are included as denominator events. Acute inpatient stay 1 of May 30–June 1 counts as a numerator event only toward the last denominator event (SNF stay 2, May 15–25).</i></p> <p><i>Acute inpatient stay 2 of June 5–8 does not count toward the numerator, because the last denominator event (SNF stay 2, May 15–25) applies only toward the closest numerator event (acute inpatient stay 1, May 30–June 1).</i></p>
<b>Summary of changes</b>	<ul style="list-style-type: none"> <li>• Updated the measure description.</li> <li>• Integrated the Risk Adjustment General Guidelines into the <i>Guidance</i> section.</li> <li>• Moved the definition of “classification period” to the <i>Risk adjustment comorbidity category determination</i> section.</li> <li>• Added “direct transfer” to the <i>Definitions</i> section.</li> <li>• Added administrative gender codes to the initial population.</li> <li>• Clarified in step 2 of the denominator that SNDs with a direct transfer with a discharge date after November 1 are excluded.</li> <li>• Removed the pregnancy exclusion from the numerator.</li> </ul>
<b>Data element tables</b>	<p><b>Reporting: Denominator</b> The number of SNDs for each age group, for each category (30-day hospitalization, 60-day hospitalization), reported as the Denominator.</p> <p><b>Reporting: Numerator</b> The number of observed acute inpatient admission or observation stay hospitalizations for each age group, for each category (30-day hospitalization, 60-day hospitalization), reported as the ObservedCount.</p> <p><b>Calculated: Observed hospitalization rate</b> The number of observed acute inpatient admission or observation stay hospitalizations (ObservedCount) divided by the number of SNDs to the community (Denominator) for each age group and total, for each category (30-day hospitalization, 60-day hospitalization). Calculated by IDSS as the ObservedRate.</p> <p><b>Reporting: Count of expected hospitalizations</b></p> <p><b>Step 1.</b> Calculate the number of expected inpatient admission or observation stay hospitalizations for each age group, for each category (30-day hospitalization, 60-day hospitalization).</p> <p><b>Step 2.</b> Round to 4 decimal places using the .5 rule and report these values as the ExpectedCount.</p> <p><b>Calculated: Expected hospitalization rate</b> The number of expected acute inpatient admission or observation stay hospitalizations (ExpectedCount) divided by the number of SNDs to the community (Denominator) for each age group and total, for each category (30-day hospitalization, 60-day hospitalization). Calculated by IDSS as the ExpectedRate.</p>

	<p><b>Reporting: Variance</b></p> <p><b>Step 1.</b> Calculate the variance (<i>Risk Adjustment Calculation</i>, step 8) for each group, for each category (30-day hospitalization, 60-day hospitalization).</p> <p><b>Step 2.</b> Round to 4 decimal places using the .5 rule and report these values as the CountVariance.</p> <p><b>Calculated: O/E ratio</b></p> <p>The number of observed acute inpatient admission or observation stay hospitalizations (ObservedCount) divided by the number of expected acute inpatient admission or observation stay hospitalizations (ExpectedCount) for each age group and total, for each category (30-day hospitalization, 60-day hospitalization). Calculated by IDSS as the OE.</p> <p>Organizations that submit HEDIS data to NCQA must provide the following data elements.</p>
<b>Rules for Allowable Adjustments</b>	<p><b>Copyright and use:</b> The “Rules for Allowable Adjustments of HEDIS” (the “Rules”) describe how NCQA’s HEDIS measure specifications can be adjusted for other populations, if applicable. The Rules, reviewed and approved by NCQA measure experts, provide for expanded use of HEDIS measures without changing their clinical intent.</p> <p><b>Adjusted HEDIS measures may not be used for HEDIS health plan reporting.</b></p> <p>The measures under the Risk Adjusted Utilization domain allow two types of <i>Rules for Allowable Adjustments</i> sections:</p> <ol style="list-style-type: none"> <li>1. <i>Rules for Allowable Adjustments for Risk-Adjusted Measurement.</i> This section must be followed for adjustments when calculating the full measure specifications, which includes all risk adjusted rates (expected</li> </ol>

rates, risk adjustment, O/E) and calculation components (count of index stays, observed events).

2. *Rules for Allowable Adjustments for Observed Measurement (rates without risk adjustment)*. This section must be followed when adjusting the calculation of observed events only. When applying these adjustments, organizations must not include risk adjustment logic.

The intent of including two types of Rules is to allow organizations to adjust measures without compromising measure validity. Risk adjustment is based on statistical prediction models specifically calibrated to each measure.

**The following are the Rules for Allowable Adjustments for Risk-Adjusted Measurement of the Hospitalization Following Discharge From a Skilled Nursing Facility measure (count of SND, count of observed hospitalizations, risk adjustment determination, count of expected hospitalizations risk adjustment weighting, O/E ratio, variance).**

#### **ADJUSTMENTS ALLOWED**

- *Benefits*. Organizations are not required to use a benefit.
- *Telehealth*. Services/events that allow the use of synchronous telehealth visits, telephone visits and asynchronous telehealth (e-visits, virtual check-ins) may be stratified to identify services performed via telehealth. This adjustment is not allowed for events, numerators and exclusions that do not allow the use of telehealth.

#### **ADJUSTMENTS ALLOWED WITH LIMITS**

- *Other*. Organizations may only adjust the initial population criteria to focus on an area of interest defined by gender, sociodemographic characteristics or geographical region. NCQA recommends evaluating risk model performance and validity within adjusted populations. Organizations may not adjust for a clinical subpopulation (e.g., persons with a diabetes diagnosis).
- *Measurement period adjustments*. Organizations may only change the measurement period by 1 year.
- *Denominator*. Organizations may include denied claims to calculate the initial population. The logic may not be changed.
- *Exclusions*. The LTI exclusion is not required and may be removed.
- *Risk adjustment determination, risk adjustment weighting, expected hospitalizations, variance*. Organizations may include denied claims to calculate these events. Risk adjustment determinations, weighting and calculations of expected events logic may not be changed.
- *Numerator*. Organizations may include denied claims to calculate the numerators. Value sets and logic may not be changed.

#### **ADJUSTMENTS NOT ALLOWED**

- *Product lines*. Organizations may not adjust product lines.
- *Attribution*. Organizations are required to use enrollment criteria.
- *Ages*. The age determination dates may not be changed.
- *Supplemental data*. Supplemental data may not be used to identify initial population, denominator and numerator events.

- *Exclusions.* The hospice exclusion must be applied. Logic may not be changed.

**The following are the Rules for Allowable Adjustments for Observed Measurement of the Hospitalization Following Discharge From a Skilled Nursing Facility measure observed events (count of SND, count of observed hospitalizations).**

#### **ADJUSTMENTS ALLOWED**

- *Product lines.* When adjusting this measure to assess for observed events only, organizations are not required to use product line criteria; product lines may be combined, and all (or no) product line criteria may be used.
- *Attribution.* Organizations are not required to use enrollment criteria.
- *Benefits.* Organizations are not required to use a benefit.
- *Other.* Organizations may adjust the initial population criteria to focus on an area of interest defined by gender, race, ethnicity, socioeconomic or sociodemographic characteristics, geographic region or another characteristic.
- *Measurement period adjustments.* Organizations may adjust the measurement period.
- *Exclusions.* Hospice and LTI exclusions are not required.
- *Telehealth.* Services/events that allow the use of synchronous telehealth visits, telephone visits and asynchronous telehealth (e-visits, virtual check-ins) may be stratified to identify services performed via telehealth. This adjustment is not allowed for events, numerators and exclusions that do not allow the use of telehealth.
- *Supplemental data.* Supplemental data may be used to identify initial population, denominator, exclusion and numerator events.

#### **Adjustments allowed with limits**

- *Ages.* Age determination dates may be changed (e.g., select, "age as of June 30"). The denominator age range may not be expanded.
- *Denominator.* Organizations may include denied claims to calculate the initial population. The logic may not be changed.
- *Numerator.* Organizations may include denied claims to calculate the numerator. Value sets and logic may not be changed.

## ***Acute Hospitalizations Following Outpatient Colonoscopy (HFC)***

<b>Measure title</b>	Acute Hospitalizations Following Outpatient Colonoscopy	<b>Measure ID</b>	HFC
<b>Description</b>	For persons 65 years of age and older, the risk-adjusted ratio of observed-to-expected unplanned acute hospitalizations (inpatient and observation stays) for any diagnosis that occurred within 15 days following select outpatient colonoscopies.		
<b>Measurement period</b>	January 1—December 31.		
<b>Copyright and disclaimer notice</b>	<p>Refer to the complete copyright and disclaimer information at the front of this publication.</p> <p>NCQA website: <a href="http://www.ncqa.org">www.ncqa.org</a>.</p> <p>Submit policy clarification support questions via My NCQA (<a href="https://my.ncqa.org">https://my.ncqa.org</a>).</p>		
<b>Clinical recommendation statement/ rationale</b>	<p>Advances in surgical technologies, perioperative care and payment structures have increased the number and variety of surgical procedures performed in outpatient settings. The most common complications requiring hospitalization following colonoscopies are perforations and gastrointestinal bleeding. Potentially avoidable hospitalizations can reduce the costs and quality benefits of transitioning procedures to outpatient settings and can be mitigated through appropriate preprocedural risk assessments, intraprocedural recognition of adverse events and care coordination with patients.</p>		
<b>Citations</b>	<p>Bongiovanni, T., C. Parzynski, I. Ranasinghe, M.A. Steinman, &amp; J.S. Ross. 2021. “Unplanned Hospital Visits After Ambulatory Surgical Care.” <i>PLoS one</i> 16(7), e0254039. <a href="https://doi.org/10.1371/journal.pone.0254039">https://doi.org/10.1371/journal.pone.0254039</a></p> <p>Cullen, K.A., M.J. Hall, A. Golosinskiy. 2009. <i>Ambulatory Surgery in the United States, 2006</i>. National Health Statistics Reports; no 11. Revised. Hyattsville, MD: National Center for Health Statistics.</p> <p>Ko, C.W., S. Riffle, L. Michaels, C. Morris, J. Holub, J.A. Shapiro, M.A. Ciol, M.B. Kimmey, L.C. Seeff, &amp; D. Lieberman. 2010. “Serious Complications Within 30 Days of Screening and Surveillance Colonoscopy Are Uncommon.” <i>Clinical Gastroenterology and Hepatology : The Official Clinical Practice Journal of the American Gastroenterological Association</i> 8(2), 166. <a href="https://doi.org/10.1016/j.cgh.2009.10.007">https://doi.org/10.1016/j.cgh.2009.10.007</a></p>		
<b>Characteristics</b>			
<b>Scoring</b>	Ratio.		
<b>Product lines</b>	Medicare.		
<b>Stratifications</b>	None.		

Guidance	Risk Adjustment Measure Specific Guidance
	<p><b>Observation stays:</b> For observation stays (<u>Observation Stay Value Set</u>) that do not have a recorded admission or discharge date, set the admission date to the earliest date of service on the claim and set the discharge date to the last date of service on the claim.</p> <p><b>Which services count?</b></p> <ul style="list-style-type: none"> <li>• Use all paid, suspended, pending and denied claims when applying risk adjustment comorbidity category determination and the hospice exclusion.</li> <li>• Do not include denied claims when identifying all other events (e.g., denominator events or observed events in the other risk adjusted utilization measures); only report claims the organization paid for or expects to pay for (i.e., claims incurred but not paid).</li> </ul> <p><b>Supplemental data exceptions:</b> Supplemental data may only be used for the hospice exclusion.</p> <p><b>Transfers:</b></p> <ul style="list-style-type: none"> <li>• Treat transfers <i>between</i> institutions as separate admissions.</li> <li>• Base transfer reports <i>within</i> an institution on the type and level of services provided.</li> <li>• Report separate admissions when the transfer is between acute and nonacute levels of service or between mental health/chemical dependency services and non-mental health/chemical dependency services.</li> <li>• Count only one admission when the transfer takes place within the same service category, but to a different level of care (e.g., from intensive care to a lesser level of care; from a lesser level of care to intensive care).</li> </ul> <p><b>Risk adjustment:</b> Organizations may not use risk assessment protocols to supplement diagnoses for calculation of the risk adjustment scores for these measures. The measurement model was developed and tested using only claims-based diagnoses; diagnoses from additional data sources would affect the validity of the models as they are currently implemented in the specification.</p> <p><b>General Rules</b></p> <p><b>Data collection methodology:</b> Administrative. Refer to <a href="#">General Guideline: Data Collection Methods</a> for additional information.</p> <p><b>Date specificity:</b> Dates must be specific enough to determine the event occurred in the period being measured.</p> <p><b>Other guidance:</b> The measure is based on episodes; therefore, it is possible for the denominator to include multiple events for the same person.</p> <p><b>Improvement notation:</b> To interpret the ratio as better or worse than expected, the ratio must be calibrated. Organizations can calibrate ratios by dividing individual organization ratios or national percentiles by the national average ratios. Organizations may be more successful at achieving fewer hospitalizations than expected, given the types of cases treated by the organization (calibrated ratio with a value &lt;1.0), or may be less successful (calibrated ratio with a value &gt;1.0).</p>

<b>Definitions</b>	
<b>Direct transfer</b>	When the discharge date from the initial stay precedes the admission date to a subsequent stay by 1 calendar day or less. <ul style="list-style-type: none"> <li>• <i>For example:</i> <ul style="list-style-type: none"> <li>– A discharge on June 1, followed by a subsequent admission on June 1 or June 2, <i>is a direct transfer</i>.</li> <li>– A discharge on June 1, followed by a subsequent admission on June 3, <i>is not a direct transfer</i>; these are two distinct stays.</li> <li>– A discharge on June 1, followed by a subsequent admission on June 2 (with discharge on June 3), followed by a subsequent admission on June 4, <i>is a direct transfer</i>.</li> </ul> </li> </ul> <p>Direct transfers may occur between different facilities, and between acute inpatient and observation.</p>
<b>Outpatient colonoscopy episode</b>	A qualifying outpatient colonoscopy that occurs on or between January 1 and December 16 of the measurement period, as identified in the denominator.
<b>Outpatient colonoscopy episode date</b>	The date of service for a qualifying outpatient colonoscopy episode. For episodes that span more than 1 calendar day, use the last service date as the episode date.
<b>Planned hospital stay</b>	A hospital stay that meets criteria in step 3 of the numerator.
<b>Initial population</b>	<p><i>Measure item count:</i> Episode.</p> <p><i>Attribution basis:</i> Enrollment.</p> <ul style="list-style-type: none"> <li>• <i>Benefits:</i> Medical.</li> <li>• <i>Continuous enrollment:</i> 365 days prior to the outpatient colonoscopy episode date through 15 days after the episode date.</li> <li>• <i>Allowable gap:</i> <ul style="list-style-type: none"> <li>– <i>365 days prior to the outpatient colonoscopy episode:</i> No more than one gap of &lt;45 days.</li> <li>– <i>Outpatient colonoscopy episode through 15 days after the episode:</i> No gaps.</li> </ul> </li> </ul> <p><i>Ages:</i> 65 years of age and older as of the outpatient colonoscopy episode.</p> <p><i>Gender/Sex criteria:</i></p> <ul style="list-style-type: none"> <li>• Administrative Gender of Female (AdministrativeGender code female).</li> <li>• Administrative Gender of Male (AdministrativeGender code male).</li> </ul> <p><b><i>Exclusion: Persons in hospice or using hospice services.</i></b>      Persons who use hospice services (<u>Hospice Encounter Value Set</u>; <u>Hospice Intervention Value Set</u>) or elect to use a hospice benefit any time during the measurement period. Organizations that use the Monthly Membership Detail Data File to identify these persons must use only the run date of the file.</p>

<b>Denominator</b>	<p><b>Outpatient colonoscopy episodes.</b></p> <p><b>Step 1.</b> Identify outpatient colonoscopy episodes on or between January 1 and December 16 of the measurement period:</p> <ol style="list-style-type: none"> <li>1. Identify all outpatient colonoscopy episodes (<u>Routine Colonoscopy Value Set with Ambulatory Surgery POS Value Set</u>).</li> <li>2. Identify the outpatient colonoscopy episode date.</li> </ol> <p><b>Step 2.</b> Exclude outpatient colonoscopy episodes that meet any of the following criteria:</p> <ul style="list-style-type: none"> <li>• Occurs the day before an inpatient stay (<u>Inpatient Stay Value Set</u>) or observation stay (<u>Observation Stay Value Set</u>) admission date or at any time during an inpatient or observation stay.</li> <li>• Occurs concurrently (on the same claim) with a high-risk GI endoscopy procedure (<u>High Risk Upper GI Endoscopy Value Set</u>).</li> <li>• Followed by a subsequent outpatient colonoscopy (<u>Routine Colonoscopy Value Set with Ambulatory Surgery POS Value Set</u>) within 15 days following the episode date.</li> <li>• History or current diagnosis of irritable bowel diseases (<u>Irritable Bowel Diseases Value Set</u>) 365 days prior to the outpatient colonoscopy episode date through 15 days after the episode date.</li> </ul>
<b>Risk adjustment factors</b>	<p><b>Risk Adjustment Determination</b></p> <p>For each outpatient colonoscopy episode, identify risk adjustment weights based on comorbidity, age and gender.</p> <p><b>Comorbidities:</b></p> <p><b>Step 1.</b> Identify all diagnoses for encounters during the 365 days prior to and on the date of the outpatient colonoscopy episode date. Include the following when identifying encounters:</p> <ul style="list-style-type: none"> <li>• Outpatient visits, ED visits, telephone visits, nonacute inpatient encounters and acute inpatient encounters (<u>Outpatient, ED, Telephone, Acute Inpatient and Nonacute Inpatient Value Set</u>) with a date of service 365 days prior to and on the date of the colonoscopy episode date.</li> <li>• Acute and nonacute inpatient discharges (<u>Inpatient Stay Value Set</u>) with a discharge date 365 days prior to and on the date of the colonoscopy episode date.</li> <li>• Outpatient colonoscopy episodes (<u>Routine Colonoscopy Value Set with Ambulatory Surgery POS Value Set</u>).</li> </ul> <p><b>Step 2.</b> Assign each diagnosis to one or more comorbid Clinical Condition (CC) category using Table CC—Mapping in the Risk Adjustment Shared Tables. If the code appears more than once in Table CC—Mapping, it is assigned to multiple CCs.</p> <p>Exclude all diagnoses that cannot be assigned to a comorbid CC category. For denominator units with no qualifying diagnoses from face-to-face encounters, skip to <i>Risk Adjustment Calculation</i>.</p>

	All digits must match exactly when mapping diagnosis codes to the comorbid CCs.																							
	<b>Step 3.</b> Determine HCCs for each comorbid CC identified. Refer to Table HCC—Rank.  For each denominator unit's comorbid CC list, match the comorbid CC code to the comorbid CC code in the table, and assign: <ul style="list-style-type: none"><li>• The ranking group.</li><li>• The rank.</li><li>• The HCC.</li></ul> For comorbid CCs that do not match to Table HCC—Rank, use the comorbid CC as the HCC and assign a rank of 1. One comorbid CC can map to multiple HCCs; each HCC can have one or more comorbid CCs.																							
	<b>Step 4.</b> Assess each ranking group separately and select only the highest ranked HCC in each ranking group using the "Rank" column (1 is the highest rank possible).  Drop all other HCCs in each ranking group, and de-duplicate the HCC list if necessary. <ul style="list-style-type: none"><li>• <i>For example</i>, assume a denominator unit with the following comorbid CCs: CC-85, CC-17 and CC-19 (assume no other CCs).<ul style="list-style-type: none"><li>– CC-85 does not have a map to the ranking table and becomes HCC-85.</li><li>– HCC-17 and HCC-19 are part of Diabetes Ranking Group 1. Because CC-17 is ranked higher than CC-19 in Ranking Group Diabetes 1, the comorbidity is assigned as HCC-17 for Ranking Group 1.</li></ul></li></ul> The final comorbidities for this denominator unit are HCC-17 and HCC-85.																							
	<b>Table HCC—Rank</b> <table border="1"> <thead> <tr> <th>Ranking Group</th><th>CC</th><th>Description</th><th>Rank</th><th>HCC</th></tr> </thead> <tbody> <tr> <td>NA</td><td>CC-85</td><td>Congestive Heart Failure</td><td>NA</td><td>HCC-85</td></tr> <tr> <td rowspan="3">Diabetes 1</td><td>CC-17</td><td>Diabetes With Acute Complications</td><td>1</td><td>HCC-17</td></tr> <tr> <td>CC-18</td><td>Diabetes With Chronic Complications</td><td>2</td><td>HCC-18</td></tr> <tr> <td>CC-19</td><td>Diabetes Without Complications</td><td>3</td><td>HCC-19</td></tr> </tbody> </table>	Ranking Group	CC	Description	Rank	HCC	NA	CC-85	Congestive Heart Failure	NA	HCC-85	Diabetes 1	CC-17	Diabetes With Acute Complications	1	HCC-17	CC-18	Diabetes With Chronic Complications	2	HCC-18	CC-19	Diabetes Without Complications	3	HCC-19
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	<b>Step 5.</b> Identify combination HCCs listed in Table HCC—Comb.  Some combinations suggest a greater amount of risk when observed together. <ul style="list-style-type: none"><li>• <i>For example</i>, when diabetes and CHF are present, an increased amount of risk is evident. Additional HCCs are selected to account for these relationships.</li></ul> Compare each denominator unit's list of unique HCCs to those in the <i>Comorbid HCC</i> columns in Table HCC—Comb and assign any additional HCC conditions.																							

Comorbid HCC 1	Comorbid HCC 2	Comorbid HCC 3	HCC-Combination	HCC-Comb Description
HCC-17	HCC-85	NA	HCC-901	Combination: Diabetes and CHF
HCC-18	HCC-85	NA	HCC-901	Combination: Diabetes and CHF
HCC-19	HCC-85	NA	HCC-901	Combination: Diabetes and CHF




	<p><i>If there are overlapping combinations, use both sets of combinations.</i> Based on the combinations, a denominator unit can have none, one or more of these added HCCs.</p> <ul style="list-style-type: none"> <li>• For example, for a denominator unit with comorbidities HCC-17 and HCC-85 (assume no other HCCs), assign HCC-901 in addition to HCC-17 and HCC-85. This does not replace HCC-17 and HCC-85.</li> </ul> <p><b>Table HCC—Comb</b></p> <table border="1"> <thead> <tr> <th>Comorbid HCC 1</th><th>Comorbid HCC 2</th><th>Comorbid HCC 3</th><th>HCC-Combination</th><th>HCC-Comb Description</th></tr> </thead> <tbody> <tr> <td>HCC-17</td><td>HCC-85</td><td>NA</td><td>HCC-901</td><td>Combination: Diabetes and CHF</td></tr> <tr> <td>HCC-18</td><td>HCC-85</td><td>NA</td><td>HCC-901</td><td>Combination: Diabetes and CHF</td></tr> <tr> <td>HCC-19</td><td>HCC-85</td><td>NA</td><td>HCC-901</td><td>Combination: Diabetes and CHF</td></tr> </tbody> </table>	Comorbid HCC 1	Comorbid HCC 2	Comorbid HCC 3	HCC-Combination	HCC-Comb Description	HCC-17	HCC-85	NA	HCC-901	Combination: Diabetes and CHF	HCC-18	HCC-85	NA	HCC-901	Combination: Diabetes and CHF	HCC-19	HCC-85	NA	HCC-901	Combination: Diabetes and CHF
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Risk adjustment	<p><b>Risk Adjustment Calculation</b></p> <p>For each outpatient colonoscopy episode, use the following steps to identify the 15-day hospitalization risk adjustment weights based on comorbidity, age and gender.</p> <p><b>Step 1.</b> For each outpatient colonoscopy episode with a Comorbidity HCC category, link the comorbidity weights.</p> <p><b>Step 2.</b> Link the age and gender weights for each outpatient colonoscopy episode.</p> <p><b>Step 3.</b> Sum all weights (comorbidities, age and gender) associated with each outpatient colonoscopy episode and use the formula below to calculate the estimated hospitalization risk for each episode:</p> $\text{Estimated Hospitalization Risk} = \frac{e^{(\sum \text{WeightsForEpisode})}}{1+e^{(\sum \text{WeightsForEpisode})}}$ <p><b>OR</b></p> $\text{Estimated Hospitalization Risk} = [\exp (\text{sum of weights for episode})] / [1 + \exp (\text{sum of weights for episode})]$ <p><b>Note:</b> "Exp" refers to the exponential or antilog function.</p> <p>Truncate the estimated hospitalization risk for each episode to 10 decimal places. Do not truncate or round in previous steps.</p> <p><b>Step 4.</b> Calculate the count of expected hospitalizations for each age. The count of expected hospitalizations is the sum of the estimated hospitalizations risk for each outpatient colonoscopy episode for each age.</p> $\text{Count of Expected Hospitalizations} = \sum (\text{Estimated Hospitalization Risk})$ <p><b>Step 5.</b> Use the formula below and the estimated hospitalization risk calculated in step 4 to calculate the variance for each outpatient colonoscopy episode.</p>																				

	<p>Variance = Estimated Hospitalization Risk x (1 – Estimated Hospitalization Risk)</p> <p>Truncate the variance for each outpatient colonoscopy episode to 10 decimal places.</p> <ul style="list-style-type: none"> <li>• <i>For example</i>, if the estimated hospitalization risk is 0.1518450741 for an outpatient colonoscopy episode, then the hospitalization variance for this episode is <math>0.1518450741 \times 0.8481549259 = 0.1287881475</math>.</li> </ul> <p><b>Note:</b> Organizations must sum the variances for each age when populating the variance cells in the reporting tables. When reporting, round the variance to 4 decimal places using the .5 rule.</p>
Numerator	<p><b>Acute hospitalization within 15 days of the outpatient colonoscopy episode.</b></p> <p><b>Step 1.</b> For each outpatient colonoscopy episode, identify all acute inpatient admissions and observation stay hospitalizations with an admission date within 15 days after the outpatient colonoscopy episode.</p> <p>To identify acute inpatient and observation admissions:</p> <ol style="list-style-type: none"> <li>1. Identify all acute and nonacute inpatient stays (<u>Inpatient Stay Value Set</u>) and observation stays (<u>Observation Stay Value Set</u>).</li> <li>2. Exclude nonacute inpatient stays (<u>Nonacute Inpatient Stay Value Set</u>).</li> <li>3. Identify the admission date for the stay.</li> </ol> <p><b>Step 2.</b> For discharges with one or more direct transfers, use the last discharge.</p> <p>Using the discharges identified in step 1, identify direct transfers between acute inpatient and observation using the definition of direct transfer.</p> <p><b>Step 3.</b> For the remaining discharges, exclude inpatient and observation stay discharges with any of the following criteria on the discharge claim:</p> <ul style="list-style-type: none"> <li>• A principal diagnosis of a malignant neoplasm (<u>Malignant Neoplasms Value Set</u>, <u>Other Malignant Neoplasm of Skin Value Set</u>).</li> <li>• A planned hospital stay using any of the following: <ul style="list-style-type: none"> <li>– A principal diagnosis of maintenance chemotherapy (<u>Chemotherapy Encounter Value Set</u>).</li> <li>– A principal diagnosis of rehabilitation (<u>Rehabilitation Value Set</u>).</li> <li>– An organ transplant (<u>Kidney Transplant Value Set</u>, <u>Bone Marrow Transplant Value Set</u>, <u>Organ Transplant Other Than Kidney Value Set</u>, <u>Introduction of Autologous Pancreatic Cells Value Set</u>).</li> <li>– A potentially planned procedure (<u>Potentially Planned Procedures Value Set</u>) without a principal acute diagnosis (<u>Acute Condition Value Set</u>).</li> </ul> </li> </ul> <p><b>Note</b></p> <ul style="list-style-type: none"> <li>• 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.</li> </ul>

	<ul style="list-style-type: none"> <li>Only one inpatient admission or observation stay hospitalization may be included in the numerator for each unique outpatient colonoscopy episode denominator event. If there are multiple numerator events that meet criteria for a singular denominator event, only count the numerator event closest to the outpatient colonoscopy episode.</li> </ul> <p>For example, consider the following events:</p> <ul style="list-style-type: none"> <li>Outpatient colonoscopy episode: May 10.</li> <li>Observation stay: May 13–14.</li> <li>Acute inpatient stay: May 16–20.</li> </ul> <p>Both the observation stay of May 13–14 and the acute inpatient stay of May 16–20 are within 15 days of the outpatient colonoscopy episode on May 10. Only the observation stay is included in the numerator because it is the hospitalization event closest to the outpatient colonoscopy episode.</p>
<b>Summary of changes</b>	<ul style="list-style-type: none"> <li>This is a first-year measure.</li> </ul>
<b>Data element tables</b>	<p><b>Reporting: Denominator</b> The number of outpatient colonoscopy episodes, reported as the Denominator.</p> <p><b>Reporting: Numerator</b> The number of observed acute inpatient admission or observation stay hospitalizations, reported as the ObservedCount.</p> <p><b>Calculated: Observed hospitalization rate</b> The number of observed acute inpatient admission or observation stay hospitalizations (ObservedCount) divided by the number of outpatient colonoscopy episodes (Denominator). Calculated by IDSS as the ObservedRate.</p> <p><b>Reporting: Count of expected hospitalizations</b></p> <p><b>Step 1.</b> Calculate the number of expected inpatient admission or observation stay hospitalizations.</p> <p><b>Step 2.</b> Round to 4 decimal places using the .5 rule and report these values as the ExpectedCount.</p> <p><b>Calculated: Expected hospitalization rate</b> The number of expected acute inpatient admission or observation stay hospitalizations (ExpectedCount) divided by the number of outpatient colonoscopy episodes (Denominator). Calculated by IDSS as the ExpectedRate.</p> <p><b>Reporting: Variance</b></p> <p><b>Step 1.</b> Calculate the variance (<i>Risk Adjustment Calculation</i>, step 5).</p> <p><b>Step 2.</b> Round to 4 decimal places using the .5 rule and report these values as the CountVariance.</p> <p><b>Calculated: O/E ratio</b> The number of observed acute inpatient admission or observation stay hospitalizations (ObservedCount) divided by the number of expected acute inpatient admissions or observation stay hospitalizations (ExpectedCount). Calculated by IDSS as the OE.</p>

	<p>Organizations that submit HEDIS data to NCQA must provide the following data elements.</p> <p><b>Table HFC-3: Data Elements for Acute Hospitalizations Following Outpatient Colonoscopy</b></p> <table border="1"> <thead> <tr> <th>Metric</th><th>Data Element</th><th>Reporting Instructions</th></tr> </thead> <tbody> <tr> <td>Colonoscopy</td><td>Denominator</td><td>Report once</td></tr> <tr> <td></td><td>ObservedCount</td><td>Report once</td></tr> <tr> <td></td><td>ObservedRate</td><td>ObservedCount / Denominator (Percent)</td></tr> <tr> <td></td><td>ExpectedCount</td><td>Report once</td></tr> <tr> <td></td><td>ExpectedRate</td><td>ExpectedCount / Denominator (Percent)</td></tr> <tr> <td></td><td>CountVariance</td><td>Report once</td></tr> <tr> <td></td><td>OE</td><td>ObservedCount / ExpectedCount</td></tr> </tbody> </table>	Metric	Data Element	Reporting Instructions	Colonoscopy	Denominator	Report once		ObservedCount	Report once		ObservedRate	ObservedCount / Denominator (Percent)		ExpectedCount	Report once		ExpectedRate	ExpectedCount / Denominator (Percent)		CountVariance	Report once		OE	ObservedCount / ExpectedCount
Metric	Data Element	Reporting Instructions																							
Colonoscopy	Denominator	Report once																							
	ObservedCount	Report once																							
	ObservedRate	ObservedCount / Denominator (Percent)																							
	ExpectedCount	Report once																							
	ExpectedRate	ExpectedCount / Denominator (Percent)																							
	CountVariance	Report once																							
	OE	ObservedCount / ExpectedCount																							
Rules for Allowable Adjustments	<p><b>Copyright and use:</b> The “Rules for Allowable Adjustments of HEDIS” (the “Rules”) describe how NCQA’s HEDIS measure specifications can be adjusted for other populations, if applicable. The Rules, reviewed and approved by NCQA measure experts, provide for expanded use of HEDIS measures without changing their clinical intent.</p> <p><b>Adjusted HEDIS measures may not be used for HEDIS health plan reporting.</b></p> <p>The measures under the Risk Adjusted Utilization domain allow two types of <i>Rules for Allowable Adjustments</i> sections:</p> <ol style="list-style-type: none"> <li>1. <i>Rules for Allowable Adjustments for Risk-Adjusted Measurement.</i> This section must be followed for adjustments when calculating the full measure specifications, which includes all risk adjusted rates (expected rates, risk adjustment, O/E) and calculation components (count of index stays, observed events).</li> <li>2. <i>Rules for Allowable Adjustments for Observed Measurement (rates without risk adjustment).</i> This section must be followed when adjusting the calculation of observed events only. When applying these adjustments, organizations must not include risk adjustment logic.</li> </ol> <p>The intent of including two types of Rules is to allow organizations to adjust measures without compromising measure validity. Risk adjustment is based on statistical prediction models specifically calibrated to each measure.</p> <p><b>The following are the Rules for Allowable Adjustments for <u>Risk-Adjusted Measurement</u> of the Acute Hospitalizations Following Outpatient Colonoscopy measure (expected hospitalization rate, risk adjustment determination, risk adjustment weighting, variance, O/E ratio).</b></p> <p><b>ADJUSTMENTS ALLOWED</b></p> <ul style="list-style-type: none"> <li>• <i>Benefits.</i> Organizations are not required to use a benefit.</li> <li>• <i>Telehealth.</i> Services/events that allow the use of synchronous telehealth visits, telephone visits and asynchronous telehealth (e-visits, virtual check-ins) may be stratified to identify services performed via telehealth. This</li> </ul>																								

	<p>adjustment is not allowed for events, numerators and exclusions that do not allow the use of telehealth.</p> <p><b>ADJUSTMENTS ALLOWED WITH LIMITS</b></p> <ul style="list-style-type: none"> <li>• <i>Other.</i> Organizations may only adjust the initial population criteria to focus on an area of interest defined by gender, sociodemographic characteristics or geographical region. NCQA recommends evaluating risk model performance and validity within adjusted populations. Organizations may not adjust for a clinical subpopulation (e.g., persons with a diabetes diagnosis).</li> <li>• <i>Measurement period adjustments.</i> Organizations may only change the measurement period by 1 year.</li> <li>• <i>Denominator.</i> Organizations may include denied claims to calculate denominator events. Value sets and logic may not be changed.</li> <li>• <i>Risk adjustment determination, risk adjustment weighting, expected hospitalizations, variance.</i> Organizations may include denied claims to calculate these events. Risk adjustment determinations, weighting and calculations of expected events logic may not be changed.</li> <li>• <i>Numerator.</i> Organizations may include denied claims to calculate the numerator. Value sets and logic may not be changed.</li> </ul> <p><b>ADJUSTMENTS NOT ALLOWED</b></p> <ul style="list-style-type: none"> <li>• <i>Product lines.</i> Organizations may not adjust product lines.</li> <li>• <i>Attribution.</i> Organizations are required to use enrollment criteria.</li> <li>• <i>Ages.</i> The age determination dates may not be changed.</li> <li>• <i>Supplemental data.</i> Supplemental data may not be used to identify initial population (with the exception of the hospice exclusion), denominator and numerator events.</li> <li>• <i>Exclusions.</i> The hospice exclusion must be applied. Logic may not be changed.</li> </ul> <p><b>The following are the Rules for Allowable Adjustments for <u>Observed Measurement</u> of the Acute Hospitalizations Following Outpatient Colonoscopy measure observed events (denominator, numerator, observed hospitalization rate).</b></p> <p><b>ADJUSTMENTS ALLOWED</b></p> <ul style="list-style-type: none"> <li>• <i>Product lines.</i> When adjusting this measure to assess for observed events only, organizations are not required to use product line criteria; product lines may be combined, and all (or no) product line criteria may be used.</li> <li>• <i>Ages.</i> The observed event age range may be expanded. Age determination dates may be changed (e.g., select, “age as of June 30”).</li> <li>• <i>Attribution.</i> Organizations are not required to use enrollment criteria.</li> <li>• <i>Benefits.</i> Organizations are not required to use a benefit.</li> <li>• <i>Other.</i> Organizations may adjust the initial population criteria to focus on an area of interest defined by gender, race, ethnicity, socioeconomic or sociodemographic characteristics, geographic region or another characteristic.</li> </ul>
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- *Measurement period adjustments.* Organizations may adjust the measurement period.
- *Exclusions.* Hospice exclusion is not required.
- *Telehealth.* Services/events that allow the use of synchronous telehealth visits, telephone visits and asynchronous telehealth (e-visits, virtual check-ins) may be stratified to identify services performed via telehealth. This adjustment is not allowed for events, numerators and exclusions that do not allow the use of telehealth.
- *Supplemental data.* Supplemental data may be used to identify initial population, denominator, exclusion and numerator events.

**ADJUSTMENTS ALLOWED WITH LIMITS**

- *Denominator.* Organizations may include denied claims to calculate denominator events. Value sets and logic may not be changed.
- *Numerator.* Organizations may include denied claims to calculate the numerator. Value sets and logic may not be changed.

## **Acute Hospitalizations Following Outpatient General Surgery (HFG)**

<b>Measure title</b>	Acute Hospitalizations Following Outpatient General Surgery	<b>Measure ID</b>	HFG
<b>Description</b>	For persons 65 years of age and older, the risk-adjusted ratio of observed-to-expected unplanned acute hospitalizations (inpatient and observation stays) for any diagnosis that occurred within 15 days following select outpatient general surgeries.		
<b>Measurement period</b>	January 1–December 31.		
<b>Copyright and disclaimer notice</b>	<p>Refer to the complete copyright and disclaimer information at the front of this publication.</p> <p>NCQA website: <a href="http://www.ncqa.org">www.ncqa.org</a>.</p> <p>Submit policy clarification support questions via My NCQA (<a href="https://my.ncqa.org">https://my.ncqa.org</a>).</p>		
<b>Clinical recommendation statement/rationale</b>	<p>Advances in surgical technologies, perioperative care and payment structures have increased the number and variety of surgical procedures performed in outpatient settings. The most common reason for hospital visits following nonselective general surgery procedures is surgical site infections, which negatively impact patient outcomes and are associated with significant financial costs. Postoperative complications can be better identified and managed through a multidisciplinary approach to postoperative care coordination, technological advancements allowing for improved patient communication and adherence to evidence-based methods during preoperative risk assessments.</p>		
<b>Citations</b>	<p>Bongiovanni, T., C. Parzynski, I. Ranasinghe, M.A. Steinman, &amp; J.S. Ross. 2021. “Unplanned Hospital Visits After Ambulatory Surgical Care.” <i>PLoS one</i> 16(7), e0254039. <a href="https://doi.org/10.1371/journal.pone.0254039">https://doi.org/10.1371/journal.pone.0254039</a></p> <p>Cullen, K.A., M.J. Hall, A. Golosinski. 2009. <i>Ambulatory Surgery in the United States, 2006</i>. National Health Statistics Reports; no 11. Revised. Hyattsville, MD: National Center for Health Statistics.</p> <p>Javed, H., O.A. Olanrewaju, F. Ansah Owusu, A. Saleem, P. Pavani, H. Tariq, B.S. Vasquez Ortiz, R. Ram, &amp; G. Varrassi. 2023. “Challenges and Solutions in Postoperative Complications: A Narrative Review in General Surgery.” <i>Cureus</i>, 15(12), e50942. <a href="https://doi.org/10.7759/cureus.50942">https://doi.org/10.7759/cureus.50942</a></p> <p>Rossi, I.R., S.W. Ross, A.K. May, &amp; C.E. Reinke. 2021. “Readmission After Emergency General Surgery: NSQIP Review of Risk, Cause and Ideal Follow-Up.” <i>Journal of Surgical Research</i>, 260, 359–68. <a href="https://doi.org/10.1016/j.jss.2020.11.035">https://doi.org/10.1016/j.jss.2020.11.035</a></p>		
<b>Characteristics</b>			
<b>Scoring</b>	Ratio.		
<b>Product lines</b>	Medicare.		

<b>Stratifications</b>	None.
<b>Guidance</b>	<p><b>Risk Adjustment Measure-Specific Guidance</b></p> <p><b>Observation stays:</b> For observation stays (<u>Observation Stay Value Set</u>) that do not have a recorded admission or discharge date, set the admission date to the earliest date of service on the claim and set the discharge date to the last date of service on the claim.</p> <p><b>Which services count?</b></p> <ul style="list-style-type: none"> <li>• Use all paid, suspended, pending, and denied claims when applying risk adjustment comorbidity category determination and the hospice exclusion.</li> <li>• Do not include denied claims when identifying all other events (e.g., denominator events or observed events in the other risk adjusted utilization measures); only report claims the organization paid for or expects to pay for (i.e., claims incurred but not paid).</li> </ul> <p><b>Supplemental data exceptions:</b> Supplemental data may only be used for the hospice exclusion.</p> <p><b>Transfers:</b></p> <ul style="list-style-type: none"> <li>• Treat transfers <i>between</i> institutions as separate admissions.</li> <li>• Base transfer reports <i>within</i> an institution on the type and level of services provided.</li> <li>• Report separate admissions when the transfer is between acute and nonacute levels of service or between mental health/chemical dependency services and non-mental health/chemical dependency services.</li> <li>• Count only one admission when the transfer takes place within the same service category, but to a different level of care (e.g., from intensive care to a lesser level of care; from a lesser level of care to intensive care).</li> </ul> <p><b>Risk adjustment:</b> Organizations may not use risk assessment protocols to supplement diagnoses for calculation of the risk adjustment scores for these measures. The measurement model was developed and tested using only claims-based diagnoses; diagnoses from additional data sources would affect the validity of the models as they are currently implemented in the specification.</p> <p><b>General Rules</b></p> <p><b>Data collection methodology:</b> Administrative. Refer to <a href="#">General Guideline: Data Collection Methods</a> for additional information.</p> <p><b>Date specificity:</b> Dates must be specific enough to determine the event occurred in the period being measured.</p> <p><b>Other guidance:</b> The measure is based on episodes; therefore, it is possible for the denominator to include multiple events for the same person.</p> <p><b>Improvement notation:</b> To interpret the ratio as better or worse than expected, the ratio must be calibrated. Organizations can calibrate ratios by dividing individual organization ratios or national percentiles by the national average ratios. Organizations may be more successful at achieving fewer hospitalizations than expected, given the types of cases treated by the</p>

	organization (calibrated ratio with a value <1.0), or may be less successful (calibrated ratio with a value >1.0).
<b>Definitions</b>	
<b>Direct transfer</b>	<p>When the discharge date from the initial stay precedes the admission date to a subsequent stay by 1 calendar day or less.</p> <ul style="list-style-type: none"> <li>• <i>For example:</i> <ul style="list-style-type: none"> <li>– A discharge on June 1, followed by a subsequent admission on June 1 or June 2, <i>is a direct transfer</i>.</li> <li>– A discharge on June 1, followed by a subsequent admission on June 3, <i>is not a direct transfer</i>; these are two distinct stays.</li> <li>– A discharge on June 1, followed by a subsequent admission on June 2 (with discharge on June 3), followed by a subsequent admission on June 4, <i>is a direct transfer</i>.</li> </ul> </li> </ul> <p>Direct transfers may occur between different facilities, and between acute inpatient and observation.</p>
<b>Outpatient general surgery episode</b>	A qualifying outpatient general surgery that occurs on or between January 1 and December 16 of the measurement period, as identified in the denominator.
<b>Outpatient general surgery episode date</b>	<p>The date of service for a qualifying outpatient general surgery episode.</p> <p>For episodes that span more than 1 calendar day, use the last service date as the episode date.</p>
<b>Planned hospital stay</b>	A hospital stay that meets criteria in step 3 of the numerator.
<b>Initial population</b>	<p><i>Measure item count:</i> Episode.</p> <p><i>Attribution basis:</i> Enrollment.</p> <ul style="list-style-type: none"> <li>• <i>Benefits:</i> Medical.</li> <li>• <i>Continuous enrollment:</i> 365 days prior to the outpatient general surgery episode date through 15 days after the episode date.</li> <li>• <i>Allowable gap:</i> <ul style="list-style-type: none"> <li>– <i>365 days prior to the date of the outpatient general surgery episode:</i> No more than one gap of ≤45 days.</li> <li>– <i>Outpatient general surgery episode through 15 days after the episode:</i> No gaps.</li> </ul> </li> </ul> <p><i>Ages:</i> 65 years of age and older as of the outpatient general surgery episode date.</p> <p><i>Gender/Sex criteria:</i></p> <ul style="list-style-type: none"> <li>• Administrative Gender of Female (AdministrativeGender code female).</li> <li>• Administrative Gender of Male (AdministrativeGender code male).</li> </ul>

	<p><b>Exclusion: Persons in hospice or using hospice services.</b></p> <p>Persons who use hospice services (<u>Hospice Encounter Value Set</u>; <u>Hospice Intervention Value Set</u>) or elect to use a hospice benefit any time during the measurement period. Organizations that use the Monthly Membership Detail Data File to identify these persons must use only the run date of the file.</p>
<b>Denominator</b>	<p><b>Outpatient general surgery episodes.</b></p> <p><b>Step 1.</b> Identify outpatient general surgery episodes on or between January 1 and December 16 of the measurement period:</p> <ol style="list-style-type: none"> <li>1. Identify all outpatient general surgery episodes (<u>General Surgery Value Set with Ambulatory Surgery POS Value Set</u>).</li> <li>2. Identify the outpatient general surgery episode date.</li> </ol> <p><b>Step 2.</b> Exclude outpatient general surgery episodes that occur the day before an inpatient stay (<u>Inpatient Stay Value Set</u>) or observation stay (<u>Observation Stay Value Set</u>) admission date or at any time during an inpatient or observation stay.</p>
<b>Risk adjustment factors</b>	<p><b>Risk Adjustment Determination</b></p> <p>For each outpatient general surgery episode, identify risk adjustment weights based on procedure subtype, comorbidity, age and gender.</p> <p><b>Procedure subtype:</b></p> <p><b>Step 1.</b> Identify all CPT codes associated with each outpatient general surgery episode date. Some episode dates will be associated with more than one CPT code.</p> <p><b>Step 2.</b> Assign each CPT code to a procedure subtype using Table Proc—Mapping in the Risk Adjustment Shared Tables. Capture all associated CCS categories for each episode. Exclude CPT codes that cannot be assigned to a CCS category. If multiple CPT codes map to one CCS category, only count that CCS category once.</p> <ul style="list-style-type: none"> <li>• <i>For example</i>, assume an episode date has CPT 10160, CPT 11762 and CPT 15934 codes. <ul style="list-style-type: none"> <li>– CPT 10160 maps to CCS 170 (Excision of skin lesion).</li> <li>– CPT 11762 maps to CCS 175 (Other OR therapeutic procedures on skin and breast).</li> <li>– CPT 15934 maps to CCS 170 (Excision of skin lesion).</li> </ul> </li> </ul> <p>The final procedure subtypes for this episode date are CCS 170 and CCS 175. Only count CCS 170 once.</p> <p><b>Comorbidities:</b></p> <p><b>Step 1.</b> Identify all diagnoses for encounters during the 365 days prior to and on the date of the outpatient general surgery episode date. Include the following when identifying encounters:</p>

- Outpatient visits, ED visits, telephone visits, nonacute inpatient encounters and acute inpatient encounters (Outpatient, ED, Telephone, Acute Inpatient and Nonacute Inpatient Value Set) with a date of service 365 days prior to and on the date of the outpatient general surgery episode date.
- Acute and nonacute inpatient discharges (Inpatient Stay Value Set) with a discharge date 365 days prior to and on the date of the outpatient general surgery episode date.
- Outpatient general surgery episodes (General Surgery Value Set with Ambulatory Surgery POS Value Set).

**Step 2.** Assign each diagnosis to one or more comorbid Clinical Condition (CC) category using Table CC—Mapping in the Risk Adjustment Shared Tables. If the code appears more than once in Table CC—Mapping, it is assigned to multiple CCs.

Exclude all diagnoses that cannot be assigned to a comorbid CC category. For denominator units with no qualifying diagnoses from face-to-face encounters, skip to *Risk Adjustment Calculation*.

All digits must match exactly when mapping diagnosis codes to the comorbid CCs.

**Step 3.** Determine HCCs for each comorbid CC identified. Refer to Table HCC—Rank.

For each denominator unit's comorbid CC list, match the comorbid CC code to the comorbid CC code in the table, and assign:

- The ranking group.
- The rank.
- The HCC.

For comorbid CCs that do not match to Table HCC—Rank, use the comorbid CC as the HCC and assign a rank of 1. One comorbid CC can map to multiple HCCs; each HCC can have one or more comorbid CCs.

**Step 4.** Assess each ranking group separately and select only the highest ranked HCC in each ranking group using the “Rank” column (1 is the highest rank possible).

Drop all other HCCs in each ranking group, and de-duplicate the HCC list if necessary.

- *For example*, assume a denominator unit with the following comorbid CCs: CC-85, CC-17 and CC-19 (assume no other CCs).
  - CC-85 does not have a map to the ranking table and becomes HCC-85.
  - HCC-17 and HCC-19 are part of Diabetes Ranking Group 1. Because CC-17 is ranked higher than CC-19 in Ranking Group Diabetes 1, the comorbidity is assigned as HCC-17 for Ranking Group 1.

The final comorbidities for this denominator unit are HCC-17 and HCC-85.

<b>Table HCC—Rank</b>					
Ranking Group	CC	Description		Rank	HCC
NA	CC-85	Congestive Heart Failure		NA	HCC-85
Diabetes 1	CC-17	Diabetes With Acute Complications		1	HCC-17
	CC-18	Diabetes With Chronic Complications		2	HCC-18
	CC-19	Diabetes Without Complications		3	HCC-19

**Step 5.** Identify combination HCCs listed in Table HCC—Comb.

Some combinations suggest a greater amount of risk when observed together. For example, when diabetes and CHF are present, an increased amount of risk is evident. Additional HCCs are selected to account for these relationships.

Compare each denominator unit's list of unique HCCs to those in the *Comorbid HCC* columns in Table HCC—Comb and assign any additional HCC conditions.

*If there are overlapping combinations, use both sets of combinations.* Based on the combinations, a denominator unit can have none, one or more of these added HCCs.

- *For example*, for a denominator unit with comorbidities HCC-17 and HCC-85 (assume no other HCCs), assign HCC-901 in addition to HCC-17 and HCC-85. This *does not* replace HCC-17 and HCC-85.

**Table HCC—Comb**

Comorbid HCC 1	Comorbid HCC 2	Comorbid HCC 3	HCC-Combination	HCC-Comb Description
HCC-17	HCC-85	NA	HCC-901	Combination: Diabetes and CHF
HCC-18	HCC-85	NA	HCC-901	Combination: Diabetes and CHF
HCC-19	HCC-85	NA	HCC-901	Combination: Diabetes and CHF

**Risk adjustment**

**Risk Adjustment Calculation**

For each outpatient general surgery episode, use the following steps to identify the 15-day hospitalization risk adjustment weights based on procedure subtype, comorbidity, age and gender.

**Step 1.** For each outpatient general surgery episode with a procedure subtype, link the subtype weights.

**Step 2.** For each outpatient general surgery episode with a Comorbidity HCC category, link the comorbidity weights.

**Step 3.** Link the age and gender weights for each outpatient general surgery episode.

**Step 4.** Sum all weights (procedure subtype, comorbidities, age and gender) associated with each outpatient general surgery episode and use the formula below to calculate the estimated hospitalization risk for each episode:

	<p style="text-align: center;"><b>Estimated Hospitalization Risk = <math>\frac{e^{(\sum \text{WeightsForEpisode})}}{1+e^{(\sum \text{WeightsForEpisode})}}</math></b></p> <p><b>OR</b></p> <p style="text-align: center;">Estimated Hospitalization Risk = [exp (sum of weights for episode)] / [ 1 + exp (sum of weights for episode)]</p> <p><b>Note:</b> "Exp" refers to the exponential or antilog function.</p> <p>Truncate the estimated hospitalization risk for each episode to 10 decimal places. Do not truncate or round in previous steps.</p> <p><b>Step 5.</b> Calculate the count of expected hospitalizations for each age. The count of expected hospitalizations is the sum of the estimated hospitalization risk calculated for each outpatient general surgery episode for each age.</p> <p style="text-align: center;">Count of Expected Hospitalizations = <math>\sum</math> (Estimated Hospitalization Risk)</p> <p><b>Step 6.</b> Use the formula below and the estimated hospitalization risk calculated in step 5 to calculate the variance for each outpatient general surgery episode.</p> <p style="text-align: center;">Variance = Estimated Hospitalization Risk x (1 – Estimated Hospitalization Risk)</p> <p>Truncate the variance for each outpatient general surgery episode to 10 decimal places.</p> <ul style="list-style-type: none"> <li>• <i>For example</i>, if the estimated hospitalization risk is 0.1518450741 for an outpatient general surgery episode, then the hospitalization variance for this outpatient general surgery episode is 0.1518450741 x 0.8481549259 = 0.1287881475.</li> </ul> <p><b>Note:</b> Organizations must sum the variances for each age when populating the variance cells in the reporting tables. When reporting, round the variance to 4 decimal places using the .5 rule.</p>
<b>Numerator</b>	<p><b>Acute hospitalization within 15 days of the outpatient general surgery episode.</b></p> <p><b>Step 1.</b> For each outpatient general surgery episode, identify all acute inpatient admissions and observation stay hospitalizations with an admission date within 15 days after the outpatient general surgery episode.</p> <p>To identify acute inpatient and observation admissions:</p> <ol style="list-style-type: none"> <li>1. Identify all acute and nonacute inpatient stays (<u>Inpatient Stay Value Set</u>) and observation stays (<u>Observation Stay Value Set</u>).</li> <li>2. Exclude nonacute inpatient stays (<u>Nonacute Inpatient Stay Value Set</u>).</li> <li>3. Identify the admission date for the stay.</li> </ol> <p><b>Step 2.</b> For discharges with one or more direct transfers, use the last discharge.</p> <p>Using the discharges identified in step 1, identify direct transfers between acute inpatient and observation using the definition of direct transfer.</p> <p><b>Step 3.</b> For the remaining discharges, exclude inpatient and observation stay discharges with any of the following criteria on the discharge claim:</p>

	<ul style="list-style-type: none"> <li>• A principal diagnosis of maintenance chemotherapy (<a href="#">Chemotherapy Encounter Value Set</a>).</li> <li>• A principal diagnosis of rehabilitation (<a href="#">Rehabilitation Value Set</a>).</li> <li>• An organ transplant (<a href="#">Kidney Transplant Value Set</a>, <a href="#">Bone Marrow Transplant Value Set</a>, <a href="#">Organ Transplant Other Than Kidney Value Set</a>, <a href="#">Introduction of Autologous Pancreatic Cells Value Set</a>).</li> <li>• A potentially planned procedure (<a href="#">Potentially Planned Procedures Value Set</a>) without a principal acute diagnosis (<a href="#">Acute Condition Value Set</a>).</li> </ul> <p><b>Note</b></p> <ul style="list-style-type: none"> <li>• 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.</li> <li>• Only one inpatient admission or observation stay hospitalization may be included in the numerators for each unique outpatient general surgery episode denominator event. If there are multiple numerator events that meet criteria for a singular denominator event, only count the numerator event closest to the outpatient general surgery episode.</li> </ul> <p>For example, consider the following events:</p> <ul style="list-style-type: none"> <li>– Outpatient general surgery episode: May 10.</li> <li>– Observation stay: May 13–14.</li> <li>– Acute inpatient stay: May 16–20.</li> </ul> <p>Both the observation stay of May 13–14 and the acute inpatient stay of May 16–20 are within 15 days of the outpatient general surgery episode on May 10. Only the observation stay is included in the numerator because it is the hospitalization event closest to the outpatient general surgery episode.</p> <ul style="list-style-type: none"> <li>• Count each unique acute inpatient admission or observation stay hospitalization only once toward the numerator for the last denominator event. If a single numerator event meets criteria for multiple denominator events, only attribute the numerator event to the last denominator event.</li> </ul> <p>For example, consider the following events:</p> <ul style="list-style-type: none"> <li>– Outpatient general surgery episode 1: May 10.</li> <li>– Outpatient general surgery episode 2: May 15.</li> <li>– Acute inpatient stay: May 18.</li> </ul> <p>The outpatient general surgery episodes of May 10 and May 15 are included as denominator events. The acute inpatient stay counts as a numerator event only toward the last denominator event (episode 2, May 15).</p>
<b>Summary of changes</b>	<ul style="list-style-type: none"> <li>• This is a first-year measure.</li> </ul>
<b>Data element tables</b>	<p><b>Reporting: Denominator</b> The number of outpatient general surgery episodes, reported as the Denominator.</p> <p><b>Reporting: Numerator</b> The number of observed acute inpatient admission or observation stay hospitalizations, reported as the ObservedCount.</p>

	<p><b>Calculated: Observed hospitalization rate</b> The number of observed acute inpatient admission or observation stay hospitalizations (ObservedCount) divided by the number of outpatient general surgery episodes (Denominator). Calculated by IDSS as the ObservedRate.</p> <p><b>Reporting: Count of expected hospitalizations</b></p> <p><b>Step 1.</b> Calculate the number of expected inpatient admission or observation stay hospitalizations.</p> <p><b>Step 2.</b> Round to 4 decimal places using the .5 rule and report these values as the ExpectedCount.</p> <p><b>Calculated: Expected hospitalization rate</b> The number of expected acute inpatient admission or observation stay hospitalizations (ExpectedCount) divided by the number of outpatient general surgery episodes (Denominator). Calculated by IDSS as the ExpectedRate.</p> <p><b>Reporting: Variance</b></p> <p><b>Step 1.</b> Calculate the variance (<i>Risk Adjustment Calculation</i>, step 6).</p> <p><b>Step 2.</b> Round to 4 decimal places using the .5 rule and report these values as the CountVariance.</p> <p><b>Calculated: O/E ratio</b> The number of observed acute inpatient admission or observation stay hospitalizations (ObservedCount) divided by the number of expected acute inpatient admission or observation stay hospitalizations (ExpectedCount). Calculated by IDSS as the OE.</p> <p>Organizations that submit HEDIS data to NCQA must provide the following data elements.</p>
<b>Rules for Allowable Adjustments</b>	<p><b>Copyright and use:</b> The “Rules for Allowable Adjustments of HEDIS” (the “Rules”) describe how NCQA’s HEDIS measure specifications can be adjusted for other populations, if applicable. The Rules, reviewed and approved by NCQA measure experts, provide for expanded use of HEDIS measures without changing their clinical intent.</p> <p><b>Adjusted HEDIS measures may not be used for HEDIS health plan reporting.</b></p>

The measures under the Risk Adjusted Utilization domain allow two types of *Rules for Allowable Adjustments* sections:

1. *Rules for Allowable Adjustments for Risk-Adjusted Measurement.* This section must be followed for adjustments when calculating the full measure specifications, which includes all risk adjusted rates (expected rates, risk adjustment, O/E) and calculation components (count of index stays, observed events).
2. *Rules for Allowable Adjustments for Observed Measurement (rates without risk adjustment).* This section must be followed when adjusting the calculation of observed events only. When applying these adjustments, organizations must not include risk adjustment logic.

The intent of including two types of Rules is to allow organizations to adjust measures without compromising measure validity. Risk adjustment is based on statistical prediction models specifically calibrated to each measure.

**The following are the Rules for Allowable Adjustments for Risk-Adjusted Measurement of the Acute Hospitalizations Following Outpatient General Surgery measure (expected hospitalization rate, risk adjustment determination, risk adjustment calculation, variance, O/E ratio).**

#### **ADJUSTMENTS ALLOWED**

- *Benefits.* Organizations are not required to use a benefit.
- *Telehealth.* Services/events that allow the use of synchronous telehealth visits, telephone visits and asynchronous telehealth (e-visits, virtual check-ins) may be stratified to identify services performed via telehealth. This adjustment is not allowed for events, numerators and exclusions that do not allow the use of telehealth.

#### **ADJUSTMENTS ALLOWED WITH LIMITS**

- *Other.* Organizations may only adjust the initial population criteria to focus on an area of interest defined by gender, sociodemographic characteristics or geographical region. NCQA recommends evaluating risk model performance and validity within adjusted populations. Organizations may not adjust for a clinical subpopulation (e.g., persons with a diabetes diagnosis).
- *Measurement period adjustments.* Organizations may only change the measurement period by 1 year.
- *Denominator.* Organizations may include denied claims to calculate denominator events. Value sets and logic may not be changed.
- *Risk adjustment determination, risk adjustment calculation, expected hospitalizations, variance.* Organizations may include denied claims to calculate these events. Risk adjustment determinations, weighting and calculations of expected events logic may not be changed.
- *Numerator.* Organizations may include denied claims to calculate the numerator. Value sets and logic may not be changed.

	<p><b>ADJUSTMENTS NOT ALLOWED</b></p> <ul style="list-style-type: none"><li>• <i>Product lines.</i> Organizations may not adjust product lines.</li><li>• <i>Attribution.</i> Organizations are required to use enrollment criteria.</li><li>• <i>Ages.</i> The age determination dates may not be changed.</li><li>• <i>Supplemental data.</i> Supplemental data may not be used to identify initial population, denominator and numerator events.</li><li>• <i>Exclusions.</i> The hospice exclusion must be applied. Logic may not be changed.</li></ul> <p><b>The following are is for the Rules for Allowable Adjustments for <u>Observed Measurement</u> of the Acute Hospitalizations Following Outpatient General Surgery measure observed events (denominator, numerator, observed hospitalization rate).</b></p> <p><b>ADJUSTMENTS ALLOWED</b></p> <ul style="list-style-type: none"><li>• <i>Product lines.</i> When adjusting this measure to assess for observed events only, organizations are not required to use product line criteria; product lines may be combined, and all (or no) product line criteria may be used.</li><li>• <i>Ages.</i> The observed event age range may be expanded. Age determination dates may be changed (e.g., select, “age as of June 30”).</li><li>• <i>Attribution.</i> Organizations are not required to use enrollment criteria.</li><li>• <i>Benefits.</i> Organizations are not required to use a benefit.</li><li>• <i>Other.</i> Organizations may adjust the initial population criteria to focus on an area of interest defined by gender, race, ethnicity, socioeconomic or sociodemographic characteristics, geographic region or another characteristic.</li><li>• <i>Measurement period adjustments.</i> Organizations may adjust the measurement period.</li><li>• <i>Exclusions.</i> Hospice exclusion is not required.</li><li>• <i>Telehealth.</i> Services/events that allow the use of synchronous telehealth visits, telephone visits and asynchronous telehealth (e-visits, virtual check-ins) may be stratified to identify services performed via telehealth. This adjustment is not allowed for events, numerators and exclusions that do not allow the use of telehealth.</li><li>• <i>Supplemental data.</i> Supplemental data may be used to identify initial population, denominator, exclusion and numerator events.</li></ul> <p><b>ADJUSTMENTS ALLOWED WITH LIMITS</b></p> <ul style="list-style-type: none"><li>• <i>Denominator.</i> Organizations may include denied claims to calculate denominator events. Value sets and logic may not be changed.</li><li>• <i>Numerator.</i> Organizations may include denied claims to calculate the numerator. Value sets and logic may not be changed.</li></ul>
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## Acute Hospitalizations Following Outpatient Orthopedic Surgery (HFO)

<b>Measure title</b>	Acute Hospitalizations Following Outpatient Orthopedic Surgery	<b>Measure ID</b>	HFO
<b>Description</b>	For persons 65 years of age and older, the risk-adjusted ratio of observed-to-expected unplanned acute hospitalizations (inpatient and observation stays) for any diagnosis that occurred within 15 days following select outpatient orthopedic surgeries.		
<b>Measurement period</b>	January 1–December 31.		
<b>Copyright and disclaimer notice</b>	<p>Refer to the complete copyright and disclaimer information at the front of this publication.</p> <p>NCQA website: <a href="http://www.ncqa.org">www.ncqa.org</a>.</p> <p>Submit policy clarification support questions via My NCQA (<a href="https://my.ncqa.org">https://my.ncqa.org</a>).</p>		
<b>Clinical recommendation statement/rationale</b>	<p>Advances in surgical technologies, perioperative care and payment structures have increased the number and variety of surgical procedures performed in outpatient settings. In one study, researchers found the most common reason for emergency department (ED) visits within 30 days of outpatient orthopedic surgery was infection. Following outpatient orthopedic surgery, wound management, improved preprocedural risk assessments and improved patient counseling of risk factors can minimize ED visits and complications.</p>		
<b>Citations</b>	<p>Bernatz, J.T., J.L. Tueting, S. Hetzel, &amp; P.A. Anderson. 2016. “What Are the 30-day Readmission Rates Across Orthopaedic Subspecialties?” <i>Clinical Orthopaedics and Related Research</i> 474(3), 838–47. <a href="https://doi.org/10.1007/s11999-015-4602-5">https://doi.org/10.1007/s11999-015-4602-5</a></p> <p>Bongiovanni, T., C. Parzynski, I. Ranasinghe, M.A. Steinman, &amp; J.S. Ross. 202). “Unplanned Hospital Visits After Ambulatory Surgical Care.” <i>Plos one</i> 16(7), e0254039. <a href="https://doi.org/10.1371/journal.pone.0254039">https://doi.org/10.1371/journal.pone.0254039</a></p> <p>Cullen, K.A., M.J. Hall, A. Golosinskiy. 2009. <i>Ambulatory Surgery in the United States, 2006</i>. National Health Statistics Reports; no 11. Revised. Hyattsville, MD: National Center for Health Statistics.</p> <p>Gonzalez, M., A. Ganta, &amp; A. Sapienza. 2020. “Postoperative Inpatient Conversions Following Ambulatory Orthopedic Surgery.” <i>Bulletin of the Hospital for Joint Disease</i> 78(4), 255–9.</p>		
<b>Characteristics</b>			
<b>Scoring</b>	Ratio.		
<b>Product lines</b>	Medicare.		
<b>Stratifications</b>	None.		

Guidance	Risk Adjustment Measure Specific Guidance
	<p><b>Observation stays:</b> For observation stays (<u>Observation Stay Value Set</u>) that do not have a recorded admission or discharge date, set the admission date to the earliest date of service on the claim and set the discharge date to the last date of service on the claim.</p> <p><b>Which services count?</b></p> <ul style="list-style-type: none"> <li>• Use all paid, suspended, pending and denied claims when applying risk adjustment comorbidity category determination and the hospice exclusion.</li> <li>• Do not include denied claims when identifying all other events (e.g., denominator events or observed events in the other risk adjusted utilization measures); only report claims the organization paid for or expects to pay for (i.e., claims incurred but not paid).</li> </ul> <p><b>Supplemental data exceptions:</b> Supplemental data may only be used for the hospice exclusion.</p> <p><b>Transfers:</b></p> <ul style="list-style-type: none"> <li>• Treat transfers <i>between</i> institutions as separate admissions.</li> <li>• Base transfer reports <i>within</i> an institution on the type and level of services provided.</li> <li>• Report separate admissions when the transfer is between acute and nonacute levels of service or between mental health/chemical dependency services and non-mental health/chemical dependency services.</li> <li>• Count only one admission when the transfer takes place within the same service category, but to a different level of care (e.g., from intensive care to a lesser level of care; from a lesser level of care to intensive care).</li> </ul> <p><b>Risk adjustment:</b> Organizations may not use risk assessment protocols to supplement diagnoses for calculation of the risk adjustment scores for these measures. The measurement model was developed and tested using only claims-based diagnoses; diagnoses from additional data sources would affect the validity of the models as they are currently implemented in the specification.</p> <p><b>General Rules</b></p> <p><b>Data collection methodology:</b> Administrative. Refer to <a href="#">General Guideline: Data Collection Methods</a> for additional information.</p> <p><b>Date specificity:</b> Dates must be specific enough to determine the event occurred in the period being measured.</p> <p><b>Other guidance:</b> The measure is based on episodes; therefore, it is possible for the denominator to include multiple events for the same person.</p> <p><b>Improvement notation:</b> To interpret the rate as better or worse than expected, the rate must be calibrated. Organizations can calibrate rates by dividing individual organization rates or national percentiles by the national average rate. Organizations may be more successful at achieving fewer hospitalizations than expected, given the types of cases treated by the organization (calibrated rate with a value &lt;1.0), or may be less successful (calibrated rate with a value &gt;1.0).</p>

<b>Definitions</b>	
<b>Direct transfer</b>	When the discharge date from the initial stay precedes the admission date to a subsequent stay by 1 calendar day or less. <ul style="list-style-type: none"> <li>• <i>For example:</i> <ul style="list-style-type: none"> <li>– A discharge on June 1, followed by a subsequent admission on June 1 or June 2, <i>is a direct transfer</i>.</li> <li>– A discharge on June 1, followed by a subsequent admission on June 3, <i>is not a direct transfer</i>; these are two distinct stays.</li> <li>– A discharge on June 1, followed by a subsequent admission on June 2 (with discharge on June 3), followed by a subsequent admission on June 4, <i>is a direct transfer</i>.</li> </ul> </li> </ul> <p>Direct transfers may occur between different facilities, and between acute inpatient and observation.</p>
<b>Outpatient orthopedic surgery episode</b>	A qualifying outpatient orthopedic surgery that occurs on or between January 1 and December 16 of the measurement period, as identified in the denominator.
<b>Outpatient orthopedic surgery episode date</b>	The date of service for a qualifying outpatient orthopedic surgery episode. For episodes that span more than 1 calendar day, use the last service date as the episode date.
<b>Planned hospital stay</b>	A hospital stay that meets criteria in step 3 of the numerator.
<b>Initial population</b>	<p><i>Measure item count:</i> Episode.</p> <p><i>Attribution basis:</i> Enrollment.</p> <ul style="list-style-type: none"> <li>• <i>Benefits:</i> Medical.</li> <li>• <i>Continuous enrollment:</i> 365 days prior to the outpatient orthopedic surgery episode date through 15 days after the outpatient orthopedic surgery episode date.</li> <li>• <i>Allowable gap:</i> <ul style="list-style-type: none"> <li>– <i>365 days prior to the date of the outpatient orthopedic surgery episode:</i> No more than one gap in enrollment of ≤45 days.</li> <li>– <i>Earliest date of the outpatient orthopedic surgery episode and 15 days following the last date of the outpatient orthopedic surgery episode:</i> No gaps.</li> </ul> </li> </ul> <p><i>Ages:</i> 65 years of age and older as of the outpatient orthopedic surgery episode.</p> <p><i>Gender/Sex criteria:</i></p> <ul style="list-style-type: none"> <li>• Administrative Gender of Female (AdministrativeGender code female).</li> <li>• Administrative Gender of Male (AdministrativeGender code male).</li> </ul>

	<p><b>Exclusion: Persons in hospice or using hospice services.</b></p> <p>Persons who use hospice services (<u>Hospice Encounter Value Set</u>; <u>Hospice Intervention Value Set</u>) or elect to use a hospice benefit any time during the measurement period. Organizations that use the Monthly Membership Detail Data File to identify these persons must use only the run date of the file.</p>
<b>Denominator</b>	<p><b>Outpatient orthopedic surgery episodes.</b></p> <p><b>Step 1.</b> Identify outpatient orthopedic surgery episodes on or between January 1 and December 16 of the measurement period:</p> <ol style="list-style-type: none"> <li>1. Identify all outpatient orthopedic surgery episodes (<u>Orthopedic Surgery Value Set with Ambulatory Surgery POS Value Set</u>).</li> <li>2. Identify the outpatient orthopedic surgery episode date.</li> </ol> <p><b>Step 2.</b> Exclude outpatient orthopedic surgery episodes that occur the day before an inpatient stay (<u>Inpatient Stay Value Set</u>) or observation stay (<u>Observation Stay Value Set</u>) admission date or at any time during an inpatient or observation stay.</p>
<b>Risk adjustment factors</b>	<p><b>Risk Adjustment Determination</b></p> <p>For each outpatient orthopedic surgery episode, identify risk adjustment weights based on procedure subtype, comorbidity, age and gender.</p> <p><b>Procedure subtype:</b></p> <p><b>Step 1.</b> Identify all CPT codes associated with each outpatient orthopedic surgery episode date. Some episode dates will be associated with more than one CPT code.</p> <p><b>Step 2.</b> Assign each CPT code to a procedure subtype using Table Proc—Mapping in the Risk Adjustment Shared Tables. Capture all associated CCS categories for each episode. Exclude CPT codes that cannot be assigned to a CCS category. If multiple CPT codes map to one CCS category, only count that CCS category once.</p> <ul style="list-style-type: none"> <li>• <i>For example</i>, assume an episode date has CPT 15920, CPT 20150 and CPT 20520 codes. <ul style="list-style-type: none"> <li>– CPT 15920 maps to CCS 142 (Partial excision bone).</li> <li>– CPT 20150 maps to CCS 142 (Partial excision bone).</li> <li>– CPT 20520 maps to CCS 160 (Other therapeutic procedures on muscles and tendons).</li> </ul> The final procedure subtypes for this episode date are CCS 142 and CCS 160. Only count CCS 142 once. </li> </ul> <p><b>Comorbidities:</b></p> <p><b>Step 1.</b> Identify all diagnoses for encounters during the 365 days prior to and on the date of the outpatient orthopedic surgery episode date. Include the following when identifying encounters:</p>

- Outpatient visits, ED visits, telephone visits, nonacute inpatient encounters and acute inpatient encounters (Outpatient, ED, Telephone, Acute Inpatient and Nonacute Inpatient Value Set) with a date of service 365 days prior to and on the date of the outpatient orthopedic surgery episode date.
- Acute and nonacute inpatient discharges (Inpatient Stay Value Set) with a discharge date 365 days prior to and on the date of the outpatient orthopedic surgery episode date.
- Outpatient orthopedic surgery episodes (Orthopedic Surgery Value Set with Ambulatory Surgery POS Value Set).

**Step 2.** Assign each diagnosis to one or more comorbid Clinical Condition (CC) category using Table CC—Mapping in the Risk Adjustment Shared Tables. If the code appears more than once in Table CC—Mapping, it is assigned to multiple CCs.

Exclude all diagnoses that cannot be assigned to a comorbid CC category. For denominator units with no qualifying diagnoses from face-to-face encounters, skip to *Risk Adjustment Calculation*.

All digits must match exactly when mapping diagnosis codes to the comorbid CCs.

**Step 3.** Determine HCCs for each comorbid CC identified. Refer to Table HCC—Rank.

For each denominator unit's comorbid CC list, match the comorbid CC code to the comorbid CC code in the table, and assign:

- The ranking group.
- The rank.
- The HCC.

For comorbid CCs that do not match to Table HCC—Rank, use the comorbid CC as the HCC and assign a rank of 1. One comorbid CC can map to multiple HCCs; each HCC can have one or more comorbid CCs.

**Step 4.** Assess each ranking group separately and select only the highest ranked HCC in each ranking group using the “Rank” column (1 is the highest rank possible).

Drop all other HCCs in each ranking group, and de-duplicate the HCC list if necessary.

- *For example*, assume a denominator unit with the following comorbid CCs: CC-85, CC-17 and CC-19 (assume no other CCs).
  - CC-85 does not have a map to the ranking table and becomes HCC-85.
  - HCC-17 and HCC-19 are part of Diabetes Ranking Group 1. Because CC-17 is ranked higher than CC-19 in Ranking Group Diabetes 1, the comorbidity is assigned as HCC-17 for Ranking Group 1.

The final comorbidities for this denominator unit are HCC-17 and HCC-85.

<b>Table HCC—Rank</b>					
Ranking Group	CC	Description	Rank	HCC	
NA	CC-85	Congestive Heart Failure	NA	HCC-85	
Diabetes 1	CC-17	Diabetes With Acute Complications	1	HCC-17	
	CC-18	Diabetes With Chronic Complications	2	HCC-18	
	CC-19	Diabetes Without Complications	3	HCC-19	

**Step 5.** Identify combination HCCs listed in Table HCC—Comb.

Some combinations suggest a greater amount of risk when observed together. For example, when diabetes *and* CHF are present, an increased amount of risk is evident. Additional HCCs are selected to account for these relationships.

Compare each denominator unit's list of unique HCCs to those in the *Comorbid HCC* columns in Table HCC—Comb and assign any additional HCC conditions.

*If there are overlapping combinations, use both sets of combinations.* Based on the combinations, a denominator unit can have none, one or more of these added HCCs.

- *For example*, for a denominator unit with comorbidities HCC-17 and HCC-85 (assume no other HCCs), assign HCC-901 in addition to HCC-17 and HCC-85. This *does not* replace HCC-17 and HCC-85.

**Table HCC—Comb**

Comorbid HCC 1	Comorbid HCC 2	Comorbid HCC 3	HCC-Combination	HCC-Comb Description
HCC-17	HCC-85	NA	HCC-901	Combination: Diabetes and CHF
HCC-18	HCC-85	NA	HCC-901	Combination: Diabetes and CHF
HCC-19	HCC-85	NA	HCC-901	Combination: Diabetes and CHF

**Risk adjustment**

**Risk Adjustment Calculation**

For each outpatient orthopedic surgery episode, use the following steps to identify the 15-day hospitalization risk adjustment weights based on procedure subtype, comorbidity, age and gender.

**Step 1.** For each outpatient orthopedic surgery episode with a procedure subtype, link the subtype weights.

**Step 2.** For each outpatient orthopedic surgery episode with a comorbidity HCC category, link the comorbidity weights.

**Step 3.** Link the age and gender weights for each outpatient orthopedic surgery episode.

**Step 4.** Sum all weights (procedure subtype, comorbidities, age and gender) associated with each outpatient orthopedic surgery episode and use the formula below to calculate the estimated hospitalization risk for each episode:

	<p style="text-align: center;"><b>Estimated Hospitalization Risk = <math>\frac{e^{(\sum \text{WeightsForEpisode})}}{1+e^{(\sum \text{WeightsForEpisode})}}</math></b></p> <p><b>OR</b></p> <p style="text-align: center;">Estimated Hospitalization Risk = [exp (sum of weights for episode)] / [ 1 + exp (sum of weights for episode)]</p> <p><b>Note:</b> "Exp" refers to the exponential or antilog function.</p> <p>Truncate the estimated hospitalization risk for each episode to 10 decimal places. Do not truncate or round in previous steps.</p> <p><b>Step 5.</b> Calculate the count of expected hospitalizations for each age. The count of expected hospitalizations is the sum of the estimated hospitalization risk calculated for each outpatient orthopedic surgery episode for each age.</p> <p style="text-align: center;">Count of Expected Hospitalizations = <math>\sum</math> (Estimated Hospitalization Risk)</p> <p><b>Step 6.</b> Use the formula below and the estimated hospitalization risk calculated in step 5 to calculate the variance for each outpatient orthopedic surgery episode.</p> <p style="text-align: center;">Variance = Estimated Hospitalization Risk x (1 – Estimated Hospitalization Risk)</p> <p>Truncate the variance for each outpatient orthopedic surgery episode to 10 decimal places.</p> <ul style="list-style-type: none"> <li>• <i>For example</i>, if the estimated hospitalization risk is 0.1518450741 for an outpatient orthopedic surgery episode, then the hospitalization variance for this outpatient orthopedic surgery episode is 0.1518450741 x 0.8481549259 = 0.1287881475.</li> </ul> <p><b>Note:</b> Organizations must sum the variances for each age when populating the variance cells in the reporting tables. When reporting, round the variance to 4 decimal places using the .5 rule.</p>
<b>Numerator</b>	<p><b>Acute hospitalization within 15 days of the outpatient orthopedic surgery episode.</b></p> <p><b>Step 1.</b> For each outpatient orthopedic surgery episode, identify all acute inpatient admissions and observation stay hospitalizations with an admission date within 15 days after the outpatient orthopedic surgery episode.</p> <p>To identify acute inpatient and observation admissions:</p> <ol style="list-style-type: none"> <li>1. Identify all acute and nonacute inpatient stays (<u>Inpatient Stay Value Set</u>) and observation stays (<u>Observation Stay Value Set</u>).</li> <li>2. Exclude nonacute inpatient stays (<u>Nonacute Inpatient Stay Value Set</u>).</li> <li>3. Identify the admission date for the stay.</li> </ol> <p><b>Step 2.</b> For discharges with one or more direct transfers, use the last discharge.</p> <p>Using the discharges identified in step 1, identify direct transfers between acute inpatient and observation using the definition of direct transfer.</p> <p><b>Step 3.</b> For the remaining discharges, exclude inpatient and observation stay discharges with any of the following criteria on the discharge claim:</p>

	<ul style="list-style-type: none"> <li>• A principal diagnosis of maintenance chemotherapy (<a href="#">Chemotherapy Encounter Value Set</a>).</li> <li>• A principal diagnosis of rehabilitation (<a href="#">Rehabilitation Value Set</a>).</li> <li>• An organ transplant (<a href="#">Kidney Transplant Value Set</a>, <a href="#">Bone Marrow Transplant Value Set</a>, <a href="#">Organ Transplant Other Than Kidney Value Set</a>, <a href="#">Introduction of Autologous Pancreatic Cells Value Set</a>).</li> <li>• A potentially planned procedure (<a href="#">Potentially Planned Procedures Value Set</a>) without a principal acute diagnosis (<a href="#">Acute Condition Value Set</a>).</li> </ul> <p><b>Note</b></p> <ul style="list-style-type: none"> <li>• <i>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.</i></li> <li>• <i>Only one inpatient admission or observation stay hospitalization may be included in the numerators for each unique outpatient orthopedic surgery episode denominator event. If there are multiple numerator events that meet criteria for a singular denominator event, only count the numerator event closest to the outpatient orthopedic surgery episode.</i></li> </ul> <p>For example, consider the following events:</p> <ul style="list-style-type: none"> <li>– <i>Outpatient orthopedic surgery episode: May 10.</i></li> <li>– <i>Observation stay: May 13–14.</i></li> <li>– <i>Acute inpatient stay: May 16–20.</i></li> </ul> <p><i>Both the observation stay of May 13–14 and the acute inpatient stay of May 16–20 are within 15 days of the outpatient orthopedic surgery episode on May 10. Only the observation stay is included in the numerator because it is the hospitalization event closest to the outpatient orthopedic surgery episode.</i></p> <ul style="list-style-type: none"> <li>• <i>Count each unique acute inpatient admission or observation stay hospitalization only once toward the numerator for the last denominator event. If a single numerator event meets criteria for multiple denominator events, only attribute the numerator event to the last denominator event.</i></li> </ul> <p>For example, consider the following events:</p> <ul style="list-style-type: none"> <li>– <i>Outpatient orthopedic surgery episode 1: May 10.</i></li> <li>– <i>Outpatient orthopedic surgery episode 2: May 15.</i></li> <li>– <i>Acute inpatient stay: May 18.</i></li> </ul> <p><i>The outpatient orthopedic surgery episodes of May 10 and May 15 are included as denominator events. The acute inpatient stay counts as a numerator event only toward the last denominator event (episode 2, May 15).</i></p>
<b>Summary of changes</b>	<ul style="list-style-type: none"> <li>• This is a first-year measure.</li> </ul>
<b>Data element tables</b>	<p><b>Reporting: Denominator</b> The number of outpatient orthopedic surgery episodes, reported as the Denominator.</p> <p><b>Reporting: Numerator</b> The number of observed acute inpatient admission or observation stay hospitalizations, reported as the ObservedCount.</p>

	<p><b>Calculated: Observed hospitalization rate</b> The number of observed acute inpatient admission or observation stay hospitalizations (ObservedCount) divided by the number of outpatient orthopedic surgery episodes (Denominator). Calculated by IDSS as the ObservedRate.</p> <p><b>Reporting: Count of expected hospitalizations</b></p> <p><b>Step 1.</b> Calculate the number of expected inpatient admission or observation stay hospitalizations.</p> <p><b>Step 2.</b> Round to 4 decimal places using the .5 rule and report these values as the ExpectedCount.</p> <p><b>Calculated: Expected hospitalization rate</b> The number of expected acute inpatient admission or observation stay hospitalizations (ExpectedCount) divided by the number of outpatient orthopedic surgery episodes (Denominator). Calculated by IDSS as the ExpectedRate.</p> <p><b>Reporting: Variance</b></p> <p><b>Step 1.</b> Calculate the variance (<i>Risk Adjustment Calculation</i>, step 6).</p> <p><b>Step 2.</b> Round to 4 decimal places using the .5 rule and report these values as the CountVariance.</p> <p><b>Calculated: O/E ratio</b> The number of observed acute inpatient admission or observation stay hospitalizations (ObservedCount) divided by the number of expected acute inpatient admission or observation stay hospitalizations (ExpectedCount). Calculated by IDSS as the OE.</p> <p>Organizations that submit HEDIS data to NCQA must provide the following data elements.</p> <p><b>Table HFG-3: Data Elements for Acute Hospitalizations Following Outpatient Orthopedic Surgery</b></p> <table border="1"> <thead> <tr> <th>Metric</th><th>Data Element</th><th>Reporting Instructions</th></tr> </thead> <tbody> <tr> <td rowspan="7">OrthoSurgery</td><td>Denominator</td><td>Report once</td></tr> <tr> <td>ObservedCount</td><td>Report once</td></tr> <tr> <td>ObservedRate</td><td>ObservedCount / Denominator (Percent)</td></tr> <tr> <td>ExpectedCount</td><td>Report once</td></tr> <tr> <td>ExpectedRate</td><td>ExpectedCount / Denominator (Percent)</td></tr> <tr> <td>CountVariance</td><td>Report once</td></tr> <tr> <td>OE</td><td>ObservedCount / ExpectedCount</td></tr> </tbody> </table>	Metric	Data Element	Reporting Instructions	OrthoSurgery	Denominator	Report once	ObservedCount	Report once	ObservedRate	ObservedCount / Denominator (Percent)	ExpectedCount	Report once	ExpectedRate	ExpectedCount / Denominator (Percent)	CountVariance	Report once	OE	ObservedCount / ExpectedCount
Metric	Data Element	Reporting Instructions																	
OrthoSurgery	Denominator	Report once																	
	ObservedCount	Report once																	
	ObservedRate	ObservedCount / Denominator (Percent)																	
	ExpectedCount	Report once																	
	ExpectedRate	ExpectedCount / Denominator (Percent)																	
	CountVariance	Report once																	
	OE	ObservedCount / ExpectedCount																	
Rules for Allowable Adjustments	<p><b>Copyright and use:</b> The “Rules for Allowable Adjustments of HEDIS” (the “Rules”) describe how NCQA’s HEDIS measure specifications can be adjusted for other populations, if applicable. The Rules, reviewed and approved by NCQA measure experts, provide for expanded use of HEDIS measures without changing their clinical intent.</p>																		

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

The measures under the Risk Adjusted Utilization domain allow two types of *Rules for Allowable Adjustments* sections:

1. *Rules for Allowable Adjustments for Risk-Adjusted Measurement.* This section must be followed for adjustments when calculating the full measure specifications, which includes all risk adjusted rates (expected rates, risk adjustment, O/E) and calculation components (count of index stays, observed events).
2. *Rules for Allowable Adjustments for Observed Measurement (rates without risk adjustment).* This section must be followed when adjusting the calculation of observed events only. When applying these adjustments, organizations must not include risk adjustment logic.

The intent of including two types of Rules is to allow organizations to adjust measures without compromising measure validity. Risk adjustment is based on statistical prediction models specifically calibrated to each measure.

**The following are the Rules for Allowable Adjustments for Risk-Adjusted Measurement of the Acute Hospitalizations Following Outpatient Orthopedic Surgery measure (expected hospitalization rate, risk adjustment determination, risk adjustment weighting, variance, O/E ratio).**

**ADJUSTMENTS ALLOWED**

- *Benefits.* Organizations are not required to use a benefit.
- *Telehealth.* Services/events that allow the use of synchronous telehealth visits, telephone visits and asynchronous telehealth (e-visits, virtual check-ins) may be stratified to identify services performed via telehealth. This adjustment is not allowed for events, numerators and exclusions that do not allow the use of telehealth.

**ADJUSTMENTS ALLOWED WITH LIMITS**

- *Other.* Organizations may only adjust the initial population criteria to focus on an area of interest defined by gender, sociodemographic characteristics or geographical region. NCQA recommends evaluating risk model performance and validity within adjusted populations. Organizations may not adjust for a clinical subpopulation (e.g., persons with a diabetes diagnosis).
- *Measurement period adjustments.* Organizations may only change the measurement period by 1 year.
- *Denominator.* Organizations may include denied claims to calculate denominator events. Value sets and logic may not be changed.
- *Risk adjustment determination, risk adjustment weighting, expected hospitalizations, variance.* Organizations may include denied claims to calculate these events. Risk adjustment determinations, weighting and calculations of expected events logic may not be changed.
- *Numerator.* Organizations may include denied claims to calculate the numerator. Value sets and logic may not be changed.

**ADJUSTMENTS NOT ALLOWED**

- *Product lines.* Organizations may not adjust product lines.
- *Attribution.* Organizations are required to use enrollment criteria.
- *Ages.* The age determination dates may not be changed.
- *Supplemental data.* Supplemental data may not be used to identify initial population, denominator and numerator events.
- *Exclusions.* The hospice exclusion must be applied. Logic may not be changed.

The following are the Rules for Allowable Adjustments for Observed Measurement of the Acute Hospitalizations Following Outpatient Orthopedic Surgery measure observed events (denominator, numerator, observed hospitalization rate).

**ADJUSTMENTS ALLOWED**

- *Product lines.* When adjusting this measure to assess for observed events only, organizations are not required to use product line criteria; product lines may be combined, and all (or no) product line criteria may be used.
- *Ages.* The observed event age range may be expanded. Age determination dates may be changed (e.g., select, "age as of June 30").
- *Attribution.* Organizations are not required to use enrollment criteria.
- *Benefits.* Organizations are not required to use a benefit.
- *Other.* Organizations may adjust the initial population criteria to focus on an area of interest defined by gender, race, ethnicity, socioeconomic or sociodemographic characteristics, geographic region or another characteristic.
- *Measurement period adjustments.* Organizations may adjust the measurement period.
- *Exclusions.* Hospice exclusion is not required.
- *Telehealth.* Services/events that allow the use of synchronous telehealth visits, telephone visits and asynchronous telehealth (e-visits, virtual check-ins) may be stratified to identify services performed via telehealth. This adjustment is not allowed for events, numerators and exclusions that do not allow the use of telehealth.
- *Supplemental data.* Supplemental data may be used to identify initial population, denominator, exclusion and numerator events.

**ADJUSTMENTS ALLOWED WITH LIMITS**

- *Denominator.* Organizations may include denied claims to calculate denominator events. Value sets and logic may not be changed.
- *Numerator.* Organizations may include denied claims to calculate the numerator. Value sets and logic may not be changed.

## **Acute Hospitalizations Following Outpatient Urologic Surgery (HFU)**

<b>Measure title</b>	Acute Hospitalizations Following Outpatient Urologic Surgery	<b>Measure ID</b>	HFU
<b>Description</b>	For persons 65 years of age and older, the risk-adjusted ratio of observed-to-expected unplanned acute hospitalizations (inpatient and observation stays) for any diagnosis that occurred within 15 days following select outpatient urologic surgeries.		
<b>Measurement period</b>	January 1–December 31.		
<b>Copyright and disclaimer notice</b>	<p>Refer to the complete copyright and disclaimer information at the front of this publication.</p> <p>NCQA website: <a href="http://www.ncqa.org">www.ncqa.org</a>.</p> <p>Submit policy clarification support questions via My NCQA (<a href="https://my.ncqa.org">https://my.ncqa.org</a>).</p>		
<b>Clinical recommendation statement/ rationale</b>	<p>Advances in surgical technologies, perioperative care and payment structures have increased the number and variety of surgical procedures performed in outpatient settings. The variety of complications following urologic surgery depends on patient characteristics, surgical approach and types of medical devices utilized during the procedure. Common complications include postoperative bleeding, serious injury and urinary retention, all of which can be mitigated through adhering to evidence-based guidelines for clinical practice to reduce preventable admissions.</p>		
<b>Citations</b>	<p>Bongiovanni, T., C. Parzynski, I. Ranasinghe, M.A. Steinman, &amp; J.S. Ross. 2021. “Unplanned Hospital Visits After Ambulatory Surgical Care.” <i>PloS one</i>, 16(7), e0254039. <a href="https://doi.org/10.1371/journal.pone.0254039">https://doi.org/10.1371/journal.pone.0254039</a></p> <p>Cornu, J.N., T. Herrmann, O. Traxer, &amp; B. Matlaga. 2016. “Prevention and Management Following Complications from Endourology Procedures.” <i>European Urology Focus</i>, 2(1), 49–59. <a href="https://doi.org/10.1016/j.euf.2016.03.014">https://doi.org/10.1016/j.euf.2016.03.014</a></p> <p>Cullen, K.A., M.J. Hall, A. Golosinskiy. 2009. <i>Ambulatory Surgery in the United States, 2006</i>. National Health Statistics Reports; no 11. Revised. Hyattsville, MD: National Center for Health Statistics.</p>		
<b>Characteristics</b>			
<b>Scoring</b>	Ratio.		
<b>Product lines</b>	Medicare.		
<b>Stratifications</b>	None.		

Guidance	<b>Risk Adjustment Measure Specific Guidance</b>
	<p><b>Observation stays:</b> For observation stays (<u>Observation Stay Value Set</u>) that do not have a recorded admission or discharge date, set the admission date to the earliest date of service on the claim and set the discharge date to the last date of service on the claim.</p> <p><b>Which services count?</b></p> <ul style="list-style-type: none"> <li>• Use all paid, suspended, pending, and denied claims when applying risk adjustment comorbidity category determination and the hospice exclusion.</li> <li>• Do not include denied claims when identifying all other events (e.g., denominator events or observed events in the other risk adjusted utilization measures); only report claims the organization paid for or expects to pay for (i.e., claims incurred but not paid).</li> </ul> <p><b>Supplemental data exceptions:</b> Supplemental data may only be used for the hospice exclusion.</p> <p><b>Transfers:</b></p> <ul style="list-style-type: none"> <li>• Treat transfers <i>between</i> institutions as separate admissions.</li> <li>• Base transfer reports <i>within</i> an institution on the type and level of services provided.</li> <li>• Report separate admissions when the transfer is between acute and nonacute levels of service or between mental health/chemical dependency services and non-mental health/chemical dependency services.</li> <li>• Count only one admission when the transfer takes place within the same service category, but to a different level of care (e.g., from intensive care to a lesser level of care; from a lesser level of care to intensive care).</li> </ul> <p><b>Risk adjustment:</b> Organizations may not use risk assessment protocols to supplement diagnoses for calculation of the risk adjustment scores for these measures. The measurement model was developed and tested using only claims-based diagnoses; diagnoses from additional data sources would affect the validity of the models as they are currently implemented in the specification.</p> <p><b>General Rules</b></p> <p><b>Data collection methodology:</b> Administrative. Refer to <a href="#">General Guideline: Data Collection Methods</a> for additional information.</p> <p><b>Date specificity:</b> Dates must be specific enough to determine the event occurred in the period being measured.</p> <p><b>Other guidance:</b> The measure is based on episodes; therefore, it is possible for the denominator to include multiple events for the same person.</p> <p><b>Improvement notation:</b> To interpret the ratio as better or worse than expected, the ratio must be calibrated. Organizations can calibrate ratios by dividing individual organization ratios or national percentiles by the national average ratios. Organizations may be more successful at achieving fewer hospitalizations than expected, given the types of cases treated by the organization (calibrated ratios with a value &lt;1.0), or may be less successful (calibrated ratios with a value &gt;1.0).</p>

<b>Definitions</b>	
<b>Direct transfer</b>	When the discharge date from the initial stay precedes the admission date to a subsequent stay by 1 calendar day or less. <ul style="list-style-type: none"> <li>• <i>For example:</i> <ul style="list-style-type: none"> <li>– A discharge on June 1, followed by a subsequent admission on June 1 or June 2, <i>is a direct transfer</i>.</li> <li>– A discharge on June 1, followed by a subsequent admission on June 3, <i>is not a direct transfer</i>; these are two distinct stays.</li> <li>– A discharge on June 1, followed by a subsequent admission on June 2 (with discharge on June 3), followed by a subsequent admission on June 4, <i>is a direct transfer</i>.</li> </ul> </li> </ul> <p>Direct transfers may occur between different facilities, and between acute inpatient and observation.</p>
<b>Outpatient urologic surgery episode</b>	A qualifying outpatient urologic surgery that occurs on or between January 1 and December 16 of the measurement period, as identified in the denominator. For episodes that span more than 1 calendar day, use the last service date as the episode date.
<b>Outpatient urologic surgery episode date</b>	The date of service for a qualifying outpatient urologic surgery episode. For episodes that span more than 1 calendar day, use the last service date as the episode date.
<b>Planned hospital stay</b>	A hospital stay that meets criteria in step 3 of the numerator.
<b>Initial population</b>	<p><i>Measure item count:</i> Episode.</p> <p><i>Attribution basis:</i> Enrollment.</p> <ul style="list-style-type: none"> <li>• <i>Benefits:</i> Medical.</li> <li>• <i>Continuous enrollment:</i> 365 days prior to the outpatient urologic surgery episode through 15 days after the outpatient urologic surgery episode.</li> <li>• <i>Allowable gap:</i> <ul style="list-style-type: none"> <li>– <i>365 days prior to the date of the outpatient urologic surgery episode:</i> No more than one gap of ≤45 days.</li> <li>– <i>Outpatient urologic surgery episode through 15 days after the episode:</i> No gaps.</li> </ul> </li> </ul> <p><i>Ages:</i> 65 years of age and older as of the outpatient urologic surgery episode.</p> <p><i>Gender/Sex criteria:</i></p> <ul style="list-style-type: none"> <li>• Administrative Gender of Female (AdministrativeGender code female).</li> <li>• Administrative Gender of Male (AdministrativeGender code male).</li> </ul>

	<p><b>Exclusion: Persons in hospice or using hospice services.</b></p> <p>Persons who use hospice services (<u>Hospice Encounter Value Set</u>; <u>Hospice Intervention Value Set</u>) or elect to use a hospice benefit any time during the measurement period. Organizations that use the Monthly Membership Detail Data File to identify these persons must use only the run date of the file.</p>
<b>Denominator</b>	<p><b>Outpatient urologic surgery episodes.</b></p> <p><b>Step 1.</b> Identify outpatient urologic surgeries on or between January 1 and December 16 of the measurement period:</p> <ol style="list-style-type: none"> <li>1. Identify all outpatient urologic surgeries (<u>Urologic Surgery Value Set with Ambulatory Surgery POS Value Set</u>).</li> <li>2. Identify the outpatient urologic surgery episode date.</li> </ol> <p><b>Step 2.</b> Exclude outpatient urologic surgery episode dates that occur the day before an inpatient stay (<u>Inpatient Stay Value Set</u>) or observation stay (<u>Observation Stay Value Set</u>) admission date or at any time during an inpatient or observation stay.</p>
<b>Risk adjustment factors</b>	<p><b>Risk Adjustment Determination</b></p> <p>For each outpatient urologic surgery episode, identify risk adjustment weights based on procedure subtype, comorbidity, age and gender.</p> <p><b>Procedure subtype:</b></p> <p><b>Step 1.</b> Identify all CPT codes associated with each outpatient urologic surgery episode date. Some episode dates will be associated with more than one CPT code.</p> <p><b>Step 2.</b> Assign each CPT code to a procedure subtype using Table Proc—Mapping in the Risk Adjustment Shared Tables. Capture all associated CCS categories for each episode. Exclude CPT codes that cannot be assigned to a CCS category. If multiple CPT codes map to one CCS category, only count that CCS category once.</p> <ul style="list-style-type: none"> <li>• <i>For example</i>, assume an episode date has CPT 50590, CPT 50945 and CPT 51040 codes. <ul style="list-style-type: none"> <li>– CPT 50590 maps to CCS 107 (Extracorporeal lithotripsy, urinary).</li> <li>– CPT 50945 maps to CCS 112 (Other OR therapeutic procedures of urinary tract).</li> <li>– CPT 51040 maps to CCS 112 (Other OR therapeutic procedures of urinary tract).</li> </ul> </li> </ul> <p>The final procedure subtypes for this episode date are CCS 107 and CCS 112. Only count CCS 112 once.</p> <p><b>Comorbidities:</b></p> <p><b>Step 1.</b> Identify all diagnoses for encounters during the 365 days prior to and on the date of the outpatient urologic surgery episode date. Include the following when identifying encounters:</p>

- Outpatient visits, ED visits, telephone visits, nonacute inpatient encounters and acute inpatient encounters (Outpatient, ED, Telephone, Acute Inpatient and Nonacute Inpatient Value Set) with a date of service 365 days prior to and on the date of the outpatient urologic surgery episode date.
- Acute and nonacute inpatient discharges (Inpatient Stay Value Set) with a discharge date 365 days prior to and on the date of the outpatient urologic surgery episode date.
- Outpatient urologic surgeries (Urologic Surgery Value Set with Ambulatory Surgery POS Value Set).

**Step 2.** Assign each diagnosis to one or more comorbid Clinical Condition (CC) category using Table CC—Mapping in the Risk Adjustment Shared Tables. If the code appears more than once in Table CC—Mapping, it is assigned to multiple CCs.

Exclude all diagnoses that cannot be assigned to a comorbid CC category. For denominator units with no qualifying diagnoses from face-to-face encounters, skip to *Risk Adjustment Calculation*.

All digits must match exactly when mapping diagnosis codes to the comorbid CCs.

**Step 3.** Determine HCCs for each comorbid CC identified. Refer to Table HCC—Rank.

For each denominator unit's comorbid CC list, match the comorbid CC code to the comorbid CC code in the table, and assign:

- The ranking group.
- The rank.
- The HCC.

For comorbid CCs that do not match to Table HCC—Rank, use the comorbid CC as the HCC and assign a rank of 1. One comorbid CC can map to multiple HCCs; each HCC can have one or more comorbid CCs.

**Step 4.** Assess each ranking group separately and select only the highest ranked HCC in each ranking group using the “Rank” column (1 is the highest rank possible).

Drop all other HCCs in each ranking group, and de-duplicate the HCC list if necessary.

- *For example*, assume a denominator unit with the following comorbid CCs: CC-85, CC-17 and CC-19 (assume no other CCs).
  - CC-85 does not have a map to the ranking table and becomes HCC-85.
  - HCC-17 and HCC-19 are part of Diabetes Ranking Group 1. Because CC-17 is ranked higher than CC-19 in Ranking Group Diabetes 1, the comorbidity is assigned as HCC-17 for Ranking Group 1.

The final comorbidities for this denominator unit are HCC-17 and HCC-85.

<b>Table HCC—Rank</b>					
Ranking Group	CC	Description		Rank	HCC
NA	CC-85	Congestive Heart Failure		NA	HCC-85
Diabetes 1	CC-17	Diabetes With Acute Complications		1	HCC-17
	CC-18	Diabetes With Chronic Complications		2	HCC-18
	CC-19	Diabetes Without Complications		3	HCC-19

**Step 5.** Identify combination HCCs listed in Table HCC—Comb.

Some combinations suggest a greater amount of risk when observed together. For example, when diabetes *and* CHF are present, an increased amount of risk is evident. Additional HCCs are selected to account for these relationships.

Compare each denominator unit's list of unique HCCs to those in the *Comorbid HCC* columns in Table HCC—Comb and assign any additional HCC conditions.

*If there are overlapping combinations, use both sets of combinations.* Based on the combinations, a denominator unit can have none, one or more of these added HCCs.

- *For example*, for a denominator unit with comorbidities HCC-17 and HCC-85 (assume no other HCCs), assign HCC-901 in addition to HCC-17 and HCC-85. This *does not* replace HCC-17 and HCC-85.

**Table HCC—Comb**

Comorbid HCC 1	Comorbid HCC 2	Comorbid HCC 3	HCC-Combination	HCC-Comb Description
HCC-17	HCC-85	NA	HCC-901	Combination: Diabetes and CHF
HCC-18	HCC-85	NA	HCC-901	Combination: Diabetes and CHF
HCC-19	HCC-85	NA	HCC-901	Combination: Diabetes and CHF

**Risk adjustment**

**Risk Adjustment Calculation**

For each outpatient urologic surgery episode, use the following steps to identify the 15-day hospitalization risk adjustment weights based on procedure subtype, comorbidity, age and gender.

**Step 1.** For each outpatient urologic surgery episode with a procedure subtype, link the subtype weights.

**Step 2.** For each outpatient urologic surgery episode with a Comorbidity HCC category, link the comorbidity weights.

**Step 3.** Link the age and gender weights for each outpatient urologic surgery episode.

	<p><b>Step 4.</b> Sum all weights (procedure subtype, comorbidities, age and gender) associated with each outpatient urologic surgery episode and use the formula below to calculate the estimated hospitalization risk for each episode:</p> $\text{Estimated Hospitalization Risk} = \frac{e^{(\sum \text{WeightsForEpisode})}}{1+e^{(\sum \text{WeightsForEpisode})}}$ <p><b>OR</b></p> $\text{Estimated Hospitalization Risk} = [\exp (\text{sum of weights for episode})] / [ 1 + \exp (\text{sum of weights for episode})]$ <p><b>Note:</b> "Exp" refers to the exponential or antilog function.</p> <p>Truncate the estimated hospitalization risk for each episode to 10 decimal places. Do not truncate or round in previous steps.</p> <p><b>Step 5.</b> Calculate the count of expected hospitalizations for each age. The count of expected hospitalizations is the sum of the estimated hospitalization risk calculated for each outpatient urologic surgery episode for each age.</p> $\text{Count of Expected Hospitalizations} = \sum (\text{Estimated Hospitalization Risk})$ <p><b>Step 6.</b> Use the formula below and the estimated hospitalization risk calculated in step 5 to calculate the variance for each outpatient urologic surgery episode.</p> $\text{Variance} = \text{Estimated Hospitalization Risk} \times (1 - \text{Estimated Hospitalization Risk})$ <p>Truncate the variance for each outpatient urologic surgery episode to 10 decimal places.</p> <ul style="list-style-type: none"> <li>• <i>For example</i>, if the estimated hospitalization risk is 0.1518450741 for an outpatient urologic surgery episode, then the hospitalization variance for this outpatient urologic surgery episode is <math>0.1518450741 \times 0.8481549259 = 0.1287881475</math>.</li> </ul> <p><b>Note:</b> Organizations must sum the variances for each age when populating the variance cells in the reporting tables. When reporting, round the variance to 4 decimal places using the .5 rule.</p>
Numerator	<p><b>Acute hospitalization within 15 days of the outpatient urologic surgery episode.</b></p> <p><b>Step 1.</b> For each outpatient urologic surgery episode, identify all acute inpatient admissions and observation stay hospitalizations with an admission date within 15 days after the outpatient urologic surgery episode.</p> <p>To identify acute inpatient and observation admissions:</p> <ol style="list-style-type: none"> <li>4. Identify all acute and nonacute inpatient stays (<u>Inpatient Stay Value Set</u>) and observation stays (<u>Observation Stay Value Set</u>).</li> <li>5. Exclude nonacute inpatient stays (<u>Nonacute Inpatient Stay Value Set</u>).</li> <li>6. Identify the admission date for the stay.</li> </ol> <p><b>Step 2.</b> For discharges with one or more direct transfers, use the last discharge.</p> <p>Using the discharges identified in step 1, identify direct transfers between acute inpatient and observation using the definition of direct transfer.</p>

	<p><b>Step 3.</b> For the remaining discharges, exclude inpatient and observation stay discharges with any of the following criteria on the discharge claim:</p> <ul style="list-style-type: none"> <li>• A principal diagnosis of maintenance chemotherapy (<a href="#">Chemotherapy Encounter Value Set</a>).</li> <li>• A principal diagnosis of rehabilitation (<a href="#">Rehabilitation Value Set</a>).</li> <li>• An organ transplant (<a href="#">Kidney Transplant Value Set</a>, <a href="#">Bone Marrow Transplant Value Set</a>, <a href="#">Organ Transplant Other Than Kidney Value Set</a>, <a href="#">Introduction of Autologous Pancreatic Cells Value Set</a>).</li> <li>• A potentially planned procedure (<a href="#">Potentially Planned Procedures Value Set</a>) without a principal acute diagnosis (<a href="#">Acute Condition Value Set</a>).</li> </ul> <p><b>Note</b></p> <ul style="list-style-type: none"> <li>• 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.</li> <li>• Only one inpatient admission or observation stay hospitalization may be included in the numerators for each unique outpatient urologic surgery denominator event. If there are multiple numerator events that meet criteria for a singular denominator event, only count the numerator event closest to the outpatient urologic surgery.</li> </ul> <p>For example, consider the following events:</p> <ul style="list-style-type: none"> <li>– Outpatient urologic surgery episode: May 10.</li> <li>– Observation stay: May 13–14.</li> <li>– Acute inpatient stay: May 16–May 20.</li> </ul> <p>Both the observation stay of May 13–14 and the acute inpatient stay of May 16–May 20 are within 15 days of the outpatient urologic surgery episode on May 10. Only the observation stay is included in the numerator because it is the hospitalization event closest to the outpatient urologic surgery episode.</p> <ul style="list-style-type: none"> <li>• Count each unique acute inpatient admission or observation stay hospitalization only once toward the numerator for the last denominator event. If a single numerator event meets criteria for multiple denominator events, only attribute the numerator event to the last denominator event.</li> </ul> <p>For example, consider the following events:</p> <ul style="list-style-type: none"> <li>– Outpatient urologic surgery episode 1: May 10.</li> <li>– Outpatient urologic surgery episode 2: May 15.</li> <li>– Acute inpatient stay: May 18.</li> </ul> <p>The outpatient urologic surgery episodes of May 10 and May 15 are included as denominator events. The acute inpatient stay counts as a numerator event only toward the last denominator event (episode 2, May 15).</p>
<b>Summary of changes</b>	<ul style="list-style-type: none"> <li>• This is a first-year measure.</li> </ul>
<b>Data element tables</b>	<p><b>Reporting: Denominator</b> The number of outpatient urologic surgery episodes, reported as the Denominator.</p>

	<p><b>Reporting: Numerator</b> The number of observed acute inpatient admission or observation stay hospitalizations, reported as the ObservedCount.</p> <p><b>Calculated: Observed hospitalization rate</b> The number of observed acute inpatient admission or observation stay hospitalizations (ObservedCount) divided by the number of outpatient urologic surgery episodes (Denominator). Calculated by IDSS as the ObservedRate.</p> <p><b>Reporting: Count of expected hospitalizations</b></p> <p><b>Step 1.</b> Calculate the number of expected inpatient admission or observation stay hospitalizations.</p> <p><b>Step 2.</b> Round to 4 decimal places using the .5 rule and report these values as the ExpectedCount.</p> <p><b>Calculated: Expected hospitalization rate</b> The number of expected acute inpatient admission or observation stay hospitalizations (ExpectedCount) divided by the number of outpatient urologic surgery episodes (Denominator). Calculated by IDSS as the ExpectedRate.</p> <p><b>Reporting: Variance</b></p> <p><b>Step 1.</b> Calculate the variance (<i>Risk Adjustment Calculation</i>, step 6).</p> <p><b>Step 2.</b> Round to 4 decimal places using the .5 rule and report these values as the CountVariance.</p> <p><b>Calculated: O/E ratio</b> The number of observed acute inpatient admission or observation stay hospitalizations (ObservedCount) divided by the number of expected acute inpatient admission or observation stay hospitalizations (ExpectedCount). Calculated by IDSS as the OE.</p> <p>Organizations that submit HEDIS data to NCQA must provide the following data elements.</p>
<b>Rules for Allowable Adjustments</b>	<p><b>Copyright and use:</b> The “Rules for Allowable Adjustments of HEDIS” (the “Rules”) describe how NCQA’s HEDIS measure specifications can be adjusted for other populations, if applicable. The Rules, reviewed and approved by NCQA measure experts, provide for expanded use of HEDIS measures without changing their clinical intent.</p>

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

The measures under the Risk Adjusted Utilization domain allow two types of *Rules for Allowable Adjustments* sections:

1. *Rules for Allowable Adjustments for Risk-Adjusted Measurement.* This section must be followed for adjustments when calculating the full measure specifications, which includes all risk adjusted rates (expected rates, risk adjustment, O/E) and calculation components (count of index stays, observed events).
2. *Rules for Allowable Adjustments for Observed Measurement (rates without risk adjustment).* This section must be followed when adjusting the calculation of observed events only. When applying these adjustments, organizations must not include risk adjustment logic.

The intent of including two types of Rules is to allow organizations to adjust measures without compromising measure validity. Risk adjustment is based on statistical prediction models specifically calibrated to each measure.

**The following are the Rules for Allowable Adjustments for Risk-Adjusted Measurement of the Acute Hospitalizations Following Outpatient Urologic Surgery measure (expected hospitalization rate, risk adjustment determination, risk adjustment weighting, variance, O/E ratio).**

**ADJUSTMENTS ALLOWED**

- *Benefits.* Organizations are not required to use a benefit.
- *Telehealth.* Services/events that allow the use of synchronous telehealth visits, telephone visits and asynchronous telehealth (e-visits, virtual check-ins) may be stratified to identify services performed via telehealth. This adjustment is not allowed for events, numerators and exclusions that do not allow the use of telehealth.

**ADJUSTMENTS ALLOWED WITH LIMITS**

- *Other.* Organizations may only adjust the initial population criteria to focus on an area of interest defined by gender, sociodemographic characteristics or geographical region. NCQA recommends evaluating risk model performance and validity within adjusted populations. Organizations may not adjust for a clinical subpopulation (e.g., persons with a diabetes diagnosis).
- *Measurement period adjustments.* Organizations may only change the measurement period by 1 year.
- *Denominator.* Organizations may include denied claims to calculate denominator events. Value sets and logic may not be changed.
- *Risk adjustment determination, risk adjustment weighting, expected hospitalizations, variance.* Organizations may include denied claims to calculate these events. Risk adjustment determinations, weighting and calculations of expected events logic may not be changed.
- *Numerator.* Organizations may include denied claims to calculate the numerator. Value sets and logic may not be changed.

**ADJUSTMENTS NOT ALLOWED**

- *Product lines.* Organizations may not adjust product lines.
- *Attribution.* Organizations are required to use enrollment criteria.
- *Ages.* The age determination dates may not be changed.
- *Supplemental data.* Supplemental data may not be used to identify initial population, denominator, exclusion and numerator events.
- *Exclusions.* The hospice exclusion must be applied. Logic may not be changed.

**The following are the Rules for Allowable Adjustments for Observed Measurement of the Acute Hospitalizations Following Outpatient Urologic Surgery measure observed events (denominator, numerator, observed hospitalization rate).**

**ADJUSTMENTS ALLOWED**

- *Product lines.* When adjusting this measure to assess for observed events only, organizations are not required to use product line criteria; product lines may be combined, and all (or no) product line criteria may be used.
- *Ages.* The observed event age range may be expanded. Age determination dates may be changed (e.g., select, "age as of June 30").
- *Attribution.* Organizations are not required to use enrollment criteria.
- *Benefits.* Organizations are not required to use a benefit.
- *Other.* Organizations may adjust the initial population criteria to focus on an area of interest defined by gender, race, ethnicity, socioeconomic or sociodemographic characteristics, geographic region or another characteristic.
- *Measurement period adjustments.* Organizations may adjust the measurement period.
- *Exclusions.* Hospice exclusion is not required.
- *Telehealth.* Services/events that allow the use of synchronous telehealth visits, telephone visits and asynchronous telehealth (e-visits, virtual check-ins) may be stratified to identify services performed via telehealth. This adjustment is not allowed for events, numerators and exclusions that do not allow the use of telehealth.
- *Supplemental data.* Supplemental data may be used to identify initial population, denominator, exclusion and numerator events.

**ADJUSTMENTS ALLOWED WITH LIMITS**

- *Denominator.* Organizations may include denied claims to calculate denominator events. Value sets and logic may not be changed.
- *Numerator.* Organizations may include denied claims to calculate the numerator. Value sets and logic may not be changed.

## Acute Hospital Utilization (AHU)

Measure title	Acute Hospital Utilization	Measure ID	AHU
<b>Description</b>	For persons 18 years of age and older, the risk-adjusted ratio of observed-to-expected acute inpatient and observation stay discharges during the measurement period.		
<b>Measurement period</b>	January 1–December 31.		
<b>Copyright and disclaimer notice</b>	<p>Refer to the complete copyright and disclaimer information at the front of this publication.</p> <p>NCQA website: <a href="http://www.ncqa.org">www.ncqa.org</a>.</p> <p>Submit policy clarification support questions via My NCQA (<a href="https://my.ncqa.org">https://my.ncqa.org</a>).</p>		
<b>Clinical recommendation statement/ rationale</b>	<p>Hospitalizations put patients at risk of adverse events and are costly, accounting for about a third of all annual health care expenditures in the US. While not all acute hospitalizations can be avoided, studies have shown that payer-level interventions (e.g., proper care coordination and case management for patients with complex medical needs or multiple comorbid conditions) are effective at reducing overall hospital utilization.</p>		
<b>Citations</b>	<p>Covinsky, K.E., E. Pierluissi, &amp; C.B. Johnston. 2011. “Hospitalization-Associated Disability.” <i>JAMA: The Journal of the American Medical Association</i> 306(16), 1782–93.</p> <p>McDermott, K.W., A. Elixhauser, R. Sun. 2017. “Trends in Hospital Inpatient Stays in the United States, 2005–2014.” HCUP Statistical Brief #225. Agency for Healthcare Research and Quality, Rockville, MD.  <a href="http://www.hcup-us.ahrq.gov/reports/statbriefs/sb225-Inpatient-US-Stays-Trends.pdf">www.hcup-us.ahrq.gov/reports/statbriefs/sb225-Inpatient-US-Stays-Trends.pdf</a></p> <p>Mkanta, W.N., N.R. Chumbler, K. Yang, R. Saigal, and M. Abdollahi. 2016. “Cost and Predictors of Hospitalizations for Ambulatory Care - Sensitive Conditions Among Medicaid Enrollees in Comprehensive Managed Care Plans.” <i>Health Services Research and Managerial Epidemiology</i> 3, 2333392816670301.</p> <p>Kaiser Family Foundation (KFF). (2019). <i>An Overview of Medicare</i>.  <a href="https://www.kff.org/medicare/issue-brief/an-overview-of-medicare/">https://www.kff.org/medicare/issue-brief/an-overview-of-medicare/</a></p>		
<b>Characteristics</b>			
<b>Scoring</b>	Ratio.		
<b>Product lines</b>	<ul style="list-style-type: none"> <li>• Commercial.</li> <li>• Medicare.</li> <li>• Medicaid.</li> </ul>		

<b>Stratifications</b>  <b>Guidance</b>	<p>Age as of the last day of the measurement period for Medicaid.</p> <ul style="list-style-type: none"> <li>• 18–21 years.</li> <li>• 22–34 years.</li> <li>• 35–44 years.</li> <li>• 45–54 years.</li> <li>• 55–64 years.</li> </ul> <p>Ages as of the last day of the measurement period for commercial and Medicare.</p> <ul style="list-style-type: none"> <li>• 18–44 years.</li> <li>• 45–54 years.</li> <li>• 55–64 years.</li> <li>• 65–74 years.</li> <li>• 75–84 years.</li> <li>• 85+ years.</li> </ul> <p><b>Programming Guidance</b></p> <p><b>Dual enrollment:</b> Persons with dual commercial and Medicaid enrollment may only be reported in the commercial product line. Persons with dual Medicaid/Medicare enrollment may only be reported in the Medicare product line. Dual enrollment is assessed after the continuous enrollment criteria are applied. To meet criteria for dual enrollment, persons must have dual enrollment at the end of the continuous enrollment period.</p> <p><b>Risk Adjustment Measure Specific Guidance</b></p> <p><b>Observation stays:</b> For observation stays (<u>Observation Stay Value Set</u>) that do not have a recorded admission or discharge date, set the admission date to the earliest date of service on the claim and set the discharge date to the last date of service on the claim.</p> <p><b>Which services count?</b></p> <ul style="list-style-type: none"> <li>• Use all paid, suspended, pending, and denied claims when applying risk adjustment comorbidity category determination and the hospice exclusion.</li> <li>• Do not include denied claims when identifying all other events (e.g., observed events); only report claims the organization paid for or expects to pay for (i.e., claims incurred but not paid).</li> </ul> <p><b>Supplemental data exceptions:</b> Supplemental data may only be used for the hospice exclusion.</p> <p><b>Transfers:</b></p> <ul style="list-style-type: none"> <li>• Treat transfers <i>between</i> institutions as separate admissions.</li> <li>• Base transfer reports <i>within</i> an institution on the type and level of services provided.</li> <li>• Report separate admissions when the transfer is between acute and nonacute levels of service or between mental health/chemical dependency services and non-mental health/chemical dependency services.</li> </ul>
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	<ul style="list-style-type: none"> <li>Count only one admission when the transfer takes place within the same service category, but to a different level of care (e.g., from intensive care to a lesser level of care; from a lesser level of care to intensive care).</li> </ul> <p><b>Risk adjustment:</b> Organizations may not use risk assessment protocols to supplement diagnoses for calculation of the risk adjustment scores for these measures. The measurement model was developed and tested using only claims-based diagnoses; diagnoses from additional data sources would affect the validity of the models as they are currently implemented in the specification.</p> <p><b>General Rules</b></p> <p><b>Data collection methodology:</b> Administrative. Refer to <a href="#">General Guideline: Data Collection Methods</a> for additional information.</p> <p><b>Date specificity:</b> Dates must be specific enough to determine the event occurred in the period being measured.</p> <p><b>Improvement notation:</b> To interpret the ratio as better or worse than expected, the ratio must be calibrated. Organizations can calibrate ratios by dividing individual organization ratios or national percentiles by the national average ratio. Organizations may be more successful at achieving fewer hospitalizations than expected, given the types of cases treated by the organization (calibrated ratio with a value &lt;1.0), or may be less successful (calibrated ratio with a value &gt;1.0).</p>
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<b>Definitions</b>	
<b>Direct transfer</b>	<p>When the discharge date from the initial stay precedes the admission date to a subsequent stay by 1 calendar day or less.</p> <ul style="list-style-type: none"> <li><i>For example:</i> <ul style="list-style-type: none"> <li>A discharge on June 1, followed by a subsequent admission on June 1 or June 2, <i>is a direct transfer</i>.</li> <li>A discharge on June 1, followed by a subsequent admission on June 3, <i>is not a direct transfer</i>; these are two distinct stays.</li> <li>A discharge on June 1, followed by a subsequent admission on June 2 (with discharge on June 3), followed by a subsequent admission on June 4, <i>is a direct transfer</i>.</li> </ul> </li> </ul> <p>Direct transfers may occur between different facilities, and between acute inpatient and observation.</p>
<b>Outlier</b>	<p>Medicare enrollees with four or more inpatient or observation stay discharges during the measurement period.</p> <p>Medicaid enrollees with six or more inpatient or observation stay discharges during the measurement period.</p> <p>Commercial enrollees with three or more inpatient or observation stay discharges during the measurement period.</p>
<b>Nonoutlier</b>	<p>Medicare enrollees with three or fewer inpatient or observation stay discharges during the measurement period.</p> <p>Medicaid enrollees with five or fewer inpatient or observation stay discharges during the measurement period.</p>

<b>Planned hospital stay</b>	Commercial enrollees with two or fewer inpatient or observation stay discharges during the measurement period.  A hospital stay is considered planned if it meets criteria in step 3 of the measure observation.
<b>PPD</b>	Predicted probability of discharge. The predicted probability of a person having any discharge in the measurement period.
<b>PUCD</b>	Predicted unconditional count of discharges. The predicted unconditional count of discharges for persons during the measurement period.
<b>Initial population</b>	<p><i>Measure item count:</i> Person.</p> <p><i>Attribution basis:</i> Enrollment.</p> <ul style="list-style-type: none"> <li>• <i>Benefits:</i> Medical.</li> <li>• <i>Continuous enrollment:</i> The measurement period and the year prior to the measurement period.</li> <li>• <i>Allowable gap:</i> No more than one gap of ≤45 days during each year of continuous enrollment. No gap on the last day of the measurement period.</li> </ul> <p><i>Ages:</i></p> <ul style="list-style-type: none"> <li>• <i>Commercial and Medicare:</i> 18 years of age and older as of the last day of the measurement period.</li> <li>• <i>Medicaid:</i> 18–64 years of age as of the last day of the measurement period.</li> </ul> <p><i>Gender/Sex criteria:</i></p> <ul style="list-style-type: none"> <li>• Administrative Gender of Female (AdministrativeGender code female).</li> <li>• Administrative Gender of Male (AdministrativeGender code male).</li> </ul> <p><i>Exclusion: Persons in hospice or using hospice services.</i></p> <p>Persons who use hospice services (<u>Hospice Encounter Value Set</u>; <u>Hospice Intervention Value Set</u>) or elect to use a hospice benefit any time during the measurement period. Organizations that use the Monthly Membership Detail Data File to identify these persons must use only the run date of the file.</p>
<b>Measure observation</b>	<p><b>Calculation of observed events</b></p> <p>Use the following steps to identify and categorize acute inpatient and observation stay discharges.</p> <p><b>Step 1.</b> Identify all acute inpatient and observation stay discharges during the measurement period.</p> <ol style="list-style-type: none"> <li>1. Identify all acute and nonacute inpatient stays (<u>Inpatient Stay Value Set</u>) and observation stays (<u>Observation Stay Value Set</u>).</li> <li>2. Exclude nonacute inpatient stays (<u>Nonacute Inpatient Stay Value Set</u>).</li> <li>3. Identify the discharge date for the stay.</li> </ol>

	<p><b>Step 2.</b> 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 using the definition of direct transfer.</p> <p><b>Step 3.</b> For the remaining acute inpatient and observation stay discharges, exclude inpatient and observation stay discharges with any of the following criteria on the discharge claim:</p> <ul style="list-style-type: none"> <li>• A principal diagnosis of mental health or chemical dependency (<a href="#">Mental and Behavioral Disorders Value Set</a>).</li> <li>• A principal diagnosis of live-born infant (<a href="#">Deliveries Infant Record Value Set</a>) or maternity-related principal diagnosis (<a href="#">Maternity Diagnosis Value Set</a>).</li> <li>• A maternity-related stay (<a href="#">Maternity Value Set</a>).</li> <li>• A planned hospital stay using any of the following: <ul style="list-style-type: none"> <li>– A principal diagnosis of maintenance chemotherapy (<a href="#">Chemotherapy Encounter Value Set</a>).</li> <li>– A principal diagnosis of rehabilitation (<a href="#">Rehabilitation Value Set</a>).</li> <li>– An organ transplant (<a href="#">Kidney Transplant Value Set</a>, <a href="#">Bone Marrow Transplant Value Set</a>, <a href="#">Organ Transplant Other Than Kidney Value Set</a>, <a href="#">Introduction of Autologous Pancreatic Cells Value Set</a>).</li> <li>– A potentially planned procedure (<a href="#">Potentially Planned Procedures Value Set</a>) without a principal acute diagnosis (<a href="#">Acute Condition Value Set</a>).</li> </ul> </li> <li>• Inpatient and observation stays with a discharge for death.</li> </ul> <p><b>Note:</b> 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.</p> <p><b>Step 4.</b> Remove discharges for outliers and report these persons as outliers. Count discharges with one or more direct transfers (identified in step 2) as one discharge when identifying outliers.</p> <p><b>Step 5.</b> Calculate the total using all discharges identified after completing steps 1–4.</p>
<b>Risk adjustment factors</b>	<p><b>Risk Adjustment Determination</b></p> <p>For each discharge among nonoutliers, identify risk adjustment weights based on comorbidity, age and gender. Weights are specific to product line (Medicare Under 65, Medicare 65 Plus, Medicaid, commercial). Refer to the reporting indicator column in the risk adjustment tables to ensure that weights are linked appropriately.</p> <p><b>Comorbidities:</b></p> <p><b>Step 1.</b> Identify all diagnoses for encounters during the year prior to the measurement period. Include the following when identifying encounters:</p> <ul style="list-style-type: none"> <li>• Outpatient visits, ED visits, telephone visits, nonacute inpatient encounters and acute inpatient encounters (<a href="#">Outpatient, ED, Telephone, Acute Inpatient and Nonacute Inpatient Value Set</a>) with a date of service during the year prior to the measurement period.</li> </ul>

- Acute and nonacute inpatient discharges (Inpatient Stay Value Set) with a discharge date during the year prior to the measurement period.

**Step 2.** Assign each diagnosis to one or more comorbid Clinical Condition (CC) category using Table CC—Mapping in the Risk Adjustment Shared Tables. If the code appears more than once in Table CC—Mapping, it is assigned to multiple CCs.

Exclude all diagnoses that cannot be assigned to a comorbid CC category. For persons with no qualifying diagnoses from face-to-face encounters, skip to Risk Adjustment Calculation.

All digits must match exactly when mapping diagnosis codes to the comorbid CCs.

**Step 3.** Determine HCCs for each comorbid CC identified. Refer to Table HCC—Rank.

For each person's comorbid CC list, match the comorbid CC code to the comorbid CC code in the table, and assign:

- The ranking group.
- The rank.
- The HCC.

For comorbid CCs that do not match to Table HCC—Rank, use the comorbid CC as the HCC and assign a rank of 1. One comorbid CC can map to multiple HCCs; each HCC can have one or more comorbid CCs.

**Step 4.** Assess each ranking group separately and select only the highest ranked HCC in each ranking group using the “Rank” column (1 is the highest rank possible).

Drop all other HCCs in each ranking group, and de-duplicate the HCC list if necessary.

- *For example*, assume a person with the following comorbid CCs: CC-85, CC-17 and CC-19 (assume no other CCs).
  - CC-85 does not have a map to the ranking table and becomes HCC-85.
  - HCC-17 and HCC-19 are part of Diabetes Ranking Group 1. Because CC-17 is ranked higher than CC-19 in Ranking Group Diabetes 1, the comorbidity is assigned as HCC-17 for Ranking Group 1.

The final comorbidities for this person are HCC-17 and HCC-85.

**Table HCC—Rank**

Ranking Group	CC	Description	Rank	HCC
NA	CC-85	Congestive Heart Failure	NA	HCC-85
Diabetes 1	CC-17	Diabetes With Acute Complications	1	HCC-17
	CC-18	Diabetes With Chronic Complications	2	HCC-18
	CC-19	Diabetes Without Complications	3	HCC-19

	<p><b>Step 5.</b> Identify combination HCCs listed in Table HCC—Comb.</p> <p>Some combinations suggest a greater amount of risk when observed together. For example, when diabetes <i>and</i> CHF are present, an increased amount of risk is evident. Additional HCCs are selected to account for these relationships.</p> <p>Compare each person's list of unique HCCs to those in the <i>Comorbid HCC</i> columns in Table HCC—Comb and assign any additional HCC conditions.</p> <p>If there are overlapping combinations, use both sets of combinations. Based on the combinations, a person can have none, one or more of these added HCCs.</p> <ul style="list-style-type: none"> <li>• <i>For example</i>, for a person with comorbidities HCC-17 and HCC-85 (assume no other HCCs), assign HCC-901 in addition to HCC-17 and HCC-85. This does not replace HCC-17 and HCC-85.</li> </ul> <p><b>Table HCC—Comb</b></p> <table border="1"> <thead> <tr> <th>Comorbid HCC 1</th><th>Comorbid HCC 2</th><th>Comorbid HCC 3</th><th>HCC-Combination</th><th>HCC-Comb Description</th></tr> </thead> <tbody> <tr> <td>HCC-17</td><td>HCC-85</td><td>NA</td><td>HCC-901</td><td>Combination: Diabetes and CHF</td></tr> <tr> <td>HCC-18</td><td>HCC-85</td><td>NA</td><td>HCC-901</td><td>Combination: Diabetes and CHF</td></tr> <tr> <td>HCC-19</td><td>HCC-85</td><td>NA</td><td>HCC-901</td><td>Combination: Diabetes and CHF</td></tr> </tbody> </table>	Comorbid HCC 1	Comorbid HCC 2	Comorbid HCC 3	HCC-Combination	HCC-Comb Description	HCC-17	HCC-85	NA	HCC-901	Combination: Diabetes and CHF	HCC-18	HCC-85	NA	HCC-901	Combination: Diabetes and CHF	HCC-19	HCC-85	NA	HCC-901	Combination: Diabetes and CHF
Comorbid HCC 1	Comorbid HCC 2	Comorbid HCC 3	HCC-Combination	HCC-Comb Description																	
HCC-17	HCC-85	NA	HCC-901	Combination: Diabetes and CHF																	
HCC-18	HCC-85	NA	HCC-901	Combination: Diabetes and CHF																	
HCC-19	HCC-85	NA	HCC-901	Combination: Diabetes and CHF																	
Risk adjustment	<p><b>Risk Adjustment Calculation</b></p> <p>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 visits each person might have during the measurement period.</p> <p><b>For each nonoutlier person in the initial population, assign PPD risk weights. Calculate the PPD.</b></p> <p><b>Step 1.</b> For each person with a comorbidity HCC category, link the PPD weights.</p> <p><b>Step 2.</b> Link the age-gender PPD weights for each person.</p> <p><b>Step 3.</b> Sum all PPD weights (comorbidities, age and gender) associated with the person.</p> <p><b>Step 4.</b> Calculate the predicted probability of having at least one discharge in the measurement period based on the sum of the weights for each person using the formula below.</p> $\text{PPD} = \frac{e^{(\sum \text{PPD WeightsForEachPerson})}}{1+e^{(\sum \text{PPD WeightsForEachPerson})}}$ <p>Truncate the final PPD <i>for each person</i> to 10 decimal places. Do not truncate or round in previous steps.</p>																				

For each nonoutlier person in the initial population, assign PUCD risk weights.

**Step 1.** For each person with a comorbidity HCC Category, link the PUCD weights. If a person does not have any comorbidities to which a weight could be linked, assign a weight of 1.

**Step 2.** Link the age-gender PUCD weights for each person.

**Step 3.** Calculate the predicted unconditional count of discharges in the measurement period by multiplying all PUCD weights (comorbidities, age and gender) associated with the person. Use the following formula:

$$\text{PUCD} = \text{Age/Gender Weight} * \text{HCC Weight}$$

**Note:** Multiply by each HCC associated with the person. For example, assume a person with HCC-2, HCC-10, HCC-47. The formula would be:

$$\text{PUCD} = \text{Age/Gender Weight} * \text{HCC-2} * \text{HCC-10} * \text{HCC-47}$$

Truncate the final PUCD for each person to 10 decimal places. Do not truncate or round in previous steps.

**Expected count of discharges.** Calculate the final person-level expected count of discharges using the formula below.

$$\text{Expected Count of Discharges} = \text{PPD} \times \text{PUCD}$$

Round the person-level results to 4 decimal places using the .5 rule and sum over all persons in the category.

**Step 4.** Use the formula below to calculate the covariance of the predicted outcomes for each category. For categories with a single person ( $n_c=1$ ), set the covariance to zero. Do not round the covariance before using it in step 5.

$$\text{COV}_c = \frac{\sum_{m=1}^{n_c} (\text{PPD}_m - \text{mean}(\text{PPD})_c) \times (\text{PUCD}_m - \text{mean}(\text{PUCD})_c)}{n_c - 1}$$

Where:

$c$  denotes an individual category

$n_c$  is the number of persons in the category indicated by  $c$

$m$  is an individual person within the category indicated by  $c$

$\text{PPD}_m$  is the truncated PPD for the person denoted by  $m$

$\text{mean}(\text{PPD})_c$  is the unrounded and untruncated mean PPD in the category indicated by  $c$

$\text{PUCD}_m$  is the truncated PUCD for the person denoted by  $m$

$\text{mean}(\text{PUCD})_c$  is the unrounded and untruncated mean PUCD in the category indicated by  $c$

**Step 5.** Once the covariance between PPD and PUCD for a given category is calculated, it can be used as indicated in the formula below to calculate the variance for that category.

$$\begin{aligned} \text{Variance}_c &= \sum_{m=1}^{n_c} (\text{PPD}_m \times \text{PUCD}_m)^2 \\ &\quad \times \left( 1 + (1 - \text{PPD}_m)^2 + \left( \frac{2 \times \text{COV}_c}{\text{PPD}_m \times \text{PUCD}_m} \right) \right) \end{aligned}$$

	<p>Where:</p> <p><math>c</math> denotes an individual category  <math>n_c</math> is the number of persons in the category indicated by <math>c</math>  <math>m</math> is an individual person within the category indicated by <math>c</math>  <math>PPD_m</math> is the truncated PPD for the person denoted by <math>m</math>  <math>PUCD_m</math> is the truncated PUCD for the person denoted by <math>m</math></p> <p>Round the variance for reporting to 4 decimal places using the .5 rule.</p>
<b>Summary of changes</b>	<ul style="list-style-type: none"> <li>Integrated the Risk Adjustment General Guidelines into the <i>Guidance</i> section.</li> <li>Removed the definition of the classification period and added this information into the risk adjustment calculation.</li> <li>Added “direct transfer” to the <i>Definitions</i> section.</li> <li>Added administrative gender codes to the initial population.</li> </ul>
<b>Data element tables</b>	<p><b>Reporting: Number of nonoutliers</b>  The number of nonoutlier persons for each age group, reported as the NonOutlierPersonCount.</p> <p><b>Reporting: Number of outliers</b>  The number of outlier persons for each age group, reported as the OutlierPersonCount.</p> <p><b>Calculated: Number of persons in the initial population</b>  The number of persons in the initial population (including outliers) for each age group and totals. Calculated by IDSS as the PersonCount.</p> <p><b>Calculated: Outlier rate</b>  The number of outlier persons (OutlierPersonCount) divided by the number of persons in the initial population (PersonCount) multiplied by 1,000 for each age group and totals. Calculated by IDSS as the OutlierRate.</p> <p><b>Reporting: Number of observed events among nonoutlier persons</b>  The number of observed discharges within each age group, reported as the ObservedCount.</p> <p><b>Calculated: Observed discharges per 1,000 nonoutlier persons</b>  The number of observed discharges (ObservedCount) divided by the number of nonoutlier persons in the initial population (NonOutlierPersonCount), multiplied by 1,000 within each age group and totals. Calculated by IDSS as the ObservedRate.</p> <p><b>Reporting: Number of expected events among nonoutlier persons</b>  The number of expected discharges within each age group, reported as the ExpectedCount.</p> <p><b>Calculated: Expected discharges per 1,000 nonoutlier persons</b>  The number of expected discharges (ExpectedCount) divided by the number of nonoutlier persons in the initial population (NonOutlierPersonCount), multiplied by 1,000 within each age group and totals. Calculated by IDSS as the ExpectedRate.</p>

**Reporting: Variance among nonoutlier persons**

The variance (*Risk Adjustment Calculation*, PUCD, step 5) within each age group, reported as the CountVariance.

**Calculated: O/E ratio**

The number of observed discharges among nonoutlier persons (ObservedCount) divided by the number of expected discharges among nonoutlier persons (ExpectedCount) for each age group and totals. Calculated by IDSS as the OE.

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

**Table AHU-1: Data Elements for Acute Hospital Utilization**

Metric	Age	Data Element	Reporting Instructions
AcuteHospitalUtilization	18-21	NonOutlierPersonCount	For each Stratification
	22-34	OutlierPersonCount	For each Stratification
	35-44	PersonCount	NonOutlierPersonCount + OutlierPersonCount
	18-44	OutlierRate	OutlierPersonCount / PersonCount (Permille)
	45-54	ObservedCount	For each Stratification
	55-64	ObservedRate	1000 * ObservedCount / NonOutlierPersonCount
	18-64	ExpectedCount	For each Stratification
		ExpectedRate	1000 * ExpectedCount / NonOutlierPersonCount
		CountVariance	For each Stratification
		OE	ObservedCount / ExpectedCount

**Table AHU-2/3: Data Elements for Acute Hospital Utilization**

Metric	Age	Data Element	Reporting Instructions
AcuteHospitalUtilization	18-44	NonOutlierPersonCount	For each Stratification
	45-54	OutlierPersonCount	For each Stratification
	55-64	PersonCount	NonOutlierPersonCount + OutlierPersonCount
	18-64	OutlierRate	OutlierPersonCount / PersonCount (Permille)
	65-74	ObservedCount	For each Stratification
	75-84	ObservedRate	1000 * ObservedCount / NonOutlierPersonCount
	85+	ExpectedCount	For each Stratification
	65+	ExpectedRate	1000 * ExpectedCount / NonOutlierPersonCount
	Total	CountVariance	For each Stratification
		OE	ObservedCount / ExpectedCount

## Rules for Allowable Adjustments

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

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

The measures under the Risk Adjusted Utilization domain allow two types of *Rules for Allowable Adjustments* sections:

1. *Rules for Allowable Adjustments for Risk-Adjusted Measurement.* This section must be followed for adjustments when calculating the full measure specifications, which includes all risk adjusted rates (expected rates, risk adjustment, O/E) and calculation components (count of index stays, observed events).
2. *Rules for Allowable Adjustments for Observed Measurement (rates without risk adjustment).* This section must be followed when adjusting the calculation of observed events only. When applying these adjustments, organizations must not include risk adjustment logic.

The intent of including the two different types of Rules is to allow organizations to adjust measures without compromising the measures’ validity. Risk adjustment is based on statistical prediction models that are specifically calibrated for each measure.

The following are the Rules for Allowable Adjustments for Risk-Adjusted Measurement of the Acute Hospital Utilization measure (observed discharges, expected discharges, risk adjustment determination, risk adjustment weighting, O/E, variance).

### ADJUSTMENTS ALLOWED

- *Benefits.* Organizations are not required to use a benefit.
- *Telehealth.* Services/events that allow the use of synchronous telehealth visits, telephone visits and asynchronous telehealth (e-visits, virtual check-ins) may be stratified to identify services performed via telehealth. This adjustment is not allowed for events/diagnoses, numerators and exclusions that do not allow the use of telehealth.

### ADJUSTMENTS ALLOWED WITH LIMITS

- *Other.* Organizations may only adjust the initial population criteria to focus on an area of interest defined by gender, sociodemographic characteristics or geographical region. NCQA recommends evaluating risk model performance and validity within adjusted populations. Organizations may not adjust for a clinical subpopulation (e.g., persons with a diabetes diagnosis).
- *Measurement period adjustments.* Organizations may only change the measurement period by 1 year.
- *Initial population.* Organizations may include denied claims to calculate the initial population. The logic may not be changed.

- *Discharges.* Organizations may include denied claims to calculate observed events. Only events or diagnoses that contain (or map to) codes in value sets may be used to identify visits. The value sets and logic may not be changed.
- *Outlier.* Organizations may include denied claims to calculate these events. Organizations may not adjust the outlier logic.
- *Risk adjustment determination, risk adjustment weighting, expected count of discharges, variance.* Organizations may include denied claims to calculate these events. Risk adjustment determinations, weighting and calculations of expected events logic may not be changed.

#### **ADJUSTMENTS NOT ALLOWED**

- *Product lines.* Organizations may not adjust product lines.
- *Attribution.* Organizations are required to use enrollment criteria.
- *Ages.* The age determination dates may not be changed.
- *Supplemental data.* Supplemental data may not be used to identify initial population (with the exception of the hospice exclusion) or any events.
- *Exclusions.* The hospice exclusion must be applied. Logic may not be changed.

**The following are the Rules for Allowable Adjustments for Observed Measurement of the Acute Hospital Utilization measure observed events (observed discharges).**

#### **ADJUSTMENTS ALLOWED**

- *Product lines.* When adjusting this measure to assess for observed events only, organizations are not required to use product line criteria; product lines may be combined, and all (or no) product line criteria may be used.
- *Ages.* The observed event age range may be expanded. Age determination dates may be changed (e.g., select, "age as of June 30").
- *Attribution.* Organizations are not required to use enrollment criteria.
- *Benefits.* Organizations are not required to use a benefit.
- *Other.* Organizations may use additional initial population criteria to focus on a population of interest such as gender, race and ethnicity, socioeconomic, sociodemographic characteristics, geographic region or another characteristic.
- *Measurement period adjustments.* Organizations may adjust the measurement period.
- *Exclusions.* Hospice exclusion is not required.
- *Outlier.* Organizations may adjust the outlier logic. The outlier logic is not required to be applied. The outlier thresholds may be expanded or reduced. Denied claims may be used to calculate these events.
- *Telehealth.* Services/events that allow the use of synchronous telehealth visits, telephone visits and asynchronous telehealth (e-visits, virtual check-ins) may be stratified to identify services performed via telehealth. This adjustment is not allowed for events/diagnoses, numerators and exclusions that do not allow the use of telehealth.

- *Supplemental data.* Supplemental data may be used to identify initial population and all events.

**ADJUSTMENTS ALLOWED WITH LIMITS**

- *Discharges.* Organizations may include denied claims to calculate observed events. Only events or diagnoses that contain (or map to) codes in value sets may be used to identify visits. The value sets and logic may not be changed.

## ***Emergency Department Utilization (EDU)***

<b>Measure title</b>	Emergency Department Utilization	<b>Measure ID</b>	EDU
<b>Description</b>	For people 18 years of age and older, the risk-adjusted ratio of observed-to-expected emergency department (ED) visits during the measurement period.		
<b>Measurement period</b>	January 1–December 31.		
<b>Copyright and disclaimer notice</b>	<p>Refer to the complete copyright and disclaimer information at the front of the publication.</p> <p>NCQA website: <a href="http://www.ncqa.org">www.ncqa.org</a>.</p> <p>Submit policy clarification support questions via My NCQA (<a href="https://my.ncqa.org">https://my.ncqa.org</a>).</p>		
<b>Clinical recommendation statement/ rationale</b>	<p>Each year, approximately 1 out of 5 U.S. adults uses the ED for health care, and utilization rates have trended upward in recent years. Studies have estimated that up to 60% of all ED visits are potentially preventable or nonurgent, leading to overcrowding, increased wait times and reduction in the ability of hospital staff to provide efficient, quality care to patients with truly emergent conditions. To reduce avoidable ED visits, payers can provide appropriate disease management services, access to primary care clinics and care coordination.</p>		
<b>Citations</b>	<p>Gindi, R.M., L.I. Black, &amp; R.A. Cohen. 2016. “Reasons for Emergency Room Use among U.S. Adults Aged 18–64: National Health Interview Survey, 2013–2014.” National Health Statistics Reports; No 90. Hyattsville, MD: National Center for Health Statistics.</p> <p>Sun, R., Z. Karaca, &amp; S. Wong. 2018. “Trends in Hospital Emergency Department Visits by Age and Payer, 2006–2015.” HCUP Statistical Brief #238. Agency for Healthcare Research and Quality: Rockville, MD. <a href="https://www.hcup-us.ahrq.gov/reports/statbriefs/sb238-Emergency-Department-Age-Payer-2006-2015.pdf">https://www.hcup-us.ahrq.gov/reports/statbriefs/sb238-Emergency-Department-Age-Payer-2006-2015.pdf</a></p> <p>Hu, T., K. Mortensen, &amp; J. Chen. 2018. “Medicaid Managed Care in Florida and Racial and Ethnic Disparities in Preventable Emergency Department Visits.” <i>Medical Care</i> 56: 477–83.</p> <p>Johnson, P.J., N. Ghildayal, A.C. Ward, B.C. Westgard, L.L. Boland, &amp; J.S. Hokanson. 2012. “Disparities in Potentially Avoidable Emergency Department (ED) Care: ED Visits for Ambulatory Care Sensitive Conditions.” <i>Medical Care</i> 50(12):1020–8.</p>		
<b>Characteristics</b>			
<b>Scoring</b>	Ratio.		
<b>Product lines</b>	<ul style="list-style-type: none"> <li>• Commercial.</li> <li>• Medicare.</li> </ul>		

<b>Stratifications</b>	<p>Ages as of the last day of the measurement period.</p> <ul style="list-style-type: none"> <li>• 18–44 years.</li> <li>• 45–54 years.</li> <li>• 55–64 years.</li> <li>• 65–74 years.</li> <li>• 75–84 years.</li> <li>• 18–64 years.</li> <li>• 65+ years.</li> <li>• 85+ years.</li> </ul>
<b>Guidance</b>	<p><b>Risk Adjustment Measure Specific Guidance</b></p> <p><b>Observation stays:</b> For observation stays (<u>Observation Stay Value Set</u>) that do not have a recorded admission or discharge date, set the admission date to the earliest date of service on the claim and set the discharge date to the last date of service on the claim.</p> <p><b>Which services count?</b></p> <ul style="list-style-type: none"> <li>• Use all paid, suspended, pending and denied claims when applying risk adjustment comorbidity category determination and the hospice exclusion.</li> <li>• Do not include denied claims when identifying all other events (e.g., observed events); only report claims the organization paid for or expects to pay for (i.e., claims incurred but not paid), with the exception below.</li> <li>• When confirming that an ED visit does not result in an inpatient or observation stay, all inpatient and observation stays must be considered, regardless of payment status (paid, suspended, pending, denied).</li> </ul> <p><i>For example</i>, if an ED visit is paid but an inpatient stay is denied, the ED visit resulted in an inpatient stay and is not included in the Emergency Department Utilization measure when identifying observed ED visits.</p> <p><b>Supplemental data exceptions:</b> Supplemental data may only be used for the hospice exclusion.</p> <p><b>Transfers:</b></p> <ul style="list-style-type: none"> <li>• Treat transfers <i>between</i> institutions as separate admissions.</li> <li>• Base transfer reports <i>within</i> an institution on the type and level of services provided.</li> <li>• Report separate admissions when the transfer is between acute and nonacute levels of service or between mental health/chemical dependency services and non-mental health/chemical dependency services.</li> <li>• Count only one admission when the transfer takes place within the same service category, but to a different level of care (e.g., from intensive care to a lesser level of care; from a lesser level of care to intensive care).</li> </ul> <p><b>Risk adjustment:</b> Organizations may not use risk assessment protocols to supplement diagnoses for calculation of the risk adjustment scores for these measures. The measurement model was developed and tested using only claims-based diagnoses; diagnoses from additional data sources would affect the validity of the models as they are currently implemented in the specification.</p> <p><b>General Rules</b></p> <p><b>Data collection methodology:</b> Administrative. Refer to <a href="#">General Guideline: Data Collection Methods</a> for additional information.</p>

	<p><b>Date specificity:</b> Dates must be specific enough to determine the event occurred in the period being measured.</p> <p><b>Improvement notation:</b> To interpret the ratio as better or worse than expected, the ratio must be calibrated. Organizations can calibrate ratios by dividing individual organization ratios or national percentiles by the national average ratio. Organizations may be more successful at achieving fewer ED visits than expected, given the types of cases treated by the organization (calibrated ratio with a value &lt;1.0), or may be less successful (calibrated ratio with a value &gt;1.0).</p>
<b>Definitions</b>	
<b>Outlier</b>	<p>Medicare enrollees 18–64 years of age with 6 or more ED visits in the measurement period.</p> <p>Medicare enrollees 65 years of age and older with 4 or more ED visits in the measurement period.</p> <p>Commercial enrollees 18 years of age and older with 4 or more ED visits in the measurement period.</p>
<b>Nonoutlier</b>	<p>Medicare enrollees 18–64 years of age with five or fewer ED visits during the measurement period.</p> <p>Medicare enrollees 65 years of age and older with three or fewer ED visits during the measurement period.</p> <p>Commercial enrollees 18 years of age and older with three or fewer ED visits during the measurement period.</p>
<b>PPV</b>	Predicted probability of a visit. The predicted probability of a person having an ED visit in the measurement period.
<b>PUCV</b>	Predicted unconditional count of visits. The unconditional count of ED visits during the measurement period.
<b>Initial population</b>	<p><i>Measure item count:</i> Person.</p> <p><i>Attribution basis:</i> Enrollment.</p> <ul style="list-style-type: none"> <li>• <i>Benefits:</i> Medical.</li> <li>• <i>Continuous enrollment:</i> The measurement period and the year prior to the measurement period.</li> <li>• <i>Allowable gap:</i> No more than one gap of ≤45 days during each year of continuous enrollment. No gaps on the last day of the measurement period.</li> </ul> <p><i>Ages:</i> 18 years of age and older as of the last day of the measurement period.</p> <p><i>Gender/sex criteria:</i></p> <ul style="list-style-type: none"> <li>• Administrative Gender of Female (AdministrativeGender code female).</li> <li>• Administrative Gender of Male (AdministrativeGender code male).</li> </ul>

	<p><b>Exclusion: Episodes for persons in hospice or using hospice services.</b></p> <p>Persons who use hospice services (<a href="#">Hospice Encounter Value Set</a>; <a href="#">Hospice Intervention Value Set</a>) or elect to use a hospice benefit any time during the measurement period. Organizations that use the Monthly Membership Detail Data File to identify these persons must use only the run date of the file.</p>
<b>Measure observation</b>	<p><b>Calculation of Observed Events</b></p> <p><b>Step 1.</b> Count each visit to an ED once, regardless of the intensity or duration of the visit. Count multiple ED visits on the same date of service as one visit. Identify all ED visits during the measurement period using either of the following:</p> <ul style="list-style-type: none"> <li>• An ED Visit (<a href="#">ED Value Set</a>).</li> <li>• A procedure code (<a href="#">ED Procedure Code Value Set</a>) <b>with</b> an ED place of service code (POS code 23).</li> </ul> <p>Do not include ED visits that result in an inpatient stay (<a href="#">Inpatient Stay Value Set</a>) or an observation stay (<a href="#">Observation Stay Value Set</a>).</p> <p><b>Step 2.</b> Exclude encounters with any of the following:</p> <ul style="list-style-type: none"> <li>• A principal diagnosis of mental health or chemical dependency (<a href="#">Mental and Behavioral Disorders Value Set</a>).</li> <li>• Psychiatry (<a href="#">Psychiatry Value Set</a>).</li> <li>• Electroconvulsive therapy (<a href="#">Electroconvulsive Therapy Value Set</a>).</li> </ul> <p><b>Step 3.</b> For the remaining ED visits, calculate the number of visits per person and remove visits for outlier persons. Report these persons as outliers.</p> <p><b>Step 4.</b> Calculate the total using all ED visits identified after completing steps 1–3. Assign each remaining ED visit to an age and stratification category using the reporting instructions below.</p>
<b>Risk adjustment factors</b>	<p><b>Risk Adjustment Determination</b></p> <p>For each person among nonoutliers, identify risk adjustment weights based on comorbidity, age and gender. Weights are specific to product line (Medicare Under 65, Medicare 65 Plus and commercial). Refer to the reporting indicator column in the risk adjustment tables to ensure that weights are linked appropriately.</p> <p><b>Comorbidities:</b></p> <p><b>Step 1.</b> Identify all diagnoses for encounters during the year prior to the measurement period. Include the following when identifying encounters:</p> <ul style="list-style-type: none"> <li>• Outpatient visits, ED visits, telephone visits, nonacute inpatient encounters and acute inpatient encounters (<a href="#">Outpatient, ED, Telephone, Acute Inpatient and Nonacute Inpatient Value Set</a>) with a date of service during the year prior to the measurement period.</li> <li>• Acute and nonacute inpatient discharges (<a href="#">Inpatient Stay Value Set</a>) with a discharge date during the year prior to the measurement period.</li> </ul>

**Step 2.** Assign each diagnosis to one or more comorbid Clinical Condition (CC) category using Table CC—Mapping in the Risk Adjustment Shared Tables. If the code appears more than once in Table CC—Mapping, it is assigned to multiple CCs.

Exclude all diagnoses that cannot be assigned to a comorbid CC category. For persons with no qualifying diagnoses from face-to-face encounters, skip to *Risk Adjustment Calculation*.

All digits must match exactly when mapping diagnosis codes to the comorbid CCs.

**Step 3.** Determine HCCs for each comorbid CC identified. Refer to Table HCC—Rank.

For each person's comorbid CC list, match the comorbid CC code to the comorbid CC code in the table, and assign:

- The ranking group.
- The rank.
- The HCC.

For comorbid CCs that do not match to Table HCC—Rank, use the comorbid CC as the HCC and assign a rank of 1. One comorbid CC can map to multiple HCCs; each HCC can have one or more comorbid CCs.

**Step 4.** Assess each ranking group separately and select only the highest ranked HCC in each ranking group using the “Rank” column (1 is the highest rank possible).

Drop all other HCCs in each ranking group, and de-duplicate the HCC list if necessary.

- *For example*, assume a person with the following comorbid CCs: CC-85, CC-17 and CC-19 (assume no other CCs).
  - CC-85 does not have a map to the ranking table and becomes HCC-85.
  - HCC-17 and HCC-19 are part of Diabetes Ranking Group 1. Because CC-17 is ranked higher than CC-19 in Ranking Group Diabetes 1, the comorbidity is assigned as HCC-17 for Ranking Group 1.

The final comorbidities for this person are HCC-17 and HCC-85.

**Table HCC—Rank**

Ranking Group	CC	Description	Rank	HCC
NA	CC-85	Congestive Heart Failure	NA	HCC-85
Diabetes 1	CC-17	Diabetes With Acute Complications	1	HCC-17
	CC-18	Diabetes With Chronic Complications	2	HCC-18
	CC-19	Diabetes Without Complications	3	HCC-19

Comorbid HCC 1	Comorbid HCC 2	Comorbid HCC 3	HCC-Combination	HCC-Comb Description
HCC-17	HCC-85	NA	HCC-901	Combination: Diabetes and CHF
HCC-18	HCC-85	NA	HCC-901	Combination: Diabetes and CHF
HCC-19	HCC-85	NA	HCC-901	Combination: Diabetes and CHF




	<p><b>Step 5.</b> Identify combination HCCs listed in Table HCC—Comb.</p> <p>Some combinations suggest a greater amount of risk when observed together. For example, when diabetes <i>and</i> CHF are present, an increased amount of risk is evident. Additional HCCs are selected to account for these relationships.</p> <p>Compare each person's list of unique HCCs to those in the <i>Comorbid HCC</i> columns in Table HCC—Comb and assign any additional HCC conditions.</p> <p><i>If there are overlapping combinations, use both sets of combinations.</i> Based on the combinations, a person can have none, one or more of these added HCCs.</p> <ul style="list-style-type: none"> <li>• <i>For example</i>, for a person with comorbidities HCC-17 and HCC-85 (assume no other HCCs), assign HCC-901 in addition to HCC-17 and HCC-85. This <i>does not</i> replace HCC-17 and HCC-85.</li> </ul> <p><b>Table HCC—Comb</b></p> <table border="1"> <thead> <tr> <th>Comorbid HCC 1</th><th>Comorbid HCC 2</th><th>Comorbid HCC 3</th><th>HCC-Combination</th><th>HCC-Comb Description</th></tr> </thead> <tbody> <tr> <td>HCC-17</td><td>HCC-85</td><td>NA</td><td>HCC-901</td><td>Combination: Diabetes and CHF</td></tr> <tr> <td>HCC-18</td><td>HCC-85</td><td>NA</td><td>HCC-901</td><td>Combination: Diabetes and CHF</td></tr> <tr> <td>HCC-19</td><td>HCC-85</td><td>NA</td><td>HCC-901</td><td>Combination: Diabetes and CHF</td></tr> </tbody> </table>	Comorbid HCC 1	Comorbid HCC 2	Comorbid HCC 3	HCC-Combination	HCC-Comb Description	HCC-17	HCC-85	NA	HCC-901	Combination: Diabetes and CHF	HCC-18	HCC-85	NA	HCC-901	Combination: Diabetes and CHF	HCC-19	HCC-85	NA	HCC-901	Combination: Diabetes and CHF
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HCC-19	HCC-85	NA	HCC-901	Combination: Diabetes and CHF																	
Risk adjustment	<p><b>Risk Adjustment Calculation</b></p> <p>Calculation of risk-adjusted outcomes (counts of ED visits) uses predetermined risk weights generated by two separate regression models. Weights from each model are combined to predict how many visits each person might have during the measurement period.</p> <p><b>For each nonoutlier person in the initial population, assign PPV risk weights.</b></p> <p><b>Step 1.</b> For each person with a comorbidity HCC Category, link the PPV weights.</p> <p><b>Step 2.</b> Link the age-gender PPV weights for each person.</p> <p><b>Step 3.</b> Sum all PPV weights associated with the person (comorbidities, age and gender).</p> <p><b>Step 4.</b> Calculate the predicted probability of each person having at least one visit based on the sum of the weights for each person using the formula below.</p> $\text{PPV} = \frac{e^{(\sum \text{PPV WeightsForEachPerson})}}{1+e^{(\sum \text{PPV WeightsForEachPerson})}}$ <p>Truncate the final PPV for each person to 10 decimal places. Do not truncate or round in previous steps.</p>																				

**For each person in the initial population, assign PUCV risk weights.**

**Step 1.** For each person with a comorbidity HCC Category, link the PUCV weights. If a person does not have any comorbidities to which weights can be linked, assign a weight of 1.

**Step 2.** Link the age-gender PUCV weights for each person.

**Step 3.** Calculate the predicted unconditional count of visits in the measurement period by multiplying all PUCV weights (comorbidities, age and gender). Use the following formula:

$$\text{PUCV} = \text{Age/Gender Weight} * \text{HCC Weight}$$

**Note:** Multiply by each HCC associated with the person. For example, assume a person with HCC-2, HCC-10, HCC-47. The formula would be:

$$\text{PUCV} = \text{Age/gender Weight} * \text{HCC-2} * \text{HCC-10} * \text{HCC-47}$$

Truncate the final PUCV for each person to 10 decimal places. Do not truncate or round in previous steps.

*Expected count of ED visits.* Calculate the final person-level expected count of ED visits for each category using the formula below:

$$\text{Expected Count of ED Visits} = \text{PPV} \times \text{PUCV}$$

Round the person-level results to 4 decimal places using the .5 rule and sum over all persons in the category.

**Step 4.** Use the formula below to calculate the covariance of the predicted outcomes for each category. For categories with a single person ( $n_c=1$ ), set the covariance to zero. Do not round the covariance before using it in step 5.

$$\text{COV}_c = \frac{\sum_{m=1}^{n_c} (\text{PPV}_m - \text{mean(PPV)}_c) \times (\text{PUCV}_m - \text{mean(PUCV)}_c)}{n_c - 1}$$

Where:

$c$  denotes an individual category

$n_c$  is the number of persons in the category indicated by  $c$

$m$  is an individual person within the category indicated by  $c$

$\text{PPV}_m$  is the truncated PPV for the person denoted by  $m$

$\text{mean(PPV)}_c$  is the unrounded and untruncated mean PPV in the category indicated by  $c$

$\text{mean(PUCV)}_c$  is the unrounded and untruncated mean PUCV

$\text{PUCV}_m$  is the truncated PUCV for the person denoted by  $m$  in the category indicated by  $c$

**Step 5.** Once the covariance between PPV and PUCV for a given category is calculated, it can be used as indicated in the formula below to calculate the variance for that category.

	$\begin{aligned} Variance_c = \sum_{m=1}^{n_c} & (PPV_m \times PUCV_m)^2 \\ & \times \left( 1 + (1 - PPV_m)^2 + \left( \frac{2 \times COV_c}{PPV_m \times PUCV_m} \right) \right) \end{aligned}$ <p>Where:</p> <ul style="list-style-type: none"> <li><math>c</math> denotes an individual category</li> <li><math>n_c</math> is the number of persons in the category indicated by <math>c</math></li> <li><math>m</math> is an individual person within the category indicated by <math>c</math></li> <li><math>PPV_m</math> is the truncated PPV for the person denoted by <math>m</math></li> <li><math>PUCV_m</math> is the truncated PUCV for the person denoted by <math>m</math></li> <li><math>n_c</math> is the number of persons in the category indicated by <math>c</math></li> </ul> <p>Round the variance for reporting to 4 decimal places using the .5 rule.</p>
<b>Summary of changes</b>	<ul style="list-style-type: none"> <li>• Integrated the Risk Adjustment General Guidelines into the <i>Guidance</i> section.</li> <li>• Removed the definition of “classification period” and put the time frame in the <i>Risk adjustment comorbidity category determination</i> section.</li> <li>• Added administrative gender codes to the initial population.</li> </ul>
<b>Data element tables</b>	<p><b>Reporting: Number of nonoutliers</b> The number of nonoutlier persons for each age group, reported as the NonOutlierPersonCount.</p> <p><b>Reporting: Number of outliers</b> The number of outlier persons for each age group, reported as the OutlierPersonCount.</p> <p><b>Calculated: Number of persons in the initial population</b> The number of persons in the initial population (including outliers) for each age group and totals. Calculated by IDSS as the PersonCount.</p> <p><b>Calculated: Outlier rate</b> The number of outlier persons (OutlierPersonCount) divided by the number of persons in the initial population (PersonCount), multiplied by 1,000 for each age group and totals. Calculated by IDSS as the OutlierRate.</p> <p><b>Reporting: Number of observed events among nonoutlier persons</b> The number of observed ED visits for each age group, reported as the ObservedCount.</p> <p><b>Calculated: Observed visits per 1,000 nonoutlier persons</b> The number of observed ED visits (ObservedCount) divided by the number of nonoutlier persons in the initial population (NonOutlierPersonCount), multiplied by 1,000 for each age group and totals. Calculated by IDSS as the ObservedRate.</p> <p><b>Reporting: Number of expected events among nonoutlier persons</b> The number of expected ED visits for each age group, reported as the ExpectedCount.</p>

	<p><b>Calculated:</b> Expected visits per 1,000 nonoutlier persons</p> <p>The number of expected ED visits (ExpectedCount) divided by the number of nonoutlier persons in the initial population (NonOutlierPersonCount), multiplied by 1,000 for each age group and totals. Calculated by IDSS as the ExpectedRate.</p> <p><b>Reporting:</b> Variance among nonoutlier persons</p> <p>The variance (<i>Risk Adjustment Calculation</i>, PUCV, step 5) for each age group, reported as the CountVariance.</p> <p><b>Calculated:</b> O/E ratio</p> <p>The number of observed events among nonoutlier persons (ObservedCount) divided by the number of expected events among nonoutlier persons (ExpectedCount) for each age group and totals. Calculated by IDSS as the OE.</p> <p>Organizations that submit HEDIS data to NCQA must provide the following data elements.</p>
Rules for Allowable Adjustments	<p><b>Copyright and use:</b> The “Rules for Allowable Adjustments of HEDIS” (the “Rules”) describe how NCQA’s HEDIS measure specifications can be adjusted for other populations, if applicable. The Rules, reviewed and approved by NCQA measure experts, provide for expanded use of HEDIS measures without changing their clinical intent.</p> <p><b>Adjusted HEDIS measures may not be used for HEDIS health plan reporting.</b></p> <p>The measures under the Risk Adjusted Utilization domain allow two types of <i>Rules for Allowable Adjustments</i> sections:</p>

1. *Rules for Allowable Adjustments for Risk-Adjusted Measurement.* This section must be followed for adjustments when calculating the full measure specifications, which includes all risk adjusted rates (expected rates, risk adjustment, O/E) and calculation components (count of index stays, observed events).
2. *Rules for Allowable Adjustments for Observed Measurement (rates without risk adjustment).* This section must be followed when adjusting the calculation of observed events only. When applying these adjustments, organizations must not include risk adjustment logic.

The intent of including the two different types of Rules is to allow organizations to adjust measures without compromising the measures' validity. Risk adjustment is based on statistical prediction models that are specifically calibrated for each measure.

**The following are the Rules for Allowable Adjustments for Risk-Adjusted Measurement of the Emergency Department Utilization measure (observed ED visits, risk adjustment determination, risk adjustment weighting, expected ED visits, O/E, variance).**

#### **ADJUSTMENTS ALLOWED**

- *Benefits.* Organizations are not required to use a benefit.
- *Telehealth:* Services/events that allow the use of synchronous telehealth visits, telephone visits and asynchronous telehealth (e-visits, virtual check-ins) may be stratified to identify services performed via telehealth. This adjustment is not allowed for events, numerators and exclusions that do not allow the use of telehealth.

#### **ADJUSTMENTS ALLOWED WITH LIMITS**

- *Other.* Organizations may only adjust the initial population criteria to focus on an area of interest defined by gender, sociodemographic characteristics or geographical region. NCQA recommends evaluating risk model performance and validity within adjusted populations. Organizations may not adjust for a clinical subpopulation (e.g., persons with a diabetes diagnosis).
- *Measurement period adjustments.* Organizations may only change the measurement period by 1 year.
- *Observed event.* Organizations may include denied claims to calculate the observed events. The value sets and logic may not be changed.
- *Outlier.* Organizations may include denied claims to calculate these events. Organizations may not adjust the outlier logic.
- *Risk adjustment determination, risk adjustment weighting, expected count of ED visits, variance.* Organizations may include denied claims to calculate these events. Risk adjustment determinations, weighting and calculations of expected events logic may not be changed.

#### **ADJUSTMENTS NOT ALLOWED**

- *Product lines.* Organizations may not adjust product lines.
- *Attribution.* Organizations are required to use enrollment criteria.
- *Ages.* The age determination dates may not be changed.

- *Supplemental data.* Supplemental data may not be used to identify initial population, denominator and numerator events.
- *Exclusions.* The hospice exclusion must be applied. Logic may not be changed.

**The following are the Rules for Allowable Adjustments for Observed Measurement of the Emergency Department Utilization measure observed events (observed ED visits).**

#### **ADJUSTMENTS ALLOWED**

- *Product lines.* When adjusting this measure to assess for observed events only, organizations are not required to use product line criteria; product lines may be combined, and all (or no) product line criteria may be used.
- *Ages.* The observed event age range may be expanded. Age determination dates may be changed (e.g., select, "age as of June 30").
- *Attribution.* Organizations are not required to use enrollment criteria.
- *Benefits.* Organizations are not required to use a benefit.
- *Other.* Organizations may use additional initial population criteria to focus on a population of interest such as gender, race and ethnicity, socioeconomic, sociodemographic characteristics, geographic region or another characteristic.
- *Measurement period adjustments.* Organizations may adjust the measurement period.
- *Exclusions.* The hospice exclusion is not required.
- *Outlier.* Organizations may adjust the outlier logic. The outlier logic is not required to be applied. The outlier thresholds may be expanded or reduced. Denied claims may be used to calculate these events.
- *Telehealth.* Services/events that allow the use of synchronous telehealth visits, telephone visits and asynchronous telehealth (e-visits, virtual check-ins) may be stratified to identify services performed via telehealth. This adjustment is not allowed for events, numerators and exclusions that do not allow the use of telehealth.
- *Supplemental data.* Supplemental data may be used to identify initial population, observed event, exclusion and numerator events.

#### **ADJUSTMENTS ALLOWED WITH LIMITS**

- *Observed events.* Organizations may include denied claims to calculate the observed events. The value sets and logic may not be changed.

## Hospitalization for Potentially Preventable Complications (HPC)

<b>Measure title</b>	Hospitalization for Potentially Preventable Complications*	<b>Measure ID</b>	HPC
<b>Description</b>	For persons 67 years of age and older, the rate of discharges for ambulatory care sensitive conditions (ACSC) per 1,000 persons and the risk-adjusted ratio of observed-to-expected discharges for ACSC by chronic and acute conditions.		
<b>Measurement period</b>	January 1–December 31.		
<b>Copyright and disclaimer notice</b>	<p>*Adapted with financial support from CMS and with permission from the measure developer, the Agency for Healthcare Research and Quality (AHRQ).</p> <p>Refer to the complete copyright and disclaimer information in the front of the publication.</p> <p>NCQA website: <a href="http://www.ncqa.org">www.ncqa.org</a>.</p> <p>Submit policy clarification support questions via My NCQA (<a href="https://my.ncqa.org">https://my.ncqa.org</a>).</p>		
<b>Clinical recommendation statement/ rationale</b>	<p>Hospital and inpatient care accounts for a large component of total health care costs for older adults (41% of Medicare spending, approximately \$303 billion dollars in 2018). Hospitalization also poses several risks for older adults, who frequently develop serious conditions as a result of hospitalization such as delirium, infection and decline in functional ability.</p> <p>Reducing the rate of hospitalization for potentially preventable complications of acute and chronic conditions for older adults will improve patient health, reduce costs and improve quality of life. It is important to note that some complications or exacerbations are unavoidable and therefore the appropriate rate of hospitalization is not “zero”; however, this measure will provide important information to health plans, providers and consumers and other stakeholders about how well a system of care helps older adults with chronic and acute conditions prevent hospitalization.</p>		
<b>Citations</b>	<p>Kaiser Family Foundation (KFF). <i>The Facts on Medicare Spending and Financing</i>. <a href="https://www.kff.org/medicare/issue-brief/the-facts-on-medicare-spending-and-financing/">https://www.kff.org/medicare/issue-brief/the-facts-on-medicare-spending-and-financing/</a></p> <p>Gillick, M.R., N.A. Serrell, &amp; L.S. Gillick. 1982. “Adverse Consequences of Hospitalization in the Elderly.” <i>Social Science &amp; Medicine</i> 16(10), 1033–8.</p> <p>Covinsky, K.E., E. Pierluissi, &amp; C.B. Johnston. 2011. “Hospitalization-Associated Disability.” <i>JAMA: The Journal of the American Medical Association</i> 306(16): 1782–93.</p>		
<b>Characteristics</b>			
<b>Scoring</b>	Ratio.		
<b>Product lines</b>	Medicare.		

<b>Stratifications</b>	<p>Age as of the last day of the measurement period.</p> <ul style="list-style-type: none"> <li>• 67–74 years.</li> <li>• 75–84 years.</li> <li>• 85+ years.</li> </ul>
<b>Guidance</b>	<p><b>Risk Adjustment Measure-Specific Guidance</b></p> <p><b>Observation stays:</b> For observation stays (<u>Observation Stay Value Set</u>) that do not have a recorded admission or discharge date, set the admission date to the earliest date of service on the claim and set the discharge date to the last date of service on the claim.</p> <p><b>Which services count?</b></p> <ul style="list-style-type: none"> <li>• Use all paid, suspended, pending, and denied claims when applying risk adjustment comorbidity category determination and the hospice exclusion.</li> <li>• Do not include denied claims when identifying all other events (e.g., observed events); only report claims the organization paid for or expects to pay for (i.e., claims incurred but not paid).</li> </ul> <p><b>Supplemental data exceptions:</b> Supplemental data may only be used for the hospice exclusion.</p> <p><b>Transfers:</b></p> <ul style="list-style-type: none"> <li>• Treat transfers <i>between</i> institutions as separate admissions.</li> <li>• Base transfer reports <i>within</i> an institution on the type and level of services provided.</li> <li>• Report separate admissions when the transfer is between acute and nonacute levels of service or between mental health/chemical dependency services and non-mental health/chemical dependency services.</li> <li>• Count only one admission when the transfer takes place within the same service category, but to a different level of care (e.g., from intensive care to a lesser level of care; from a lesser level of care to intensive care).</li> </ul> <p><b>Risk adjustment:</b> Organizations may not use risk assessment protocols to supplement diagnoses for calculation of the risk adjustment scores for these measures. The measurement model was developed and tested using only claims-based diagnoses and diagnoses from additional data sources would affect the validity of the models as they are currently implemented in the specification.</p> <p><b>General Rules</b></p> <p><b>Data collection methodology:</b> Administrative. Refer to <a href="#">General Guideline: Data Collection Methods</a> for additional information.</p> <p><b>Date specificity:</b> Dates must be specific enough to determine the event occurred in the period being measured.</p> <p><b>Improvement notation:</b> To interpret the ratio as better or worse than expected, the ratio must be calibrated. Organizations can calibrate ratios themselves by dividing individual organization ratios or national percentiles by the national average ratio.</p>

	Organizations may be more successful at achieving fewer hospitalizations than expected, given the types of cases treated by the organization (calibrated ratio with a value <1.0) or may be less successful (calibrated ratio with a value >1.0).
<b>Definitions</b>	
<b>ACSC</b>	Ambulatory care sensitive condition. An acute or chronic health condition that can be managed or treated in an outpatient setting. The ambulatory care conditions included in this measure are: <ul style="list-style-type: none"> <li>• <b>Chronic ACSC:</b> diabetes short-term complications; diabetes long-term complications; uncontrolled diabetes; lower-extremity amputation among patients with diabetes; COPD; asthma; hypertension; heart failure.</li> <li>• <b>Acute ACSC:</b> Bacterial pneumonia; urinary tract infection; cellulitis; severe pressure ulcers.</li> </ul>
<b>Acute ACSC outlier</b>	Persons with three or more inpatient or observation stay acute ACSCs during the measurement period.
<b>Acute ACSC nonoutlier</b>	Persons with two or fewer inpatient or observation stay acute ACSCs during the measurement period.
<b>Chronic ACSC outlier</b>	Persons with three or more inpatient or observation stay chronic ACSCs during the measurement period.
<b>Chronic ACSC nonoutlier</b>	Persons with two or fewer inpatient or observation stay chronic ACSCs during the measurement period.
<b>Direct transfer</b>	When the discharge date from the initial stay precedes the admission date to a subsequent stay by one calendar day or less. <ul style="list-style-type: none"> <li>• <i>For example:</i> <ul style="list-style-type: none"> <li>– A discharge on June 1, followed by a subsequent admission on June 1 or June 2, <i>is a direct transfer</i>.</li> <li>– A discharge on June 1, followed by a subsequent admission on June 3, <i>is not a direct transfer</i>; these are two distinct stays.</li> <li>– A discharge on June 1, followed by a subsequent admission on June 2 (with discharge on June 3), followed by a subsequent admission on June 4, <i>is a direct transfer</i>.</li> </ul> </li> </ul> <p>Direct transfers may occur between different facilities, and between acute inpatient and observation.</p>
<b>PPD</b>	Predicted probability of discharge. The predicted probability of a person having any discharge in the measurement period.
<b>PUCD</b>	Predicted unconditional count of discharges. The predicted unconditional count of discharges for persons during the measurement period.
<b>Total ACSC outlier</b>	Persons classified as either a chronic ACSC outlier or an acute ACSC outlier.
<b>Total ACSC nonoutlier</b>	Persons who are not classified as a chronic ACSC outlier and an acute ACSC outlier.

<b>Initial population</b>	<p><b>Measure item count:</b> Persons.</p> <p><b>Attribution basis:</b> Enrollment.</p> <ul style="list-style-type: none"> <li>• <b>Benefits:</b> Medical.</li> <li>• <b>Continuous enrollment:</b> The measurement period and the year prior to the measurement period.</li> <li>• <b>Allowable gap:</b> No more than one gap of ≤45 days during each year of continuous enrollment. No gaps on the last day of the measurement period.</li> </ul> <p><b>Ages:</b> 67 years of age and older as of the last day of the measurement period</p> <p><b>Gender/sex criteria:</b></p> <ul style="list-style-type: none"> <li>• Administrative Gender of Female (AdministrativeGender code female).</li> <li>• Administrative Gender of Male (AdministrativeGender code male).</li> </ul> <p><b>Exclusions:</b> <b>Persons in hospice or using hospice services.</b></p> <p>Persons who use hospice services (<a href="#">Hospice Encounter Value Set</a>; <a href="#">Hospice Intervention Value Set</a>) or elect to use a hospice benefit any time during the measurement period. Organizations that use the Monthly Membership Detail Data File to identify these persons must use only the run date of the file.</p> <p><b>Medicare enrollees in an institutional SNP (I-SNP) or living long-term in an institution (LTI).</b></p> <ul style="list-style-type: none"> <li>• Enrolled in an I-SNP any time during the measurement period.</li> <li>• Living long-term in an institution any time during the measurement period, as identified by the LTI flag in the Monthly Membership Detail Data File. Use the run date of the file to determine if a member had an LTI flag during the measurement period.</li> </ul>
<b>Measure observation</b>	<p><b>Calculation of Observed Events</b></p> <p><b>Observed event 1: Chronic ACSC.</b></p> <p>Follow the steps below to identify the number of chronic ACSC acute inpatient and observation stay discharges.</p> <p><b>Step 1.</b> Identify all acute inpatient and observation stay discharges during the measurement period. To identify acute inpatient and observation stay discharges:</p> <ol style="list-style-type: none"> <li>1. Identify all acute and nonacute inpatient stays (<a href="#">Inpatient Stay Value Set</a>) and observation stays (<a href="#">Observation Stay Value Set</a>).</li> <li>2. Exclude nonacute inpatient stays (<a href="#">Nonacute Inpatient Stay Value Set</a>).</li> <li>3. Identify the discharge date for the stay.</li> </ol> <p><b>Step 2.</b> For discharges with one or more direct transfers, use the last discharge.</p> <p>Using the discharges identified in step 1, identify direct transfers between acute inpatient and observation using the definition of direct transfer.</p> <p><b>Step 3.</b> For the remaining acute inpatient and observation stay discharges, identify discharges with any of the following on the discharge claim:</p>

- Principal diagnosis of diabetes short-term complications (ketoacidosis, hyperosmolarity or coma; [Diabetes Short Term Complications Value Set](#)).
- Principal diagnosis of diabetes with long-term complications (renal, eye, neurological, circulatory or unspecified complications; [Diabetes Long Term Complications Value Set](#)).
- Principal diagnosis of uncontrolled diabetes ([Uncontrolled Diabetes Value Set](#)).
- A procedure code for lower extremity amputation ([Lower Extremity Amputation Procedures Value Set](#)) **with** any diagnosis of diabetes ([Diabetes Diagnosis Value Set](#)).
  - Exclude any discharge with a diagnosis of traumatic amputation of the lower extremity ([Traumatic Amputation of Lower Extremity Value Set](#)).
- Principal diagnosis of COPD ([COPD Diagnosis Value Set](#)).
  - Exclude any discharge with a diagnosis of cystic fibrosis or anomaly of the respiratory system ([Cystic Fibrosis and Respiratory System Anomalies Value Set](#)).
- Principal diagnosis of asthma ([Asthma Other Than Uncomplicated Value Set](#)).
  - Exclude any discharge with a diagnosis of cystic fibrosis or anomaly of the respiratory system ([Cystic Fibrosis and Respiratory System Anomalies Value Set](#)).
- Principal diagnosis of heart failure ([Heart Failure Diagnosis Value Set](#)).
  - Exclude any discharge with a cardiac procedure ([Cardiac Procedure Value Set](#)).
- Principal diagnosis of hypertension ([Hypertension Value Set](#)).
  - Exclude any discharge with a cardiac procedure ([Cardiac Procedure Value Set](#)).
  - Exclude any discharge with a diagnosis of Stage I-IV kidney disease ([Stage I Through IV Kidney Disease Value Set](#)) **with** a dialysis procedure ([Dialysis Value Set](#)).

**Note:** For direct transfers, use all discharges to identify principal diagnoses and exclusions in this step.

**Step 4.** Remove discharges for persons with any three or more chronic ACSC discharges during the measurement period and report these persons as chronic ACSC outliers.

**Note:** Count discharges with one or more direct transfers as one discharge when identifying outliers.

#### Observed event 2: Acute ACSC.

Follow the steps below to identify the number of acute ACSC acute inpatient and observation stay discharges.

**Step 1.** Identify all acute inpatient and observation stay discharges during the measurement period. 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.

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

Using the discharges identified in step 1, identify direct transfers between acute inpatient and observation, or between observation and acute inpatient, using the definition of direct transfer.

**Step 3.** For the remaining acute inpatient and observation stay discharges, identify discharges with any of the following on the discharge claim:

- Principal diagnosis of bacterial pneumonia ([Bacterial Pneumonia Value Set](#)).
  - Exclude any discharge with a diagnosis of sickle cell anemia HB S disease ([Sickle Cell Anemia and HB S Disease Value Set](#)).
  - Exclude any discharge with a procedure or diagnosis for immunocompromised state ([Immunocompromised State Value Set](#)).
- Principal diagnosis of urinary tract infection ([Urinary Tract Infection Value Set](#)).
  - Exclude any discharge with a diagnosis of kidney/urinary tract disorder ([Kidney and Urinary Tract Disorders Value Set](#)).
  - Exclude any discharge with a procedure or diagnosis for immunocompromised state ([Immunocompromised State Value Set](#)).
- Principal diagnosis of cellulitis ([Cellulitis Value Set](#)).
- Principal diagnosis of severe pressure ulcers ([Severe Pressure Ulcers Value Set](#)).

**Note:** For direct transfers, use all discharges to identify principal diagnoses and exclusions in this step.

**Step 4.** Remove discharges for persons with any three or more acute ACSC discharges during the measurement period and report these persons as acute ACSC outliers.

**Note:** Count discharges with one or more direct transfers as one discharge when identifying outliers.

#### Observed event 3: Total ACSC.

Follow the steps below to identify the number of total ACSC acute inpatient and observation stay discharges.

**Step 1.** Sum the discharges from the Chronic ACSC and Acute ACSC categories.

**Step 2.** Remove discharges for acute ACSC outliers or chronic ACSC outliers. Report these persons as total ACSC outliers.

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

<b>Risk adjustment factors</b>	<p><b>Risk Adjustment Determination</b></p> <p>For each nonoutlier in the Initial Population, identify risk adjustment weights based on comorbidity, age and gender. Weights are specific to reporting indicator (Chronic ACSC, Acute ACSC, Total ACSC). Refer to the reporting indicator in the risk adjustment tables to ensure that weights are linked appropriately.</p> <p><b>Comorbidities:</b></p> <p><b>Step 1.</b> Identify all diagnoses for encounters during the year prior to the measurement period. Include the following when identifying encounters:</p> <ul style="list-style-type: none"> <li>• Outpatient visits, ED visits, telephone visits, nonacute inpatient encounters and acute inpatient encounters (<u>Outpatient, ED, Telephone, Acute Inpatient and Nonacute Inpatient Value Set</u>) with a date of service during the year prior to the measurement period.</li> <li>• Acute and nonacute inpatient discharges (<u>Inpatient Stay Value Set</u>) with a discharge date during the year prior to the measurement period.</li> </ul> <p><b>Step 2.</b> Assign each diagnosis to one or more comorbid Clinical Condition (CC) category using Table CC—Mapping in the Risk Adjustment Shared Tables. If the code appears more than once in Table CC—Mapping, it is assigned to multiple CCs.</p> <p>Exclude all diagnoses that cannot be assigned to a comorbid CC category. For persons with no qualifying diagnoses from face-to-face encounters, skip to <i>Risk Adjustment Weighting</i>.</p> <p>All digits must match exactly when mapping diagnosis codes to the comorbid CCs.</p> <p><b>Step 3.</b> Determine HCCs for each comorbid CC identified. Refer to Table HCC—Rank.</p> <p>For each person's comorbid CC list, match the comorbid CC code to the comorbid CC code in the table, and assign:</p> <ul style="list-style-type: none"> <li>• The ranking group.</li> <li>• The rank.</li> <li>• The HCC.</li> </ul> <p>For comorbid CCs that do not match to Table HCC—Rank, use the comorbid CC as the HCC and assign a rank of 1. One comorbid CC can map to multiple HCCs; each HCC can have one or more comorbid CCs.</p> <p><b>Step 4.</b> Assess each ranking group separately and select only the highest ranked HCC in each ranking group using the “Rank” column (1 is the highest rank possible).</p> <p>Drop all other HCCs in each ranking group, and de-duplicate the HCC list if necessary.</p> <ul style="list-style-type: none"> <li>• <i>For example:</i> Assume a person with the following comorbid CCs: CC-85, CC-17 and CC-19 (assume no other CCs). <ul style="list-style-type: none"> <li>– CC-85 does not have a map to the ranking table and becomes HCC-85.</li> </ul> </li> </ul>
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- HCC-17 and HCC-19 are part of Diabetes Ranking Group 1. Because CC-17 is ranked higher than CC-19 in Ranking Group Diabetes 1, the comorbidity is assigned as HCC-17 for Ranking Group 1.
- The final comorbidities for this person are HCC-17 and HCC-85.

**Table HCC—Rank**

Ranking Group	CC	Description	Rank	HCC
NA	CC-85	Congestive Heart Failure	NA	HCC-85
Diabetes 1	CC-17	Diabetes With Acute Complications	1	HCC-17
	CC-18	Diabetes With Chronic Complications	2	HCC-18
	CC-19	Diabetes Without Complications	3	HCC-19

**Step 5.** Identify combination HCCs listed in Table HCC—Comb.

Some combinations suggest a greater amount of risk when observed together.

- *For example*, when diabetes and CHF are present, an increased amount of risk is evident. Additional HCCs are selected to account for these relationships.

Compare each person's list of unique HCCs to those in the *Comorbid HCC* columns in Table HCC—Comb and assign any additional HCC conditions.

*If there are overlapping combinations, use both sets of combinations.* Based on the combinations, a person can have none, one or more of these added HCCs.

- *For example*, for a person with comorbidities HCC-17 and HCC-85 (assume no other HCCs), assign HCC-901 in addition to HCC-17 and HCC-85. This *does not* replace HCC-17 and HCC-85.

**Table HCC—Comb**

Comorbid HCC 1	Comorbid HCC 2	Comorbid HCC 3	HCC-Combination	HCC-Comb Description
HCC-17	HCC-85	NA	HCC-901	Combination: Diabetes and CHF
HCC-18	HCC-85	NA	HCC-901	Combination: Diabetes and CHF
HCC-19	HCC-85	NA	HCC-901	Combination: Diabetes and CHF

**Risk adjustment****Risk Adjustment Calculation**

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 person might have during the measurement period.

For each nonoutlier person in the initial population, assign PPD risk weights. Calculate the PPD for each ACSC category (Chronic ACSC, Acute ACSC, Total ACSC).

**Step 1.** For each person with a comorbidity HCC Category, link the PPD weights.

**Step 2.** Link the age and gender PPD weights for each person.

**Step 3.** Sum all PPD weights associated with the person (comorbidities, age and gender) for each category (Chronic ACSC, Acute ACSC, Total ACSC).

**Step 4.** Calculate the predicted probability of having at least one discharge in the measurement period, based on the sum of the weights for each person, for each category (Chronic ACSC, Acute ACSC, Total ACSC), using the formula below.

$$\text{PPD} = \frac{e^{(\sum \text{PPDWeightsForEachPerson})}}{1+e^{(\sum \text{PPDWeightsForEachPerson})}}$$

Truncate the final PPD *for each person* to 10 decimal places. Do not truncate or round in previous steps.

**For each nonoutlier person in the initial population, assign PUCD risk weights. Calculate the PUCD for each ACSC category (Chronic ACSC, Acute ACSC, Total ACSC).**

**Step 1.** For each person with a comorbidity HCC Category, link the PUCD weights. If a person does not have any comorbidities to which weights can be linked, assign a weight of 1.

**Step 2.** Link the age and gender PUCD weights for each person.

**Step 3.** Calculate the predicted unconditional count of discharges in the measurement period by multiplying all PUCD weights (comorbidities, age and gender) associated with the person for each ACSC category (Chronic ACSC, Acute ACSC, Total ACSC). Use the following formula:

$$\text{PUCD} = \text{Age/Gender Weight} * \text{HCC Weight}$$

**Note:** Multiply by each HCC associated with the person. For example, assume a person with HCC-2, HCC-10, HCC-47. The formula would be:

$$\text{PUCD} = \text{Age/Gender Weight} * \text{HCC-2} * \text{HCC-10} * \text{HCC-47}$$

Truncate the final PUCD *for each person* to 10 decimal places. Do not truncate or round in prior steps.

**Expected count of discharges.** Calculate the final person-level expected count of discharges for each category using the formula below.

$$\text{Expected Count of ACSC Discharges} = \text{PPD} \times \text{PUCD}$$

Round the person-level results to 4 decimal places using the .5 rule and sum over all persons in the category.

**Step 4.** Use the formula below to calculate the covariance of the predicted outcomes for each category (age group and type of ACSC). For categories with a single person ( $n_c=1$ ), set the covariance to zero. Do not round the covariance before using it in step 5.

$$\text{COV}_c = \frac{\sum_{m=1}^{n_c} (\text{PPD}_m - \text{mean(PPD)}_c) \times (\text{PUCD}_m - \text{mean(PUCD)}_c)}{n_c - 1}$$

	<p>Where:</p> <p><math>c</math> denotes an individual category  <math>n_c</math> is the number of persons in the category indicated by <math>c</math>  <math>m</math> is an individual person within the category indicated by <math>c</math>  <math>PPD_m</math> is the truncated PPD for the person denoted by <math>m</math>  <math>mean(PPD)_c</math> is the unrounded/untruncated mean PPD in the category indicated by <math>c</math>  <math>PUCD_m</math> is the truncated PUCD for the person denoted by <math>m</math>  <math>mean(PUCD)_c</math> is the unrounded and untruncated mean PUCD in the category indicated by <math>c</math></p> <p><b>Step 5.</b> Once the covariance between PPD and PUCD for a given category is calculated, it can be used as indicated in the formula below to calculate the variance for that category.</p> $Variance_c = \sum_{m=1}^{n_c} (PPD_m \times PUCD_m)^2 \\ \times \left( 1 + (1 - PPD_m)^2 + \left( \frac{2 \times COV_c}{PPD_m \times PUCD_m} \right) \right)$ <p>Where:</p> <p><math>c</math> denotes an individual category  <math>n_c</math> is the number of persons in the category indicated by <math>c</math>  <math>m</math> is an individual person within the category indicated by <math>c</math>  <math>PPD_m</math> is the truncated PPD for the person denoted by <math>m</math>  <math>PUCD_m</math> is the truncated PUCD for the person denoted by <math>m</math>  <math>n_c</math> is the number of persons in the category indicated by <math>c</math></p> <p>Round the variance for reporting to 4 decimal places using the .5 rule.</p>
<b>Summary of changes</b>	<ul style="list-style-type: none"> <li>Integrated the Risk Adjustment General Guidelines into the <i>Guidance</i> section.</li> <li>Removed the definition of “classification period” and put this time frame in the <i>Risk adjustment comorbidity category determination</i> section.</li> <li>Added “direct transfer” to the <i>Definitions</i> section.</li> <li>Added administrative gender codes to the initial population.</li> </ul>
<b>Data element tables</b>	<p><b>Reporting: Number of chronic ACSC nonoutliers, acute ACSC nonoutliers and total ACSC nonoutliers</b>  The number of chronic ACSC nonoutliers, acute ACSC nonoutliers and total ACSC nonoutliers for each group, reported as the NonOutlierPersonCount.</p> <p><b>Reporting: Number of chronic ACSC outliers, acute ACSC outliers and total ACSC outliers</b>  The number of chronic ACSC outliers, acute ACSC outliers and total ACSC outliers for each age group, reported as the OutlierPersonCount.</p>

	<p><b>Calculated: Number of persons in the initial population</b> The number of persons in the initial population (including all outliers) for each age group and totals. Calculated by IDSS as the PersonCount.</p> <p><b>Calculated: Chronic ACSC outlier rate, acute ACSC outlier rate and total ACSC outlier rate</b></p> <ul style="list-style-type: none"> <li>• The number of chronic ACSC outlier persons (OutlierPersonCount) divided by the number of persons in the initial population (PersonCount), multiplied by 1,000 for each age group and totals. Calculated by IDSS as the OutlierRate.</li> <li>• The number of acute ACSC outlier persons (OutlierPersonCount) divided by the number of persons in the initial population (PersonCount), multiplied by 1,000 for each age group and totals. Calculated by IDSS as the OutlierRate.</li> <li>• The number of total ACSC outlier persons (OutlierPersonCount) divided by the number of persons in the initial population (PersonCount), multiplied by 1,000 for each age group and totals. Calculated by IDSS as the OutlierRate.</li> </ul> <p><b>Reporting: Number of observed events among nonoutlier persons</b> The number of observed discharges within each age group for each ACSC category and total ACSC, reported as the ObservedCount.</p> <p><b>Calculated: Observed discharges per 1,000 nonoutlier persons</b> The number of observed discharges (ObservedCount) divided by the number of nonoutlier persons in the initial population (NonOutlierPersonCount), multiplied by 1,000 for each age group and totals for each ACSC category and total ACSC. Calculated by IDSS as the ObservedRate.</p> <p><b>Reporting: Number of expected events among nonoutlier persons</b> The number of expected discharges for each age group for each ACSC category and total ACSC, reported as the ExpectedCount.</p> <p><b>Calculated: Expected discharges per 1,000 nonoutlier persons</b> The number of expected discharges (ExpectedCount) divided by the number of nonoutlier persons in the initial population (NonOutlierPersonCount), multiplied by 1,000 for each age group and totals for each ACSC category and total ACSC. Calculated by IDSS as the ExpectedRate.</p> <p><b>Reporting: Variance among nonoutlier persons</b> The variance (from <i>Risk Adjustment Calculation</i>, PUCD, step 5) for each age group for each ACSC category and total ACSC, reported as the CountVariance.</p> <p><b>Calculated: O/E ratio</b> The number of observed discharges (ObservedCount) divided by the number of expected discharges (ExpectedCount) for each age group and totals for each ACSC category and total ACSC. Calculated by IDSS as the OE.</p> <p>Organizations that submit HEDIS data to NCQA must provide the following data elements.</p>
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<b>Table HPC-3: Data Elements for Hospitalization for Potentially Preventable Complications</b>			
Metric	Age	Data Element	Reporting Instructions
Chronic	67-74	NonOutlierPersonCount	For each Metric and Stratification
Acute	75-84	OutlierPersonCount	For each Metric and Stratification
Total	85+	PersonCount	NonOutlierPersonCount + OutlierPersonCount
	Total	OutlierRate	OutlierPersonCount / PersonCount (Permille)
		ObservedCount	For each Metric and Stratification
		ObservedRate	1,000 * ObservedCount / NonOutlierPersonCount
		ExpectedCount	For each Metric and Stratification
		ExpectedRate	1,000 * ExpectedCount / NonOutlierPersonCount
		CountVariance	For each Metric and Stratification
		OE	ObservedCount / ExpectedCount

<b>Rules for Allowable Adjustments</b>	<p><b>Copyright and use:</b> The “Rules for Allowable Adjustments of HEDIS” (the “Rules”) describe how NCQA’s HEDIS measure specifications can be adjusted for other populations, if applicable. The Rules, reviewed and approved by NCQA measure experts, provide for expanded use of HEDIS measures without changing their clinical intent.</p> <p><b>Adjusted HEDIS measures <i>may not</i> be used for HEDIS health plan reporting.</b></p> <p>The measures under the Risk Adjusted Utilization domain allow two types of <i>Rules for Allowable Adjustments</i> sections:</p> <ol style="list-style-type: none"> <li>1. <i>Rules for Allowable Adjustments for Risk-Adjusted Measurement.</i> This section must be followed for adjustments when calculating the full measure specifications, which includes all risk adjusted rates (expected rates, risk adjustment, O/E) and calculation components (count of index stays, observed events).</li> <li>2. <i>Rules for Allowable Adjustments for Observed Measurement (rates without risk adjustment).</i> This section must be followed when adjusting the calculation of observed events only. When applying these adjustments, organizations must not include risk adjustment logic.</li> </ol> <p>The intent of including two types of Rules is to allow organizations to adjust measures without compromising measure validity. Risk adjustment is based on statistical prediction models specifically calibrated to each measure.</p>
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The following are the Rules for Allowable Adjustments for Risk-Adjusted Measurement of the Hospitalization for Potentially Preventable Complications measure (observed discharges, risk adjustment determination, risk adjustment weighting, count of expected discharges, variance, O/E).

#### ADJUSTMENTS ALLOWED

- *Benefits.* Organizations are not required to use a benefit.
- *Exclusions.* The I-SNP and LTI exclusions are not required.
- *Telehealth.* Services/events that allow the use of synchronous telehealth visits, telephone visits and asynchronous telehealth (e-visits, virtual check-ins) may be stratified to identify services performed via telehealth. This adjustment is not allowed for events, numerators and exclusions that do not allow the use of telehealth.

#### ADJUSTMENTS ALLOWED WITH LIMITS

- *Other.* Organizations may only adjust the initial population criteria to focus on an area of interest defined by gender, sociodemographic characteristics or geographical region. NCQA recommends evaluating risk model performance and validity within adjusted populations. Organizations may not adjust for a clinical subpopulation (e.g., persons with a diabetes diagnosis).
- *Measurement period adjustments.* Organizations may only change the measurement period by 1 year.
- *SES stratification, skilled nursing care stratification.* Stratifications not required, but if they are used the value sets, logic and product lines may not be changed.
- *Observed events.* Organizations may include denied claims to calculate the observed events. The value sets and logic may not be changed.
- *Outliers.* Organizations may include denied claims to calculate these events. Organizations may not adjust the outlier logic.
- *Risk adjustment determination, risk adjustment weighting, expected count of discharges, variance.* Organizations may include denied claims to calculate these events. Risk adjustment determinations, weighting and calculations of expected events logic may not be changed.

#### ADJUSTMENTS NOT ALLOWED:

- *Product lines.* Organizations may not adjust product lines.
- *Attribution.* Organizations are required to use enrollment criteria.
- *Ages.* The age determination dates may not be changed.
- *Supplemental data.* Supplemental data may not be used to identify initial population, observed event, and numerator events.
- *Exclusions.* The hospice exclusion must be applied. Logic may not be changed.

The following are the Rules for Allowable Adjustments for Observed Measurement of the Hospitalization for Potentially Preventable Complications measure observed events (observed discharges).

#### ADJUSTMENTS ALLOWED

- *Product lines.* When adjusting this measure to assess for observed events only, organizations are not required to use product line criteria; product lines may be combined, and all (or no) product line criteria may be used.
- *Ages.* The observed event age range may be expanded. Age determination dates may be changed (e.g., select, "age as of June 30").
- *Attribution.* Organizations are not required to use enrollment criteria.
- *Benefits.* Organizations are not required to use a benefit.
- *Other.* Organizations may adjust the initial population criteria to focus on an area of interest defined by gender, race, ethnicity, socioeconomic or sociodemographic characteristics, geographic region or another characteristic.
- *Measurement period adjustments.* Organizations may adjust the measurement period.
- *Exclusions.* The hospice, I-SNP and LTI exclusions are not required.
- *Outlier.* Organizations may adjust the outlier logic. The outlier logic is not required to be applied. The outlier thresholds may be expanded or reduced. Denied claims may be used to calculate these events.
- *Telehealth.* Services/events that allow the use of synchronous telehealth visits, telephone visits and asynchronous telehealth (e-visits, virtual check-ins) may be stratified to identify services performed via telehealth. This adjustment is not allowed for events, numerators and exclusions that do not allow the use of telehealth.
- *Supplemental data.* Supplemental data may be used to identify initial population, observed event, exclusion and numerator events.

#### ADJUSTMENTS ALLOWED WITH LIMITS

- *Observed events.* Organizations may include denied claims to calculate the observed events. The value sets and logic may not be changed.

## ***Emergency Department Visits for Hypoglycemia in Older Adults With Diabetes (EDH)***

<b>Measure title</b>	Emergency Department Visits for Hypoglycemia in Older Adults With Diabetes	<b>Measure ID</b>	EDH
<b>Description</b>	<p>For persons 67 years of age and older with diabetes (types 1 and 2), the risk-adjusted ratio of observed to expected (O/E) emergency department (ED) visits for hypoglycemia during the measurement period. Two rates are reported:</p> <ul style="list-style-type: none"> <li>• For persons 67 years of age and older with diabetes (types 1 and 2), the risk-adjusted ratio of O/E ED visits for hypoglycemia during the measurement period, stratified by dual eligibility.</li> <li>• For persons 67 years of age and older with diabetes (types 1 and 2) who had at least one dispensing event of insulin within each 180-day (6-month) treatment period from July 1 of the year prior to the measurement period through December 31 of the measurement period, the risk-adjusted ratio of O/E ED visits for hypoglycemia, stratified by dual eligibility.</li> </ul>		
<b>Measurement period</b>	January 1–December 31.		
<b>Copyright and disclaimer notice</b>	<p>Refer to the complete copyright and disclaimer information at the front of this publication.</p> <p>NCQA website: <a href="http://www.ncqa.org">www.ncqa.org</a>.</p> <p>Submit policy clarification support questions via My NCQA (<a href="https://my.ncqa.org">https://my.ncqa.org</a>).</p>		
<b>Clinical recommendation statement/ rationale</b>	<p>While the consequences of hypoglycemia can be devastating in older adults, it may be possible to reduce hypoglycemia risk through effective treatment management. Multiple clinical practice guidelines recommend adjusting treatment regimens in older adults to minimize hypoglycemia risk. For example, the American Diabetes Association (ADA) recommends routine monitoring of hypoglycemic episodes and adjusting glycemic targets and pharmacologic treatments to avoid hypoglycemia in older adults.</p> <p>The Endocrine Society recommends that clinicians design outpatient diabetes regimens specifically to minimize hypoglycemia. The American Association of Clinical Endocrinologists (AACE) and American College of Endocrinology (ACE) cites minimizing hypoglycemia as a guiding principle in its diabetes treatment algorithm and emphasizes that reducing risk of hypoglycemia should be a key consideration when selecting antihyperglycemic agents.</p>		
<b>Citations</b>	<p>American Diabetes Association Professional Practice Committee. 2025. “13. Older Adults: Standards of Care in Diabetes—2025.” <i>Diabetes Care</i> 48 (Suppl. 1):S266–82.</p> <p>Endocrine Society. 2019. “Treatment of Diabetes in Older Adults: An Endocrine Society Clinical Practice Guideline.” <i>The Journal of Clinical Endocrinology &amp; Metabolism</i> 104, no. 5: 1520. <a href="https://doi.org/10.1210/jc.2019-00198">https://doi.org/10.1210/jc.2019-00198</a></p>		

	Garber, A.J., Y. Handelsman, G. Grunberger, D. Einhorn, M.J. Abrahamson, J.I. Barzilay, L. Blonde, et al. 2020. "Consensus Statement by the American Association of Clinical Endocrinologists and American College of Endocrinology on the Comprehensive Type 2 Diabetes Management Algorithm—2020 Executive Summary." <i>Endocrine Practice</i> 26, no. 1: 107. <a href="https://doi.org/10.4158/cs-2019-0472">https://doi.org/10.4158/cs-2019-0472</a>
<b>Characteristics</b>	
<b>Scoring</b>	Ratio.
<b>Product lines</b>	Medicare.
<b>Stratifications</b>	Socioeconomic status (SES). <ul style="list-style-type: none"> <li>• Dual eligible: <ul style="list-style-type: none"> <li>– LIS/DE.</li> <li>– LIS/DE and disability.</li> </ul> </li> <li>• Not dual eligible: <ul style="list-style-type: none"> <li>– Non-LIS/DE, non-disability.</li> <li>– Disability.</li> <li>– Other.</li> <li>– Unknown.</li> </ul> </li> </ul>
	Follow the SES stratification instructions in <a href="#">General Guideline: Medicare Socioeconomic Status Stratification</a> to categorize persons into SES strata. Map persons from their SES strata to the corresponding dual eligible strata according to the categories above.
<b>Guidance</b>	<p><b>Risk Adjustment Measure Specific Guidance</b></p> <p><b>Which services count?</b></p> <ul style="list-style-type: none"> <li>• Use all paid, suspended, pending, and denied claims when applying risk adjustment comorbidity category determination and the hospice exclusion.</li> <li>• Do not include denied claims when identifying all other events (e.g., observed events); only report claims the organization paid for or expects to pay for (i.e., claims incurred but not paid).</li> </ul> <p><b>Supplemental data exceptions:</b> Supplemental data may only be used for the hospice exclusion.</p> <p><b>Transfers:</b></p> <ul style="list-style-type: none"> <li>• Treat transfers <i>between</i> institutions as separate admissions.</li> <li>• Base transfer reports <i>within</i> an institution on the type and level of services provided.</li> <li>• Report separate admissions when the transfer is between acute and nonacute levels of service or between mental health/chemical dependency services and non-mental health/chemical dependency services.</li> <li>• Count only one admission when the transfer takes place within the same service category, but to a different level of care (e.g., from intensive care to a lesser level of care; from a lesser level of care to intensive care).</li> </ul>

	<p><b>Risk adjustment:</b> Organizations may not use risk assessment protocols to supplement diagnoses for calculation of the risk adjustment scores for these measures. The measurement model was developed and tested using only claims-based diagnoses; diagnoses from additional data sources would affect the validity of the models as they are currently implemented in the specification.</p> <p><b>General Rules</b></p> <ul style="list-style-type: none"> <li>• <b>Data collection methodology:</b> Administrative. Refer to <a href="#">General Guideline: Data Collection Methods</a> for additional information.</li> <li>• <b>Date specificity:</b> Dates must be specific enough to determine the event occurred in the period being measured.</li> </ul> <p><b>Improvement notation:</b> To interpret the ratio as better or worse than expected, the ratio must be calibrated. Organizations can calibrate ratios by dividing individual organization ratios or national percentiles by the national average ratio. Organizations may be more successful at achieving fewer ED visits than expected, given the types of cases treated by the organization (calibrated ratio with a value &lt;1.0), or may be less successful (calibrated ratio with a value &gt;1.0).</p>
<b>Definitions</b>	
<b>Basal insulin</b>	Long-, intermediate-acting or mixed insulin types.
<b>Insulin</b>	Any type of insulin, including basal insulin and short- or rapid-acting insulin types.
<b>PPV</b>	Predicted probability of a visit. The predicted probability of an ED visit for hypoglycemia in the measurement period.
<b>PUCV</b>	Predicted unconditional count of visits. The predicted unconditional count of ED visits for hypoglycemia during the measurement period.
<b>Initial population</b>	<p><i>Measure item count:</i> Person.</p> <p><i>Attribution basis:</i> Enrollment.</p> <ul style="list-style-type: none"> <li>• <b>Benefits:</b> Medical and pharmacy.</li> <li>• <b>Continuous enrollment:</b> The measurement period and the year prior to the measurement period.</li> <li>• <b>Allowable gap:</b> No more than one gap of ≤45 days during each year of continuous enrollment. No gaps on the last day of the measurement period.</li> </ul> <p><i>Ages:</i> 67 years of age and older as of the last day of the measurement period.</p> <p><i>Gender/Sex criteria:</i></p> <ul style="list-style-type: none"> <li>• Administrative Gender of Female (AdministrativeGender code female).</li> <li>• Administrative Gender of Male (AdministrativeGender code male).</li> </ul>

	<p><b>Exclusions: Persons in hospice or using hospice services.</b></p> <p>Persons who use hospice services (<u>Hospice Encounter Value Set</u>; <u>Hospice Intervention Value Set</u>) or elect to use a hospice benefit any time during the measurement period. Organizations that use the Monthly Membership Detail Data File to identify these persons must use only the run date of the file.</p> <p><b>Additional initial population criteria: Rate 1—All persons with diabetes.</b> Identify persons with a diagnosis of diabetes.</p> <p>Either of the following meets criteria:</p> <ul style="list-style-type: none"> <li>• <i>Claim/encounter data.</i> At least two diagnoses of diabetes (<u>Diabetes Value Set*</u>) on different dates of service during the measurement period or the year prior to the measurement period.</li> <li>• <i>Pharmacy data.</i> At least one diagnosis of diabetes (<u>Diabetes Value Set*</u>) <b>and</b> at least one diabetes medication dispensing event of insulin or a hypoglycemic/antihyperglycemic medication (<u>Diabetes Medications List</u>) during the measurement period or the year prior to the measurement period.</li> </ul> <p><b>Additional initial population criteria: Rate 2—Persons receiving insulin.</b> All persons meeting initial population criteria for rate 1 who received insulin. Identify persons in the initial population who received at least 1 dispensing event of insulin (<u>Insulin Medications List</u>) within each of the three treatment periods:</p> <ul style="list-style-type: none"> <li>• <i>Treatment period 1:</i> July 1–December 31 of the year prior to the measurement period.</li> <li>• <i>Treatment period 2:</i> January 1–June 30 of the measurement period.</li> <li>• <i>Treatment period 3:</i> July 1–December 31 of the measurement period.</li> </ul> <p><b>Coding Guidance</b> *Do not include laboratory claims (claims with POS code 81).</p>
<b>Measure observation</b>	<p><b>Calculation of Observed Events</b></p> <p>Calculate observed events for persons in initial population 1 <b>and</b> initial population 2.</p> <p><b>Step 1.</b> Count each visit to an ED for hypoglycemia once, regardless of the intensity or duration of the visit. Count multiple ED visits for hypoglycemia on the same date of service as one visit. Identify all ED visits for hypoglycemia during the measurement period using:</p> <ul style="list-style-type: none"> <li>• An ED visit (<u>ED Value Set</u>) <b>with</b> a diagnosis of hypoglycemia (<u>Hypoglycemia Value Set</u>).</li> </ul> <p><b>Step 2.</b> Calculate the number of visits per person. For persons with more than one visit, retain only the first five. Do not report visits beyond the first five.</p> <p><b>Step 3.</b> Calculate the total using all ED visits identified after completing steps 1–2. Assign each remaining ED visit to a stratification category using the reporting instructions.</p>

<b>Risk adjustment factors</b>	<p><b>Risk Adjustment Determination</b></p> <p>For each person, identify risk adjustment weights based on receipt of basal insulin, comorbidity, age and gender. Refer to the reporting indicator column in the risk adjustment tables to ensure that weights are linked appropriately.</p> <p><b>Basal insulin:</b> Determine if the person received at least one dispensing event of basal insulin (<a href="#">Basal Insulin Medications List</a>) within each of the three treatment periods:</p> <ul style="list-style-type: none"> <li>• <i>Treatment period 1:</i> July 1–December 31 of the year prior to the measurement period.</li> <li>• <i>Treatment period 2:</i> January 1–June 30 of the measurement period.</li> <li>• <i>Treatment period 3:</i> July 1–December 31 of the measurement period.</li> </ul> <p><b>Comorbidities:</b></p> <p><b>Step 1.</b> Identify all diagnoses for encounters during the year prior to the measurement period. Include the following when identifying encounters:</p> <ul style="list-style-type: none"> <li>• Outpatient visits, ED visits, telephone visits, nonacute inpatient encounters and acute inpatient encounters (<a href="#">Outpatient, ED, Telephone, Acute Inpatient and Nonacute Inpatient Value Set</a>) with a date of service during the year prior to the measurement period.</li> <li>• Acute and nonacute inpatient discharges (<a href="#">Inpatient Stay Value Set</a>) with a discharge date during the year prior to the measurement period.</li> </ul> <p><b>Step 2.</b> Assign each diagnosis to one or more comorbid Clinical Condition (CC) category using Table CC—Mapping in the Risk Adjustment Shared Tables. If the code appears more than once in Table CC—Mapping, it is assigned to multiple CCs.</p> <p>Exclude all diagnoses that cannot be assigned to a comorbid CC category. For persons with no qualifying diagnoses from face-to-face encounters, skip to <i>Risk adjustment calculation</i>.</p> <p>All digits must match exactly when mapping diagnosis codes to the comorbid CCs.</p> <p><b>Step 3.</b> Determine HCCs for each comorbid CC identified. Refer to Table HCC—Rank.</p> <p>For each person's comorbid CC list, match the comorbid CC code to the comorbid CC code in the table, and assign:</p> <ul style="list-style-type: none"> <li>• The ranking group.</li> <li>• The rank.</li> <li>• The HCC.</li> </ul> <p>For comorbid CCs that do not match to Table HCC—Rank, use the comorbid CC as the HCC and assign a rank of 1. One comorbid CC can map to multiple HCCs; each HCC can have one or more comorbid CCs.</p> <p><b>Step 4.</b> Assess each ranking group separately and select only the highest ranked HCC in each ranking group using the “Rank” column (1 is the highest rank possible). Drop all other HCCs in each ranking group, and de-duplicate the HCC list if necessary.</p>
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- *For example*, assume a person with the following comorbid CCs: CC-85, CC-17 and CC-19 (assume no other CCs).
  - CC-85 does not have a map to the ranking table and becomes HCC-85.
  - HCC-17 and HCC-19 are part of Diabetes Ranking Group 1. Because CC-17 is ranked higher than CC-19 in Ranking Group Diabetes 1, the comorbidity is assigned as HCC-17 for Ranking Group 1.

The final comorbidities for this person are HCC-17 and HCC-85.

**Table HCC—Rank**

Ranking Group	CC	Description	Rank	HCC
NA	CC-85	Congestive Heart Failure	NA	HCC-85
Diabetes 1	CC-17	Diabetes With Acute Complications	1	HCC-17
	CC-18	Diabetes With Chronic Complications	2	HCC-18
	CC-19	Diabetes Without Complications	3	HCC-19

**Step 5.** Identify combination HCCs listed in Table HCC—Comb.

Some combinations suggest a greater amount of risk when observed together.

- *For example*, when diabetes and CHF are present, an increased amount of risk is evident. Additional HCCs are selected to account for these relationships.

Compare each person's list of unique HCCs to those in the *Comorbid HCC* columns in Table HCC—Comb and assign any additional HCC conditions.

*If there are overlapping combinations, use both sets of combinations.* Based on the combinations, an observed event can have none, one or more of these added HCCs.

- *For example*, for a person with comorbidities HCC-17 and HCC-85 (assume no other HCCs), assign HCC-901 in addition to HCC-17 and HCC-85. This *does not* replace HCC-17 and HCC-85.

**Table HCC—Comb**

Comorbid HCC 1	Comorbid HCC 2	Comorbid HCC 3	HCC-Combination	HCC-Comb Description
HCC-17	HCC-85	NA	HCC-901	Combination: Diabetes and CHF
HCC-18	HCC-85	NA	HCC-901	Combination: Diabetes and CHF
HCC-19	HCC-85	NA	HCC-901	Combination: Diabetes and CHF

**Risk adjustment**

**Risk Adjustment Calculation**

Calculation of risk-adjusted outcomes (counts of ED visits for hypoglycemia) uses predetermined risk weights generated by two separate regression models. Weights from each model are combined to predict how many ED visits

for hypoglycemia each person might have during the measurement period. Weights are specific to measure rate (rate 1—all persons with diabetes, rate 2—persons receiving insulin).

**Note:** Persons receiving insulin should be assigned two sets of risk adjustment weights; the standard set of risk weights for reporting in rate 1 (“Diabetes” metric in reporting table EDH-3) and the insulin set of risk weights for reporting in rate 2 (“Insulin” metric in reporting table EDH-3). For reporting persons receiving insulin, do not assign the insulin set of risk weights when reporting rate 1 and do not assign the standard set of risk weights when reporting rate 2.

For each person in the initial population, assign PPV risk weights. If no weight is specified for a variable, the variable is not included and should be omitted from the calculation of the predicted values for that model (e.g., basal insulin is not included as a variable in the set of risk weights for rate 2).

**Step 1.** For each person receiving basal insulin, link the basal insulin PPV weight.

**Step 2.** For each person with a comorbidity HCC category, link the PPV weights.

**Step 3.** Link the age-gender PPV weights for each person.

**Step 4.** Sum all PPV weights (basal insulin, comorbidities, age and gender) associated with the person.

**Step 5.** Calculate the predicted probability of each person having at least one visit based on the sum of the weights for each person using the formula below.

$$\text{PPV} = \frac{e^{(\sum \text{PPV WeightsForEachPerson})}}{1+e^{(\sum \text{PPV WeightsForEachPerson})}}$$

Truncate the final PPV for each person to 10 decimal places. Do not truncate or round in previous steps.

**For each person in the initial population, assign predicted unconditional count of visits (PUCV) risk weights.**

**Step 1.** For each person receiving basal insulin, link the PUCV weights. If a person is not receiving basal insulin, assign a weight of 1.

**Step 2.** For each person with a comorbidity HCC category, link the PUCV weights. If a person does not have any comorbidities to which weights can be linked, assign a weight of 1.

**Step 3.** Link the age-gender PUCV weights for each person.

**Step 4.** Calculate the predicted unconditional count of visits in the measurement period, by multiplying all PUCV weights (basal insulin, comorbidities, age and gender). Use the following formula:

$$\text{PUCV} = \text{Age/Gender Weight} * \text{HCC Weight} * \text{Basal Insulin Weight}$$

**Note:** Multiply by each HCC associated with the person. For example, assume a person with HCC-51, HCC-85, HCC-134. The formula would be:

$$\text{PUCV} = \text{Age/gender Weight} * \text{HCC-51} * \text{HCC-85} * \text{HCC-134}$$

Truncate the final PUCV for each person to 10 decimal places. Do not truncate or round in previous steps.

	<p><i>Expected count of ED visits.</i> Calculate the final person-level expected count of ED visits for hypoglycemia for each category (i.e., rate and dual-eligibility stratification) using the formula below.</p> $\text{Expected Count of ED Visits} = \text{PPV} \times \text{PUCV}$ <p>Round the person-level results to 4 decimal places using the .5 rule and sum over all persons in the category.</p> <p><b>Step 5.</b> Use the formula below to calculate the covariance of the predicted outcomes for each category (i.e., rate and dual-eligibility stratification). For categories with a single person (<math>n_c=1</math>), set the covariance to zero. Do not round the covariance before using it in step 5.</p> $\text{COV}_c = \frac{\sum_{m=1}^{n_c} (\text{PPV}_m - \text{mean(PPV)}_c) \times (\text{PUCV}_m - \text{mean(PUCV)}_c)}{n_c - 1}$ <p>Where:</p> <ul style="list-style-type: none"> <li><math>c</math> denotes an individual category</li> <li><math>n_c</math> is the number of persons in the category indicated by <math>c</math></li> <li><math>m</math> is an individual person within the category indicated by <math>c</math></li> <li><math>\text{PPV}_m</math> is the truncated PPV for the person denoted by <math>m</math></li> <li><math>\text{mean(PPV)}_c</math> is the unrounded and untruncated mean PPV in the category indicated by <math>c</math></li> <li><math>\text{PUCV}_m</math> is the truncated PUCV for the person denoted by <math>m</math></li> <li><math>\text{mean(PUCV)}_c</math> is the unrounded and untruncated mean PUCV in the category indicated by <math>c</math></li> </ul> <p><b>Step 6.</b> Once the covariance between PPV and PUCV for a given category is calculated, it can be used as indicated in the formula below to calculate the variance for that category.</p> $\text{Variance}_c = \sum_{m=1}^{n_c} (\text{PPV}_m \times \text{PUCV}_m)^2 \times \left( 1 + (1 - \text{PPV}_m)^2 + \left( \frac{2 \times \text{COV}_c}{\text{PPV}_m \times \text{PUCV}_m} \right) \right)$ <p>Where:</p> <ul style="list-style-type: none"> <li><math>c</math> denotes an individual category</li> <li><math>n_c</math> is the number of persons in the category indicated by <math>c</math></li> <li><math>m</math> is an individual person within the category indicated by <math>c</math></li> <li><math>\text{PPV}_m</math> is the truncated PPV for the person denoted by <math>m</math></li> <li><math>\text{PUCV}_m</math> is the truncated PUCV for the person denoted by <math>m</math></li> <li><math>n_c</math> is the number of persons in the category indicated by <math>c</math></li> </ul> <p>Round the variance for reporting to 4 decimal places using the .5 rule.</p>
<b>Summary of changes</b>	<ul style="list-style-type: none"> <li>Updated the measure description.</li> <li>Integrated the Risk Adjustment General Guidelines into the <i>Guidance</i> section.</li> </ul>

	<ul style="list-style-type: none"> <li>Moved the definition of “classification period” to the risk adjustment calculation.</li> <li>Added administrative gender codes to the initial population.</li> </ul>																										
<b>Data element tables</b>	<p><b>Reporting: Number of persons in the initial population</b> The number of persons in the initial population for each rate and dual-eligibility stratification, reported as the PersonCount.</p> <p><b>Reporting: Number of observed events among persons in the initial population</b> The number of observed ED visits with a diagnosis of hypoglycemia for each rate and dual-eligibility stratification, reported as the ObservedCount.</p> <p><b>Calculated: Observed events per 1,000 persons in the initial population</b> The number of observed ED visits (ObservedCount) divided by the number of persons in the initial population (PersonCount), multiplied by 1,000 within each rate and dual-eligibility stratification. Calculated by IDSS as the ObservedRate.</p> <p><b>Reporting: Number of expected events among persons in the initial population</b> The number of expected ED visits with a diagnosis of hypoglycemia within each rate and dual-eligibility stratification, reported as the ExpectedCount.</p> <p><b>Calculated: Expected visits per 1,000 persons in the initial population</b> The number of expected ED visits (ExpectedCount) divided by the number of persons in the initial population (PersonCount), multiplied by 1,000 within each rate and dual-eligibility stratification. Calculated by IDSS as the ExpectedRate.</p> <p><b>Reporting: Variance among persons in the initial population</b> The variance (Risk Adjustment Calculation, PUCV, step 3) within each rate and dual-eligibility stratification, reported as the CountVariance.</p> <p><b>Calculated: O/E ratio</b> The number of observed events among persons in the initial population (ObservedCount) divided by the number of expected events among persons in the initial population (ExpectedCount) within each rate and dual-eligibility stratification. Calculated by IDSS as the OE.</p> <p>Organizations that submit HEDIS data to NCQA must provide the following data elements.</p> <p><b>Table EDH-3: Data Elements for ED Visits for Hypoglycemia in Older Adults With Diabetes</b></p> <table border="1"> <thead> <tr> <th>Metric</th> <th>Dual Eligibility</th> <th>Data Element</th> <th>Reporting Instructions</th> </tr> </thead> <tbody> <tr> <td>Diabetes</td> <td>DualEligible</td> <td>Benefit</td> <td>Metadata</td> </tr> <tr> <td>Insulin</td> <td>NotDualEligible</td> <td>PersonCount</td> <td>For each Metric and Stratification</td> </tr> <tr> <td colspan="2" rowspan="6"></td><td>ObservedCount</td><td>For each Metric and Stratification</td> </tr> <tr> <td>ObservedRate</td><td>1000 * ObservedCount / PersonCount</td> </tr> <tr> <td>ExpectedCount</td><td>For each Metric and Stratification</td> </tr> <tr> <td>ExpectedRate</td><td>1000 * ExpectedCount / PersonCount</td> </tr> <tr> <td>CountVariance</td><td>For each Metric and Stratification</td> </tr> <tr> <td>OE</td><td>ObservedCount / ExpectedCount</td> </tr> </tbody> </table>	Metric	Dual Eligibility	Data Element	Reporting Instructions	Diabetes	DualEligible	Benefit	Metadata	Insulin	NotDualEligible	PersonCount	For each Metric and Stratification			ObservedCount	For each Metric and Stratification	ObservedRate	1000 * ObservedCount / PersonCount	ExpectedCount	For each Metric and Stratification	ExpectedRate	1000 * ExpectedCount / PersonCount	CountVariance	For each Metric and Stratification	OE	ObservedCount / ExpectedCount
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		CountVariance	For each Metric and Stratification																								
		OE	ObservedCount / ExpectedCount																								

<b>Rules for Allowable Adjustments</b>	<p><b>Copyright and use:</b> The “Rules for Allowable Adjustments of HEDIS” (the “Rules”) describe how NCQA’s HEDIS measure specifications can be adjusted for other populations, if applicable. The Rules, reviewed and approved by NCQA measure experts, provide for expanded use of HEDIS measures without changing their clinical intent.</p> <p><b>Adjusted HEDIS measures may not be used for HEDIS health plan reporting.</b></p> <p>The measures under the Risk Adjusted Utilization domain allow two types of <i>Rules for Allowable Adjustments</i> sections:</p> <ol style="list-style-type: none"><li>1. <i>Rules for Allowable Adjustments for Risk-Adjusted Measurement.</i> This section must be followed for adjustments when calculating the full measure specifications, which includes all risk adjusted rates (expected rates, risk adjustment, O/E) and calculation components (count of index stays, observed events).</li><li>2. <i>Rules for Allowable Adjustments for Observed Measurement (rates without risk adjustment).</i> This section must be followed when adjusting the calculation of Observed Events only. When applying these adjustments, organizations must not include risk adjustment logic.</li></ol> <p>The intent of including the two different types of Rules is to allow organizations to adjust measures without compromising the measures’ validity. Risk adjustment is based on statistical prediction models that are specifically calibrated for each measure.</p> <p><b>The following are the Rules for Allowable Adjustments for <u>Risk-Adjusted Measurement</u> of the Emergency Department Visits for Hypoglycemia in Older Adults With Diabetes measure (count of observed events, count of expected events, variance, risk adjustment determination, risk adjustment weighting, O/E).</b></p> <p><b>ADJUSTMENTS ALLOWED</b></p> <ul style="list-style-type: none"><li>• <i>Telehealth.</i> Services/events that allow the use of synchronous telehealth visits, telephone visits and asynchronous telehealth (e-visits, virtual check-ins) may be stratified to identify services performed via telehealth. This adjustment is not allowed for events, numerators and exclusions that do not allow the use of telehealth.</li></ul> <p><b>ADJUSTMENTS ALLOWED WITH LIMITS</b></p> <ul style="list-style-type: none"><li>• <i>Other.</i> Organizations may only adjust the initial population criteria to focus on an area of interest defined by gender, sociodemographic characteristics or geographical region. NCQA recommends evaluating risk model performance and validity within adjusted populations. Organizations may not adjust for a clinical subpopulation (e.g., persons with a diabetes diagnosis).</li><li>• <i>Measurement period adjustments.</i> Organizations may only change the measurement period by 1 year.</li><li>• <i>Calculations of observed events.</i> Organizations may include denied claims to calculate observed events. Medication lists, value sets and logic may not be changed.</li></ul>
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- *Risk adjustment determination, risk adjustment weighting, expected ED visits, variance.* Organizations may include denied claims to calculate these events. Risk adjustment determinations, weighting and calculations of expected events logic may not be changed.

#### **ADJUSTMENTS NOT ALLOWED**

- *Product lines.* Organizations may not adjust product lines.
- *Attribution.* Organizations are required to use enrollment criteria.
- *Ages.* The age determination dates may not be changed.
- *Benefits.* Organizations are required to use the benefits as defined.
- *Supplemental data.* Supplemental data may not be used to identify initial population, observed event, observed or expected events.
- *Exclusions.* The hospice exclusion must be applied. Logic may not be changed.
- *Stratifications (dual eligible and not dual eligible).* Stratifications are required. The logic may not be changed.

The following are the Rules for Allowable Adjustments for Observed Measurement of the Emergency Department Visits for Hypoglycemia in Older Adults With Diabetes measure observed events (number of persons receiving insulin, number of observed events among persons in the initial population, number of observed events among persons receiving insulin).

#### **ADJUSTMENTS ALLOWED**

- *Product lines.* When adjusting this measure to assess for observed events only, organizations are not required to use product line criteria; product lines may be combined, and all (or no) product line criteria may be used.
- *Attribution.* Organizations are not required to use enrollment criteria.
- *Benefits.* Organizations are not required to use a benefit.
- *Other.* Organizations may adjust the initial population criteria to focus on an area of interest defined by gender, race, ethnicity, socioeconomic or sociodemographic characteristics, geographic region or another characteristic.
- *Measurement period adjustments.* Organizations may adjust the measurement period.
- *Exclusions.* The hospice exclusion is not required.
- *Telehealth.* Services/events that allow the use of synchronous telehealth visits, telephone visits and asynchronous telehealth (e-visits, virtual check-ins) may be stratified to identify services performed via telehealth. This adjustment is not allowed for events, numerators and exclusions that do not allow the use of telehealth.
- *Supplemental data.* Supplemental data may be used to identify initial population and all events.

	<p><b>ADJUSTMENTS ALLOWED WITH LIMITS</b></p> <ul style="list-style-type: none"><li>• <i>Ages.</i> Age determination dates may be changed (e.g., select, “age as of June 30”). The observed event age range may not be expanded.</li><li>• <i>Calculations of observed events.</i> Organizations may include denied claims to calculate observed events. Medication lists, value sets and logic may not be changed.</li></ul> <p><b>ADJUSTMENTS NOT ALLOWED</b></p> <ul style="list-style-type: none"><li>• <i>Stratifications (dual eligible and not dual eligible).</i> Stratifications are required. The logic may not be changed.</li></ul>
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# **Measures Reported Using Electronic Clinical Data Systems**

## ***Childhood Immunization Status (CIS-E)***

Measure title	Childhood Immunization Status	Measure ID	CIS-E
<b>Description</b>	<p>The percentage of persons 2 years of age who had four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV); one measles, mumps and rubella (MMR); three haemophilus influenza type B (HiB); three hepatitis B (HepB), one chicken pox (VZV); four pneumococcal conjugate (PCV); one hepatitis A (HepA); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday.</p> <p>The measure calculates a rate for each vaccine and three combination rates.</p>		
<b>Measurement period</b>	January 1–December 31.		
<b>Copyright and disclaimer notice</b>	<p>Refer to the complete copyright and disclaimer information at the front of this publication.</p> <p>NCQA website: <a href="http://www.ncqa.org">www.ncqa.org</a>.</p> <p>Submit policy clarification support questions via My NCQA (<a href="https://my.ncqa.org">https://my.ncqa.org</a>).</p>		
<b>Clinical recommendation statement/ rationale</b>	<p>This measure looks for childhood vaccinations that should be completed by age 2, in accordance with the Centers for Disease Control and Prevention Advisory Committee on Immunization Practices (ACIP) recommended child and adolescent immunization schedule.</p>		
<b>Citations</b>	<p>Issa, A.N., A.P. Wodi, C.A. Moser, S. Cineas, S. 2025. "Advisory Committee on Immunization Practices Recommended Immunization Schedule for Children and Adolescents Aged 18 Years or Younger—United States, 2025." <i>MMWR Morb Mortal Wkly Rep</i> 74:26-29. doi: <a href="http://dx.doi.org/10.15585/mmwr.mm7402a2">http://dx.doi.org/10.15585/mmwr.mm7402a2</a>.</p>		
<b>Characteristics</b>			
<b>Scoring</b>	Proportion.		
<b>Type</b>	Process.		
<b>Product lines</b>	<ul style="list-style-type: none"> <li>• Commercial.</li> <li>• Medicaid.</li> </ul>		
<b>Stratifications</b>	<p>Combination 10: Race. (Refer to <a href="#">General Guideline: Race and Ethnicity Stratification</a>.)</p> <ul style="list-style-type: none"> <li>• American Indian or Alaska Native.</li> <li>• Asian.</li> <li>• Black or African American.</li> <li>• Middle Eastern or North African.</li> <li>• Native Hawaiian or Pacific Islander.</li> </ul>		

	<ul style="list-style-type: none"> <li>• White.</li> <li>• Some Other Race.</li> <li>• Two or More Races.</li> <li>• Asked But No Answer.</li> <li>• Unknown.</li> </ul> <p>Combination 10: Ethnicity. (Refer to <a href="#">General Guideline: Race and Ethnicity Stratification</a>.)</p> <ul style="list-style-type: none"> <li>• Hispanic or Latino.</li> <li>• Not Hispanic or Latino.</li> <li>• Asked But No Answer.</li> <li>• Unknown.</li> </ul>																																												
<b>Risk adjustment</b>	None.																																												
<b>Improvement notation</b>	Increased score indicates improvement.																																												
<b>Guidance</b>	<p><b>Data collection methodology:</b> ECDS. Refer to <a href="#">General Guideline: Data Collection Methods</a> for additional information.</p> <p><b>Date specificity:</b> Dates must be specific enough to determine the event occurred in the period being measured.</p> <p><b>What services count?</b> Use all paid, suspended, pending and denied claims.</p> <p><b>Other guidance:</b> Report rates for each vaccine and three combination rates.</p> <p><b>Combination rates:</b> Calculate the following rates for Combinations 3, 7 and 10.</p> <table border="1" style="width: 100%; border-collapse: collapse; text-align: center;"> <thead> <tr> <th>Combination</th> <th>DTaP</th> <th>IPV</th> <th>MMR</th> <th>HiB</th> <th>HepB</th> <th>VZV</th> <th>PCV</th> <th>HepA</th> <th>RV</th> <th>Influenza</th> </tr> </thead> <tbody> <tr> <td>Combination 3</td> <td>✓</td> <td>✓</td> <td>✓</td> <td>✓</td> <td>✓</td> <td>✓</td> <td>✓</td> <td></td> <td></td> <td></td> </tr> <tr> <td>Combination 7</td> <td>✓</td> <td>✓</td> <td>✓</td> <td>✓</td> <td>✓</td> <td>✓</td> <td>✓</td> <td>✓</td> <td>✓</td> <td></td> </tr> <tr> <td>Combination 10</td> <td>✓</td> </tr> </tbody> </table>	Combination	DTaP	IPV	MMR	HiB	HepB	VZV	PCV	HepA	RV	Influenza	Combination 3	✓	✓	✓	✓	✓	✓	✓				Combination 7	✓	✓	✓	✓	✓	✓	✓	✓	✓		Combination 10	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Combination	DTaP	IPV	MMR	HiB	HepB	VZV	PCV	HepA	RV	Influenza																																			
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Combination 10	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓																																			
<b>Initial population</b>	<p><b>Measure item count:</b> Person.</p> <p><b>Attribution basis:</b> Enrollment.</p> <ul style="list-style-type: none"> <li>• <b>Benefits:</b> Medical.</li> <li>• <b>Continuous enrollment:</b> 365 days prior to the person's second birthday and the second birthday.</li> <li>• <b>Allowable gap:</b> No more than one gap of ≤45 days during the continuous enrollment period. No gap on the second birthday.</li> </ul> <p><b>Ages:</b> Persons who turn 2 years of age during the measurement period.</p> <p><b>Event:</b> None.</p>																																												

<b>Denominator exclusions</b>	<p><b>Persons with a date of death.</b> Death in the measurement period, identified using data sources determined by the organization. Method and data sources are subject to review during the HEDIS audit.</p> <p><b>Persons in hospice or using hospice services.</b> Persons who use hospice services (<a href="#">Hospice Encounter Value Set</a>; <a href="#">Hospice Intervention Value Set</a>) or elect to use a hospice benefit any time during the measurement period. Organizations that use the Monthly Membership Detail Data File to identify these persons must use only the run date of the file.</p> <p><b>Contraindication to a childhood vaccine.</b> Persons who had a contraindication to a childhood vaccine (<a href="#">Contraindications to Childhood Vaccines Value Set*</a>; <a href="#">Organ and Bone Marrow Transplants Value Set</a>) on or before their second birthday.</p> <p><b>Coding Guidance</b> *Do not include laboratory claims (claims with POS code 81).</p>
<b>Denominator</b>	The initial population minus denominator exclusions.
<b>Numerator</b>	<p><b>Numerator 1: Immunization status—DTaP.</b> Persons who meet any of the following criteria on or before the second birthday:</p> <ul style="list-style-type: none"> <li>• At least four DTaP vaccinations (<a href="#">DTaP Immunization Value Set</a>; <a href="#">DTaP Vaccine Procedure Value Set</a>), with different dates of service. Do not count a vaccination administered prior to 42 days after birth.</li> <li>• Anaphylaxis due to the diphtheria, tetanus or pertussis vaccine (<a href="#">Anaphylaxis Due to Diphtheria, Tetanus or Pertussis Vaccine Value Set</a>).</li> <li>• Encephalitis due to the diphtheria, tetanus or pertussis vaccine (<a href="#">Encephalitis Due to Diphtheria, Tetanus or Pertussis Vaccine Value Set</a>).</li> </ul> <p><b>Numerator 2: Immunization status—IPV.</b> Persons who meet either of the following criteria on or before the second birthday:</p> <ul style="list-style-type: none"> <li>• At least three IPV vaccinations (<a href="#">Inactivated Polio Vaccine (IPV) Immunization Value Set</a>; <a href="#">Inactivated Polio Vaccine (IPV) Procedure Value Set</a>) with different dates of service. Do not count a vaccination administered prior to 42 days after birth.</li> <li>• Anaphylaxis due to the IPV vaccine (SNOMED CT code 471321000124106).</li> </ul> <p><b>Numerator 3: Immunization status—MMR.</b> Persons who meet any of the following criteria:</p> <ul style="list-style-type: none"> <li>• At least one MMR vaccination (<a href="#">Measles, Mumps and Rubella (MMR) Immunization Value Set</a>; <a href="#">Measles, Mumps and Rubella (MMR) Vaccine Procedure Value Set</a>) on or between the first and second birthdays.</li> <li>• All of the following any time on or before the second birthday (on the same or different date of service). <ul style="list-style-type: none"> <li>– History of measles illness (<a href="#">Measles and History of Measles Value Set*</a>).</li> </ul> </li> </ul>

- History of mumps illness ([Mumps and History of Mumps Value Set\\*](#)).
- History of rubella illness ([Rubella and History of Rubella Value Set\\*](#)).
- Anaphylaxis due to the MMR vaccine (SNOMED CT code 471331000124109) on or before the second birthday.

**Numerator 4: Immunization status—HiB.**

Persons who meet either of the following criteria on or before the second birthday:

- At least three HiB vaccinations ([Haemophilus Influenzae Type B \(HiB\) Immunization Value Set](#); [Haemophilus Influenzae Type B \(HiB\) Vaccine Procedure Value Set](#)), with different dates of service. Do not count a vaccination administered prior to 42 days after birth.
- Anaphylaxis due to the HiB vaccine (SNOMED CT code 433621000124101).

**Numerator 5: Immunization status—Hepatitis B.**

Persons who meet any of the following criteria on or before the second birthday:

- At least three hepatitis B vaccinations ([Hepatitis B Immunization Value Set](#); [Hepatitis B Vaccine Procedure Value Set](#)), with different dates of service.
  - One of the three vaccinations may be a newborn hepatitis B vaccination (ICD-10-PCS code 3E0234Z) during the 8-day period that begins on the date of birth and ends 7 days after the date of birth.
- History of hepatitis B illness ([Hepatitis B and History of Hepatitis B Value Set\\*](#)).
- Anaphylaxis due to the hepatitis B vaccine (SNOMED CT code 428321000124101).

**Numerator 6: Immunization status—VZV.**

Persons who meet any of the following criteria:

- At least one VZV vaccination ([Varicella Zoster \(VZV\) Immunization Value Set](#); [Varicella Zoster \(VZV\) Vaccine Procedure Value Set](#)) with a date of service on or between the first and second birthdays.
- History of varicella zoster (e.g., chicken pox) illness ([Varicella Zoster and History of Varicella Zoster Value Set\\*](#)) on or before the second birthday.
- Anaphylaxis due to the VZV vaccine (SNOMED CT code 471341000124104) on or before the second birthday.

**Numerator 7: Immunization status—Pneumococcal conjugate.**

Persons who meet either of the following criteria on or before the second birthday:

- At least four pneumococcal conjugate vaccinations ([Pneumococcal Conjugate Immunization Value Set](#); [Pneumococcal Conjugate Vaccine Procedure Value Set](#)) with different dates of service. Do not count a vaccination administered prior to 42 days after birth.
- Anaphylaxis due to the pneumococcal vaccine (SNOMED CT code 471141000124102).

**Numerator 8: Immunization status—Hepatitis A.**

Persons who meet any of the following criteria:

- At least one hepatitis A vaccination ([Hepatitis A Immunization Value Set](#); CPT code 90633), with a date of service on or between the first and second birthdays.
- History of hepatitis A illness ([Hepatitis A and History of Hepatitis A Value Set\\*](#)) on or before the second birthday.
- Anaphylaxis due to the hepatitis A vaccine (SNOMED CT code 471311000124103) on or before the second birthday.

**Numerator 9: Immunization status—Rotavirus.**

Persons who meet any of the following criteria:

- At least two doses of the two-dose rotavirus vaccine (CVX code 119; CPT code 90681) on different dates of service on or before the second birthday. Do not count a vaccination administered prior to 42 days after birth.
- At least three doses of the three-dose rotavirus vaccine ([Rotavirus \(3 Dose Schedule\) Immunization Value Set](#); CPT code 90680) on different dates of service on or before the second birthday. Do not count a vaccination administered prior to 42 days after birth.
- At least one dose of the two-dose rotavirus vaccine (CVX code 119; CPT code 90681) and at least two doses of the three-dose rotavirus vaccine ([Rotavirus \(3 Dose Schedule\) Immunization Value Set](#); CPT code 90680), all on different dates of service, on or before the second birthday. Do not count a vaccination administered prior to 42 days after birth.
- Anaphylaxis due to the rotavirus vaccine (SNOMED CT code 428331000124103) on or before the second birthday.

**Numerator 10: Immunization status—Influenza.**

Persons who meet either of the following criteria on or before the second birthday:

- At least two influenza vaccinations ([Influenza Immunization Value Set](#); [Influenza Vaccine Procedure Value Set](#)) with different dates of service. Do not count a vaccination administered prior to 180 days after birth.
  - An influenza vaccination recommended for children 2 years and older (e.g., LAIV) ([Influenza Virus LAIV Immunization Value Set](#); [Influenza Virus LAIV Vaccine Procedure Value Set](#)) administered on the second birthday meets criteria for one of the two required vaccinations.
- Anaphylaxis due to the influenza vaccine (SNOMED CT code 471361000124100).

**Numerator 11: Immunization status—Combination 3.**

Persons who are numerator compliant for DTaP, IPV, MMR, HiB, hepatitis B, VZV and pneumococcal indicators.

**Numerator 12: Immunization status—Combination 7.**

Persons who are numerator compliant for DTaP, IPV, MMR, HiB, hepatitis B, VZV, pneumococcal, hepatitis A and rotavirus indicators.

	<p><b>Numerator 13: Immunization status—Combination 10.</b> Persons who are numerator compliant for DTaP, IPV, MMR, HiB, hepatitis B, VZV, pneumococcal, hepatitis A, rotavirus and influenza indicators.</p> <p><b>Coding Guidance</b> *Do not include laboratory claims (claims with POS code 81).</p>																																																																																						
<b>Summary of changes</b>	<ul style="list-style-type: none"> <li>Updated the citation for clinical recommendation statement and rationale.</li> <li>Updated the race and ethnicity stratification categories to align with OMB SPD 15 2024.</li> <li>Removed the definitions of “participation” and “participation period.”</li> <li>Removed the SSoR data elements from the data element tables.</li> <li>Added instructions on allowable adjustments to the race and ethnicity stratification.</li> </ul>																																																																																						
<b>Data element tables</b>	<p>Organizations that submit HEDIS data to NCQA must provide the following data elements.</p> <p><i>Table CIS-E-A-1/2: Data Elements for Childhood Immunization Status</i></p> <table border="1"> <thead> <tr> <th>Metric</th> <th>Data Element</th> <th>Reporting Instructions</th> </tr> </thead> <tbody> <tr> <td>DTaP</td> <td>InitialPopulation</td> <td>Repeat per Metric</td> </tr> <tr> <td>IPV</td> <td>Exclusions</td> <td>Repeat per Metric</td> </tr> <tr> <td>MMR</td> <td>Denominator</td> <td>Repeat per Metric</td> </tr> <tr> <td>HiB</td> <td>Numerator</td> <td>For each Metric</td> </tr> <tr> <td>HepatitisB</td> <td>Rate</td> <td>(Percent)</td> </tr> <tr> <td>VZV</td> <td></td> <td></td> </tr> <tr> <td>PneumococcalConjugate</td> <td></td> <td></td> </tr> <tr> <td>HepatitisA</td> <td></td> <td></td> </tr> <tr> <td>Rotavirus</td> <td></td> <td></td> </tr> <tr> <td>Influenza</td> <td></td> <td></td> </tr> <tr> <td>Combo3</td> <td></td> <td></td> </tr> <tr> <td>Combo7</td> <td></td> <td></td> </tr> <tr> <td>Combo10</td> <td></td> <td></td> </tr> </tbody> </table> <p><i>Table CIS-E-B-1/2: Data Elements for Childhood Immunization Status: Stratifications by Race</i></p> <table border="1"> <thead> <tr> <th>Metric</th> <th>Race</th> <th>Data Element</th> <th>Reporting Instructions</th> </tr> </thead> <tbody> <tr> <td>Combo10</td> <td>AmericanIndianOrAlaskaNative</td> <td>InitialPopulation</td> <td>For each Stratification</td> </tr> <tr> <td></td> <td>Asian</td> <td>Exclusions</td> <td>For each Stratification</td> </tr> <tr> <td></td> <td>BlackOrAfricanAmerican</td> <td>Denominator</td> <td>For each Stratification</td> </tr> <tr> <td></td> <td>MiddleEasternOrNorthAfrican</td> <td>Numerator</td> <td>For each Stratification</td> </tr> <tr> <td></td> <td>NativeHawaiianOrPacificIslander</td> <td>Rate</td> <td>(Percent)</td> </tr> <tr> <td></td> <td>White</td> <td></td> <td></td> </tr> <tr> <td></td> <td>SomeOtherRace</td> <td></td> <td></td> </tr> <tr> <td></td> <td>TwoOrMoreRaces</td> <td></td> <td></td> </tr> <tr> <td></td> <td>AskedButNoAnswer</td> <td></td> <td></td> </tr> <tr> <td></td> <td>Unknown</td> <td></td> <td></td> </tr> </tbody> </table>	Metric	Data Element	Reporting Instructions	DTaP	InitialPopulation	Repeat per Metric	IPV	Exclusions	Repeat per Metric	MMR	Denominator	Repeat per Metric	HiB	Numerator	For each Metric	HepatitisB	Rate	(Percent)	VZV			PneumococcalConjugate			HepatitisA			Rotavirus			Influenza			Combo3			Combo7			Combo10			Metric	Race	Data Element	Reporting Instructions	Combo10	AmericanIndianOrAlaskaNative	InitialPopulation	For each Stratification		Asian	Exclusions	For each Stratification		BlackOrAfricanAmerican	Denominator	For each Stratification		MiddleEasternOrNorthAfrican	Numerator	For each Stratification		NativeHawaiianOrPacificIslander	Rate	(Percent)		White				SomeOtherRace				TwoOrMoreRaces				AskedButNoAnswer				Unknown		
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<b>Table CIS-E-C-1/2: Data Elements for Childhood Immunization Status: Stratifications by Ethnicity</b>				
Metric	Ethnicity	Data Element	Reporting Instructions	
Combo10	HispanicOrLatino	InitialPopulation	For each Stratification	
	NotHispanicOrLatino	Exclusions	For each Stratification	
	AskedButNoAnswer	Denominator	For each Stratification	
	Unknown	Numerator	For each Stratification	
		Rate	(Percent)	

<b>Rules for Allowable Adjustments</b>	<p><b>Copyright and use:</b> The “Rules for Allowable Adjustments of HEDIS” (the “Rules”) describe how NCQA’s HEDIS measure specifications can be adjusted for other populations, if applicable. The Rules, reviewed and approved by NCQA measure experts, provide for expanded use of HEDIS measures without changing their clinical intent.</p> <p><b>Adjusted HEDIS measures may not be used for HEDIS health plan reporting.</b></p> <p><b>ADJUSTMENTS ALLOWED</b></p> <ul style="list-style-type: none"> <li>• <i>Product lines.</i> Organizations are not required to use product line criteria; product lines may be combined, and all (or no) product line criteria may be used.</li> <li>• <i>Attribution.</i> Organizations are not required to use enrollment criteria.</li> <li>• <i>Benefits.</i> Organizations are not required to use a benefit.</li> <li>• <i>Other.</i> Organizations may use additional initial population criteria to focus on an area of interest defined by gender, race, ethnicity, socioeconomic or sociodemographic characteristics, geographic region or another characteristic.</li> <li>• <i>Measurement period adjustments.</i> Organizations may adjust the measurement period.</li> <li>• <i>Stratifications:</i> Race and ethnicity stratification. The race and ethnicity stratification is not required. Organizations may adjust this stratification as needed.</li> <li>• <i>Exclusions.</i> Hospice and deceased persons exclusions are not required.</li> <li>• <i>Telehealth.</i> Services/events that allow the use of synchronous telehealth visits, telephone visits and asynchronous telehealth (e-visits, virtual check-ins) may be stratified to identify services performed via telehealth. This adjustment is not allowed for events, numerators and exclusions that do not allow the use of telehealth.</li> </ul> <p><b>ADJUSTMENTS ALLOWED WITH LIMITS</b></p> <ul style="list-style-type: none"> <li>• <i>Ages.</i> Age determination dates may be changed (e.g., select, “age 2 as of June 30”). Organizations may expand the age ranges for each immunization to align with the <a href="#">CDC’s Catch-Up Immunization Schedule</a>.</li> <li>• <i>Combination rates.</i> Organizations are not required to calculate combination rates; alternate combinations of specified immunizations are allowed.</li> </ul>
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**ADJUSTMENTS NOT ALLOWED**

- *Exclusions.* The contraindication to a childhood vaccine exclusion must be applied. Value sets and logic may not be changed.
- *Numerator:* Value sets and logic may not be changed. Vaccine dose requirements may not be changed for the following indicators: DTAP, IPV, MMR, HiB, hepatitis B, VZV, pneumococcal conjugate, hepatitis A, rotavirus, influenza.

## ***Immunizations for Adolescents (IMA-E)***

Measure title	Immunizations for Adolescents*	Measure ID	IMA-E
<b>Description</b>	<p>The percentage of persons 13 years of age who had one dose of meningococcal vaccine, one tetanus, diphtheria toxoids and acellular pertussis (Tdap) vaccine, and have completed the human papillomavirus (HPV) vaccine series by their 13th birthday.</p> <p>The measure calculates a rate for each vaccine and two combination rates.</p>		
<b>Measurement period</b>	January 1–December 31.		
<b>Copyright and disclaimer notice</b>	<p><i>*Adapted with financial support from the Centers for Disease Control &amp; Prevention (CDC).</i></p> <p>Refer to the complete copyright and disclaimer information at the front of this publication.</p> <p>NCQA website: <a href="http://www.ncqa.org">www.ncqa.org</a>.</p> <p>Submit policy clarification support questions via My NCQA (<a href="https://my.ncqa.org">https://my.ncqa.org</a>).</p>		
<b>Clinical recommendation statement/ rationale</b>	<p><b>HPV:</b> The Advisory Committee on Immunization Practices (ACIP) recommends routine HPV vaccination for adolescents at age 11 or 12 years; vaccination may be given starting at age 9 years. In a two-dose schedule of HPV vaccine, the minimum interval between the first and second doses is 5 months. Persons who initiated vaccination with 9vHPV, 4vHPV or 2vHPV before their 15th birthday and received 2 doses of any HPV vaccine at the recommended dosing schedule (0, 6–12 months), or received three doses of any HPV vaccine at the recommended dosing schedule (0, 1–2, 6 months), are considered adequately vaccinated.</p> <p><b>Tdap:</b> ACIP recommends a single dose of vaccine be administered at age 11 or 12 years.</p> <p><b>Meningococcal:</b> ACIP recommends routine vaccination with a quadrivalent meningococcal conjugate vaccine (MenACWY) for adolescents aged 11 or 12 years, with a booster dose at age 16 years, or vaccination with a pentavalent vaccine for adolescents ages 10 years and older when both meningococcal B and meningococcal A, C, W and Y are indicated.</p>		
<b>Citations</b>	<p>Centers for Disease Control and Prevention (CDC). 2024. “Recommended Vaccines for Preteens and Teens.” <a href="https://www.cdc.gov/meningococcal/vaccines/preteens-teens.html">https://www.cdc.gov/meningococcal/vaccines/preteens-teens.html</a></p> <p>Liang, J.L., T. Tiwari, P. Moro, N.E. Messonnier, A. Reingold, M. Sawyer, T.A. Clark. 2018. “Prevention of Pertussis, Tetanus, and Diphtheria with Vaccines in the United States: Recommendations of the Advisory Committee on Immunization Practices (ACIP).” <i>MMWR Morb Mortal Wkly Rep</i> 67(2):1–44. doi: <a href="http://dx.doi.org/10.15585/mmwr.rr6702a1">http://dx.doi.org/10.15585/mmwr.rr6702a1</a>.</p>		

	Mbaeyi, S.A., C.H. Bozio, J. Duffy, et al. 2020. "Meningococcal Vaccination: Recommendations of the Advisory Committee on Immunization Practices, United States, 2020." MMWR Recomm Rep 69(No. RR-9):1–41. doi: <a href="http://dx.doi.org/10.15585/mmwr.rr6909a1">http://dx.doi.org/10.15585/mmwr.rr6909a1</a> . Meites, E., A. Kempe, L.E. Markowitz. 2016. "Use of a 2-Dose Schedule for Human Papillomavirus Vaccination—Updated Recommendations of the Advisory Committee on Immunization Practices." MMWR Morb Mortal Wkly Rep 65:1405–08. doi: <a href="http://dx.doi.org/10.15585/mmwr.mm6549a5">http://dx.doi.org/10.15585/mmwr.mm6549a5</a> .
<b>Characteristics</b>	
<b>Scoring</b>	Proportion.
<b>Type</b>	Process.
<b>Product lines</b>	<ul style="list-style-type: none"> <li>• Commercial.</li> <li>• Medicaid.</li> </ul>
<b>Stratifications</b>	<p>Race. (Refer to <a href="#">General Guideline: Race and Ethnicity Stratification</a>.)</p> <ul style="list-style-type: none"> <li>• American Indian or Alaska Native.</li> <li>• Asian.</li> <li>• Black or African American.</li> <li>• Middle Eastern or North African.</li> <li>• Native Hawaiian or Pacific Islander.</li> <li>• White.</li> <li>• Some Other Race.</li> <li>• Two or More Races.</li> <li>• Asked But No Answer.</li> <li>• Unknown.</li> </ul> <p>Ethnicity. (Refer to <a href="#">General Guideline: Race and Ethnicity Stratification</a>.)</p> <ul style="list-style-type: none"> <li>• Hispanic or Latino.</li> <li>• Not Hispanic or Latino.</li> <li>• Asked But No Answer.</li> <li>• Unknown.</li> </ul>
<b>Risk adjustment</b>	None.
<b>Improvement notation</b>	Increased score indicates improvement.
<b>Guidance</b>	<p><b>Data collection methodology:</b> ECDS. Refer to <a href="#">General Guideline: Data Collection Methods</a> for additional information.</p> <p><b>Date specificity:</b> Dates must be specific enough to determine the event occurred in the period being measured.</p> <p><b>Which services count?</b> When using claims, include all paid, suspended, pending and denied claims.</p>

	<p><b>Other guidance:</b> To align with ACIP recommendations:</p> <ul style="list-style-type: none"> <li>Only the quadrivalent meningococcal vaccine (serogroups A, C, W, Y) is included in the measure.</li> <li>The minimum interval for the two-dose HPV vaccination schedule is 150 days, with a 4-day grace period (146 days).</li> </ul> <p>Report rates for each vaccine and two combination rates.</p> <p><b>Combination rates:</b> Calculate the following rates for Combinations 1 and 2.</p> <table border="1"> <thead> <tr> <th>Combination</th><th>Meningococcal</th><th>Tdap</th><th>HPV</th></tr> </thead> <tbody> <tr> <td>Combination 1</td><td>✓</td><td>✓</td><td></td></tr> <tr> <td>Combination 2</td><td>✓</td><td>✓</td><td>✓</td></tr> </tbody> </table>	Combination	Meningococcal	Tdap	HPV	Combination 1	✓	✓		Combination 2	✓	✓	✓
Combination	Meningococcal	Tdap	HPV										
Combination 1	✓	✓											
Combination 2	✓	✓	✓										
<b>Initial population</b>	<p><b>Measure item count:</b> Person.</p> <p><b>Attribution basis:</b> Enrollment.</p> <ul style="list-style-type: none"> <li><b>Benefits:</b> Medical.</li> <li><b>Continuous enrollment:</b> 365 days prior to the person's 13th birthday and the 13th birthday.</li> <li><b>Allowable gap:</b> No more than one gap of ≤45 days during the measurement period. No gap on 13th birthday.</li> </ul> <p><b>Ages:</b> Persons who turn 13 years of age during the measurement period.</p> <p><b>Event:</b> None.</p>												
<b>Denominator exclusions</b>	<p><b>Persons with a date of death.</b> Death in the measurement period, identified using data sources determined by the organization. Method and data sources are subject to review during the HEDIS audit.</p> <p><b>Persons in hospice or using hospice services.</b> Persons who use hospice services (<u>Hospice Encounter Value Set</u>; <u>Hospice Intervention Value Set</u>) or elect to use a hospice benefit any time during the measurement period. Organizations that use the Monthly Membership Detail Data File to identify these persons must use only the run date of the file.</p>												
<b>Denominator</b>	The initial population minus denominator exclusions.												
<b>Numerator</b>	<p><b>Numerator 1: Immunization status— Meningococcal serogroups A, C, W, Y.</b> Persons who meet either of the following criteria:</p> <ul style="list-style-type: none"> <li>At least one meningococcal vaccine (serogroups A, C, W, Y or A, C, W, Y, B) (<u>Meningococcal Immunization Value Set</u>; <u>Meningococcal Vaccine Procedure Value Set</u>) with a date of service on or between the 10th and 13th birthdays.</li> <li>Anaphylaxis due to the meningococcal vaccine (SNOMED CT code 428301000124106) any time on or before the 13th birthday.</li> </ul>												

	<p><b>Numerator 2: Immunization status—Tdap.</b> Persons who meet any of the following criteria:</p> <ul style="list-style-type: none"> <li>• At least one tetanus, diphtheria toxoids and acellular pertussis (Tdap) vaccine (CVX code 115; CPT code 90715) with a date of service on or between the 10th and 13th birthdays.</li> <li>• Anaphylaxis due to the tetanus, diphtheria or pertussis vaccine (<a href="#">Anaphylaxis Due to Diphtheria, Tetanus or Pertussis Vaccine Value Set</a>) any time on or before the 13th birthday.</li> <li>• Encephalitis due to the tetanus, diphtheria or pertussis vaccine (<a href="#">Encephalitis Due to Diphtheria, Tetanus or Pertussis Vaccine Value Set</a>) any time on or before the 13th birthday.</li> </ul> <p><b>Numerator 3: Immunization status—HPV.</b> Persons who meet any of the following criteria:</p> <ul style="list-style-type: none"> <li>• At least two HPV vaccines (<a href="#">HPV Immunization Value Set</a>; <a href="#">HPV Vaccine Procedure Value Set</a>) on or between the 9th and 13th birthdays and with dates of service at least 146 days apart.</li> <li>• At least three HPV vaccines (<a href="#">HPV Immunization Value Set</a>; <a href="#">HPV Vaccine Procedure Value Set</a>) with different dates of service on or between the 9th and 13th birthdays.</li> <li>• Anaphylaxis due to the HPV vaccine (SNOMED CT code 428241000124101) any time on or before the 13th birthday.</li> </ul> <p><b>Numerator 4: Immunization status—Combination 1.</b> Persons who are numerator compliant for both the meningococcal and Tdap indicators.</p> <p><b>Numerator 5: Immunization status—Combination 2.</b> Persons who are numerator compliant for all three indicators (meningococcal, Tdap, HPV).</p>																		
<b>Summary of changes</b>	<ul style="list-style-type: none"> <li>• Updated citations for clinical recommendation statement and rationale.</li> <li>• Updated the race and ethnicity stratification categories to align with OMB SPD 15 2024.</li> <li>• Removed the definitions of “participation” and “participation period.”</li> <li>• Removed the SSoR data elements from the data elements tables.</li> <li>• Added instructions on allowable adjustments to the race and ethnicity stratifications.</li> </ul>																		
<b>Data element tables</b>	<p>Organizations that submit HEDIS data to NCQA must provide the following data elements.</p> <p><b>Table IMA-E-A-1/2: Data Elements for Immunizations for Adolescents</b></p> <table border="1"> <thead> <tr> <th>Metric</th> <th>Data Element</th> <th>Reporting Instructions</th> </tr> </thead> <tbody> <tr> <td>Meningococcal</td> <td>InitialPopulation</td> <td>Repeat per Metric</td> </tr> <tr> <td>Tdap</td> <td>Exclusions</td> <td>Repeat per Metric</td> </tr> <tr> <td>HPV</td> <td>Denominator</td> <td>Repeat per Metric</td> </tr> <tr> <td>Combo1</td> <td>Numerator</td> <td>For each Metric</td> </tr> <tr> <td>Combo2</td> <td>Rate</td> <td>(Percent)</td> </tr> </tbody> </table>	Metric	Data Element	Reporting Instructions	Meningococcal	InitialPopulation	Repeat per Metric	Tdap	Exclusions	Repeat per Metric	HPV	Denominator	Repeat per Metric	Combo1	Numerator	For each Metric	Combo2	Rate	(Percent)
Metric	Data Element	Reporting Instructions																	
Meningococcal	InitialPopulation	Repeat per Metric																	
Tdap	Exclusions	Repeat per Metric																	
HPV	Denominator	Repeat per Metric																	
Combo1	Numerator	For each Metric																	
Combo2	Rate	(Percent)																	

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

Metric	Race	Data Element	Reporting Instructions
Meningococcal	AmericanIndianOrAlaskaNative	InitialPopulation	For each Stratification, repeat per Metric
Tdap	Asian	Exclusions	For each Stratification, repeat per Metric
HPV	BlackOrAfricanAmerican	Denominator	For each Stratification, repeat per Metric
Combo1	MiddleEasternOrNorthAfrican	Numerator	For each Metric and Stratification
Combo2	NativeHawaiianOrPacificIslander	Rate	(Percent)
	White		
	SomeOtherRace		
	TwoOrMoreRaces		
	AskedButNoAnswer		
	Unknown		

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

Metric	Ethnicity	Data Element	Reporting Instructions
Meningococcal	HispanicOrLatino	InitialPopulation	For each Stratification, repeat per Metric
Tdap	NotHispanicOrLatino	Exclusions	For each Stratification, repeat per Metric
HPV	AskedButNoAnswer	Denominator	For each Stratification, repeat per Metric
Combo1	Unknown	Numerator	For each Metric and Stratification
Combo2		Rate	(Percent)

**Rules for Allowable Adjustments**

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

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

**ADJUSTMENTS ALLOWED**

- *Product lines.* Organizations are not required to use product line criteria; product lines may be combined, and all (or no) product line criteria may be used.
- *Attribution.* Organizations are not required to use enrollment criteria.
- *Benefits.* Organizations are not required to use a benefit.
- *Other.* Organizations may use additional initial population criteria to focus on an area of interest defined by gender, race, ethnicity, socioeconomic or sociodemographic characteristics, geographic region or another characteristic.
- *Measurement period adjustments.* Organizations may adjust the measurement period.
- *Stratifications:* Race and ethnicity stratification. The race and ethnicity stratification is not required. Organizations may adjust this stratification as needed.
- *Exclusions.* Hospice and deceased persons exclusions are not required.
- *Telehealth.* Services/events that allow the use of synchronous telehealth visits, telephone visits and asynchronous telehealth (e-visits, virtual check-ins) may be stratified to identify services performed via telehealth. This adjustment is not allowed for events, numerators and exclusions that do not allow the use of telehealth.

**ADJUSTMENTS ALLOWED WITH LIMITS**

- *Ages.* Age determination dates may be changed (e.g., select, “age 13 as of June 30”). Organizations may expand the age ranges for each immunization to align with the [CDC’s Catch-Up Immunization Schedule](#).
- *Combination rates.* Organizations are not required to calculate combination rates; alternate combinations of specified immunizations are allowed.

**ADJUSTMENTS NOT ALLOWED**

- *Numerator.* Value sets and logic may not be changed. Vaccine dose requirements may not be changed.

## ***Lead Screening in Children (LSC-E)***

<b>Measure title</b>	Lead Screening in Children	<b>Measure ID</b>	LSC-E
<b>Description</b>	The percentage of persons 2 years of age who had one or more capillary or venous lead blood test for lead poisoning by their second birthday.		
<b>Measurement period</b>	January 1–December 31.		
<b>Copyright and disclaimer notice</b>	<p>Refer to the complete copyright and disclaimer information at the front of this publication.</p> <p>NCQA website: <a href="http://www.ncqa.org">www.ncqa.org</a>.</p> <p>Submit policy clarification support questions via My NCQA (<a href="https://my.ncqa.org">https://my.ncqa.org</a>).</p>		
<b>Clinical recommendation statement/ rationale</b>	The Centers for Disease Control and Prevention recommends testing blood for lead exposure. Health care providers may use a capillary or venous sample for initial blood lead level screening.		
<b>Citations</b>	<p>Centers for Medicare &amp; Medicaid Services (CMS). (n/d) “Lead Screening.” <a href="https://www.medicaid.gov/medicaid/benefits/early-and-periodic-screening-diagnostic-and-treatment/lead-screening/index.html">https://www.medicaid.gov/medicaid/benefits/early-and-periodic-screening-diagnostic-and-treatment/lead-screening/index.html</a></p> <p>Centers for Disease Control and Prevention (CDC). (n/d) “Recommended Actions Based on Blood Lead Level.” <a href="https://www.cdc.gov/lead-prevention/hcp/clinical-guidance/?CDC_AAref_Val=https://www.cdc.gov/nceh/lead/advisory/acclpp/actions-blls.htm">https://www.cdc.gov/lead-prevention/hcp/clinical-guidance/?CDC_AAref_Val=https://www.cdc.gov/nceh/lead/advisory/acclpp/actions-blls.htm</a></p>		
<b>Characteristics</b>			
<b>Scoring</b>	Proportion.		
<b>Type</b>	Process.		
<b>Product lines</b>	Medicaid.		
<b>Stratifications</b>	None.		
<b>Risk adjustment</b>	None.		
<b>Improvement notation</b>	Increased score indicates improvement.		
<b>Guidance</b>	<p><b>Data collection methodology:</b> ECDS. Refer to <a href="#">General Guideline: Data Collection Methods</a> for additional information.</p> <p><b>Date specificity:</b> Dates must be specific enough to determine the event occurred in the period being measured.</p> <p><b>Which services count?</b> When using claims, include all paid, suspended, pending and denied claims.</p>		

<b>Initial population</b>	<p><b>Measure item count:</b> Person.</p> <p><b>Attribution basis:</b> Enrollment.</p> <ul style="list-style-type: none"> <li>• <b>Benefits:</b> Medical.</li> <li>• <b>Continuous enrollment:</b> 365 days prior to the person's second birthday and the second birthday.</li> <li>• <b>Allowable gap:</b> No more than one gap of ≤45 days during the continuous period. No gaps on the second birthday.</li> </ul> <p><b>Ages:</b> Persons who turn 2 years of age during the measurement period.</p> <p><b>Event:</b> None.</p>																		
<b>Denominator exclusions</b>	<p><b>Persons with a date of death.</b> Death in the measurement period, identified using data sources determined by the organization. Method and data sources are subject to review during the HEDIS audit.</p> <p><b>Persons in hospice or using hospice services.</b> Persons who use hospice services (<a href="#">Hospice Encounter Value Set</a>; <a href="#">Hospice Intervention Value Set</a>) or elect to use a hospice benefit any time during the measurement period. Organizations that use the Monthly Membership Detail Data File to identify these persons must use only the run date of the file.</p>																		
<b>Denominator</b>	The initial population minus denominator exclusions.																		
<b>Numerator</b>	<p><b>Lead capillary or venous blood test.</b> Persons with at least one lead capillary or venous blood test (<a href="#">Lead Tests Value Set</a>) on or before the person's second birthday.</p>																		
<b>Summary of changes</b>	<ul style="list-style-type: none"> <li>• This is the first year this measure is reported using ECDS.</li> <li>• Removed the Administrative and Hybrid Data Collection Methods.</li> </ul>																		
<b>Data element tables</b>	<p>Organizations that submit HEDIS data to NCQA must provide the following data elements.</p> <p><b>Table LSC-E-1: Data Elements for Lead Screening in Children</b></p> <table border="1" data-bbox="458 1389 1437 1670"> <thead> <tr> <th>Metric</th> <th>Data Element</th> <th>Reporting Instructions</th> </tr> </thead> <tbody> <tr> <td>LeadScreeningChildren</td> <td>InitialPopulation</td> <td>Report once</td> </tr> <tr> <td></td> <td>Exclusions</td> <td>Report once</td> </tr> <tr> <td></td> <td>Denominator</td> <td>Report once</td> </tr> <tr> <td></td> <td>Numerator</td> <td>Report once</td> </tr> <tr> <td></td> <td>Rate</td> <td>(Percent)</td> </tr> </tbody> </table>	Metric	Data Element	Reporting Instructions	LeadScreeningChildren	InitialPopulation	Report once		Exclusions	Report once		Denominator	Report once		Numerator	Report once		Rate	(Percent)
Metric	Data Element	Reporting Instructions																	
LeadScreeningChildren	InitialPopulation	Report once																	
	Exclusions	Report once																	
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	Numerator	Report once																	
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<b>Rules for Allowable Adjustments</b>	<p><b>Copyright and use:</b> The "Rules for Allowable Adjustments of HEDIS" (the "Rules") describe how NCQA's HEDIS measure specifications can be adjusted for other populations, if applicable. The Rules, reviewed and approved by NCQA measure experts, provide for expanded use of HEDIS measures without changing their clinical intent.</p>																		

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

**ADJUSTMENTS ALLOWED**

- *Product lines.* Organizations are not required to use product line criteria; product lines may be combined, and all (or no) product line criteria may be used.
- *Attribution.* Organizations are not required to use enrollment criteria.
- *Benefits.* Organizations are not required to use a benefit.
- *Ages.* The denominator age range may be expanded. The age determination dates may be changed (e.g., select, “age as of June 30”).
- *Other.* Organizations may use additional initial population criteria to focus on an area of interest defined by gender, race, ethnicity, socioeconomic or sociodemographic characteristics, geographic region or another characteristic.
- *Measurement period adjustments.* Organizations may adjust the measurement period.
- *Exclusions.* Hospice and deceased person exclusions are not required.
- *Telehealth.* Services/events that allow the use of synchronous telehealth visits, telephone visits and asynchronous telehealth (e-visits, virtual check-ins) may be stratified to identify services performed via telehealth. This adjustment is not allowed for events, numerators and exclusions that do not allow the use of telehealth.

**ADJUSTMENTS NOT ALLOWED**

- *Numerator.* The value sets and logic may not be changed.

## Breast Cancer Screening (BCS-E)

Measure title	Breast Cancer Screening	Measure ID	BCS-E
<b>Description</b>	The percentage of persons 40–74 years of age who were recommended for routine breast cancer screening and had a mammogram to screen for breast cancer.		
<b>Measurement period</b>	January 1–December 31.		
<b>Copyright and disclaimer notice</b>	<p>Refer to the complete copyright and disclaimer information at the front of this publication.</p> <p>NCQA website: <a href="http://www.ncqa.org">www.ncqa.org</a>.</p> <p>Submit policy clarification support questions via My NCQA (<a href="https://my.ncqa.org">https://my.ncqa.org</a>).</p>		
<b>Clinical recommendation statement/rationale</b>	<p>The U.S. Preventive Services Task Force (USPSTF) recommends biennial screening mammography for women aged 40–74 years. (B recommendation)</p> <p>The Fenway Institute recommends that for patients assigned female at birth who have not undergone chest reconstruction (including those who have had breast reduction), breast/chest screening recommendations are the same as for cisgender women of a similar age and medical history.</p> <p>The University of California San Francisco Center of Excellence for Transgender Health recommends that transgender men who have not undergone bilateral mastectomy, or who have only undergone breast reduction, undergo screening according to current guidelines for non-transgender women.</p> <p>The World Professional Association for Transgender Health recommends health care professionals follow local breast cancer screening guidelines developed for cisgender women in their care of transgender and gender diverse people with breasts from natal puberty who have not had gender-affirming chest surgery.</p>		
<b>Citations</b>	<p>U.S. Preventive Services Task Force. Nicholson, W.K., M. Silverstein, J.B. Wong, M.J. Barry, D. Chelmow, T. Rucker Coker, et al. June 11, 2024. “Screening for Breast Cancer: U.S. Preventive Services Task Force Recommendation Statement.” <i>JAMA</i> 331, no. 22: 1918. <a href="https://doi.org/10.1001/jama.2024.5534">https://doi.org/10.1001/jama.2024.5534</a></p> <p>Fenway Health. 2021. <i>Medical Care of Trans and Gender Diverse Adults</i>. <a href="https://fenwayhealth.org/wp-content/uploads/Medical-Care-of-Trans-and-Gender-Diverse-Adults-Spring-2021-1.pdf">https://fenwayhealth.org/wp-content/uploads/Medical-Care-of-Trans-and-Gender-Diverse-Adults-Spring-2021-1.pdf</a></p> <p>University of California San Francisco Center of Excellence for Transgender Health. 2016. <i>Guidelines for the Primary and Gender-Affirming Care of Transgender and Gender Nonbinary People</i>. <a href="https://transcare.ucsf.edu/sites/transcare.ucsf.edu/files/Transgender-PGACG-6-17-16.pdf">https://transcare.ucsf.edu/sites/transcare.ucsf.edu/files/Transgender-PGACG-6-17-16.pdf</a></p>		

	World Professional Association for Transgender Health. 2022. <i>Standards of Care for the Health of Transgender and Gender Diverse People, Version 8.</i> <a href="https://www.tandfonline.com/doi/pdf/10.1080/26895269.2022.2100644">https://www.tandfonline.com/doi/pdf/10.1080/26895269.2022.2100644</a>
<b>Characteristics</b>	
<b>Scoring</b>	Proportion.
<b>Type</b>	Process.
<b>Product lines</b>	<ul style="list-style-type: none"> <li>• Commercial.</li> <li>• Medicaid.</li> <li>• Medicare.</li> </ul>
<b>Stratifications</b>	<p>Age as of the last day of the measurement period.</p> <ul style="list-style-type: none"> <li>• 42–51 years.</li> <li>• 52–74 years.</li> </ul> <p>Race. (Refer to <a href="#">General Guideline: Race and Ethnicity Stratification</a>.)</p> <ul style="list-style-type: none"> <li>• American Indian or Alaska Native.</li> <li>• Asian.</li> <li>• Black or African American.</li> <li>• Middle Eastern or North African.</li> <li>• Native Hawaiian or Pacific Islander.</li> <li>• White.</li> <li>• Some Other Race.</li> <li>• Two or More Races.</li> <li>• Asked But No Answer.</li> <li>• Unknown.</li> </ul> <p>Ethnicity. (Refer to <a href="#">General Guideline: Race and Ethnicity Stratification</a>.)</p> <ul style="list-style-type: none"> <li>• Hispanic or Latino.</li> <li>• Not Hispanic or Latino.</li> <li>• Asked But No Answer.</li> <li>• Unknown.</li> </ul> <p>SES (Medicare only). (Refer to <a href="#">General Guideline: Medicare Socioeconomic Status Stratification</a>.)</p> <ul style="list-style-type: none"> <li>• Non-LIS/DE, Nondisability.</li> <li>• LIS/DE.</li> <li>• Disability.</li> <li>• LIS/DE and Disability.</li> <li>• Other.</li> <li>• Unknown.</li> </ul>

<b>Risk adjustment</b> <b>Improvement notation</b> <b>Guidance</b>	<p>None.</p> <p>Increased score indicates improvement.</p> <p><b>Data collection methodology:</b> ECDS. Refer to <a href="#">General Guideline: Data Collection Methods</a> for additional information.</p> <p><b>Date specificity:</b> Dates must be specific enough to determine the event occurred in the period being measured.</p> <p><b>Which services count?</b> When using claims, include all paid, suspended, pending and denied claims.</p>
<b>Initial population</b>	<p><b>Measure item count:</b> Person.</p> <p><b>Attribution basis:</b> Enrollment.</p> <ul style="list-style-type: none"> <li>• <b>Benefits:</b> Medical.</li> <li>• <b>Continuous enrollment:</b> October 1 two years prior to the measurement period through the last day of the measurement period.</li> <li>• <b>Allowable gap:</b> <ul style="list-style-type: none"> <li>– <b>Measurement period:</b> No more than one gap of ≤45 days. No gaps on the last day of the measurement period.</li> <li>– <b>Year prior to the measurement period:</b> No more than one gap of ≤45 days.</li> <li>– <b>October 1 two years prior to the measurement period through December 31 two years prior to the measurement period:</b> None.</li> </ul> </li> </ul> <p><b>Ages:</b> 42–74 years of age as of the last day of the measurement period.</p> <p><b>Gender/sex criteria (persons recommended for routine breast cancer screening):</b></p> <ul style="list-style-type: none"> <li>• Administrative Gender of Female (AdministrativeGender code female) any time in the person's history.</li> <li>• Sex assigned at birth (LOINC code 76689-9) of Female (<a href="#">Female Value Set</a>) any time in the person's history.</li> <li>• Sex Parameter for Clinical Use of Female (SexParameterForClinicalUse code female-typical) during the measurement period.</li> </ul> <p><b>Event:</b> None.</p>
<b>Denominator exclusions</b>	<p><b>Persons with a date of death.</b> Death in the measurement period, identified using data sources determined by the organization. Method and data sources are subject to review during the HEDIS audit.</p> <p><b>Persons in hospice or using hospice services.</b> Persons who use hospice services (<a href="#">Hospice Encounter Value Set</a>; <a href="#">Hospice Intervention Value Set</a>) or elect to use a hospice benefit any time during the measurement period. Organizations that use the Monthly Membership Detail Data File to identify these persons must use only the run date of the file.</p>

**Persons receiving palliative care.**

Persons receiving palliative care ([Palliative Care Assessment Value Set](#); [Palliative Care Encounter Value Set](#); [Palliative Care Intervention Value Set](#)) or who had an encounter for palliative care (ICD-10-CM code Z51.5\*) any time during the measurement period.

**Medicare enrollees, 66 years of age and older by the last day of the measurement period, in an institutional SNP (I-SNP) or living long-term in an institution (LTI).**

- Enrolled in an Institutional SNP (I-SNP) any time during the measurement period.
- Living long-term in an institution any time during the measurement period, as identified by the LTI flag in the Monthly Membership Detail Data File. Use the run date of the file to determine an LTI flag during the measurement period.

**Persons 66 years of age or older by the last day of the measurement period, with both frailty and advanced illness.**

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.
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.
  - Dispensed dementia medication ([Dementia Medications List](#)).

**Persons who had a bilateral mastectomy or both right and left unilateral mastectomies any time during their history through the last day 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).
- History of bilateral mastectomy ([History of Bilateral Mastectomy Value Set](#)).
- Any combination that indicates a mastectomy of **both the left and right** side on the same date of service or different dates of service:
  - **Left mastectomy:**
    - Unilateral mastectomy ([Unilateral Mastectomy Value Set](#)) with a left-side modifier (CPT Modifier code LT) (same procedure).
    - Unilateral mastectomy of the left breast found in clinical data ([Clinical Unilateral Mastectomy Value Set](#) with SNOMED CT code 361716006).

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

- Absence of the left breast ([Absence of Left Breast Value Set\\*](#)).
- Left unilateral mastectomy ([Unilateral Mastectomy Left Value Set](#)).

	<p><b>Right mastectomy:</b></p> <ul style="list-style-type: none"> <li>▪ Unilateral mastectomy (<a href="#">Unilateral Mastectomy Value Set</a>) <b>with</b> a right-side modifier (CPT Modifier code RT) (same procedure).</li> <li>▪ Unilateral mastectomy of the right breast found in clinical data (<a href="#">Clinical Unilateral Mastectomy Value Set</a> with SNOMED CT code 361715005).</li> <li>▪ Absence of the right breast (<a href="#">Absence of Right Breast Value Set*</a>).</li> <li>▪ Right unilateral mastectomy (<a href="#">Unilateral Mastectomy Right Value Set</a>).</li> </ul> <p><b>Gender-affirming chest surgery</b></p> <p>Persons who had gender-affirming chest surgery (CPT code 19318) with a diagnosis of gender dysphoria (<a href="#">Gender Dysphoria Value Set</a>) any time during their history through the last day of the measurement period.</p> <p><b>Coding Guidance</b></p> <p>*Do not include laboratory claims (claims with POS code 81).</p>																								
<b>Denominator</b>	The initial population minus denominator exclusions.																								
<b>Numerator</b>	<p><b>At least one mammogram.</b></p> <p>One or more mammograms (<a href="#">Mammography Value Set</a>) any time on or between October 1 two years prior to the measurement period and the last day of the measurement period.</p>																								
<b>Summary of changes</b>	<ul style="list-style-type: none"> <li>• Updated the race and ethnicity stratification categories to align with OMB SPD 15 2024.</li> <li>• Removed the definitions of “participation” and “participation period.”</li> <li>• Removed the SSoR data elements from the data element tables.</li> <li>• The combination of unilateral mastectomy with a bilateral modifier was removed.</li> <li>• Added instructions on allowable adjustments to the race and ethnicity and SES stratifications.</li> </ul>																								
<b>Data element tables</b>	<p>Organizations that submit HEDIS data to NCQA must provide the following data elements.</p> <p><b>Table BCS-E-A-1/2/3: Data Elements for Breast Cancer Screening</b></p> <table border="1"> <thead> <tr> <th>Metric</th> <th>Age</th> <th>Data Element</th> <th>Reporting Instructions</th> </tr> </thead> <tbody> <tr> <td>BreastCancerScreening</td> <td>42-51</td> <td>InitialPopulation</td> <td>For each Stratification</td> </tr> <tr> <td></td> <td>52-74</td> <td>Exclusions</td> <td>For each Stratification</td> </tr> <tr> <td></td> <td>Total</td> <td>Denominator</td> <td>For each Stratification</td> </tr> <tr> <td></td> <td></td> <td>Numerator</td> <td>For each Stratification</td> </tr> <tr> <td></td> <td></td> <td>Rate</td> <td>(Percent)</td> </tr> </tbody> </table>	Metric	Age	Data Element	Reporting Instructions	BreastCancerScreening	42-51	InitialPopulation	For each Stratification		52-74	Exclusions	For each Stratification		Total	Denominator	For each Stratification			Numerator	For each Stratification			Rate	(Percent)
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	Total	Denominator	For each Stratification																						
		Numerator	For each Stratification																						
		Rate	(Percent)																						

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

Metric	SES Stratifications	Data Element	Reporting Instructions
BreastCancerScreening	NonLisDeNondisability	InitialPopulation	For each Stratification
	LisDe	Exclusions	For each Stratification
	Disability	Denominator	For each Stratification
	LisDeAndDisability	Numerator	For each Stratification
	Other	Rate	(Percent)
	Unknown		

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

Metric	Race	Data Element	Reporting Instructions
BreastCancerScreening	AmericanIndianOrAlaskaNative	InitialPopulation	For each Stratification
	Asian	Exclusions	For each Stratification
	BlackOrAfricanAmerican	Denominator	For each Stratification
	MiddleEasternOrNorthAfrican	Numerator	For each Stratification
	NativeHawaiianOrPacificIslander	Rate	(Percent)
	White		
	SomeOtherRace		
	TwoOrMoreRaces		
	AskedButNoAnswer		
	Unknown		

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

Metric	Ethnicity	Data Element	Reporting Instructions
BreastCancerScreening	HispanicOrLatino	InitialPopulation	For each Stratification
	NotHispanicOrLatino	Exclusions	For each Stratification
	AskedButNoAnswer	Denominator	For each Stratification
	Unknown	Numerator	For each Stratification
		Rate	(Percent)

<b>Rules for Allowable Adjustments</b>	<p><b>Copyright and use:</b> The “Rules for Allowable Adjustments of HEDIS” (the “Rules”) describe how NCQA’s HEDIS measure specifications can be adjusted for other populations, if applicable. The Rules, reviewed and approved by NCQA measure experts, provide for expanded use of HEDIS measures without changing their clinical intent.</p> <p><b>Adjusted HEDIS measures may not be used for HEDIS health plan reporting.</b></p> <p><b>ADJUSTMENTS ALLOWED</b></p> <ul style="list-style-type: none"><li>• <i>Product lines.</i> Organizations are not required to use product line criteria; product lines may be combined, and all (or no) product line criteria may be used.</li><li>• <i>Attribution.</i> Organizations are not required to use enrollment criteria.</li><li>• <i>Benefits.</i> Organizations are not required to use a benefit.</li><li>• <i>Other.</i> Organizations may use additional initial population criteria to focus on an area of interest defined by gender, race, ethnicity, socioeconomic or sociodemographic characteristics, geographic region or another characteristic.</li><li>• <i>Measurement period adjustments.</i> Organizations may adjust the measurement period.</li><li>• <i>Stratifications:</i> Race and ethnicity stratification. The race and ethnicity stratification is not required. Organizations may adjust this stratification as needed.</li><li>• <i>Exclusions.</i> Hospice, deceased persons, palliative care, I-SNP, LTI, frailty or advanced illness exclusions are not required.</li><li>• <i>Telehealth.</i> Services/events that allow the use of synchronous telehealth visits, telephone visits and asynchronous telehealth (e-visits, virtual check-ins) may be stratified to identify services performed via telehealth. This adjustment is not allowed for events, numerators and exclusions that do not allow the use of telehealth.</li></ul> <p><b>ADJUSTMENTS ALLOWED WITH LIMITS</b></p> <ul style="list-style-type: none"><li>• <i>Ages.</i> Age determination dates may be changed (e.g., select, “age as of June 30”).</li><li>• <i>Stratifications:</i> SES stratification. SES stratification is not required, but if it is applied, no adjustments may be made.</li></ul> <p><b>ADJUSTMENTS NOT ALLOWED</b></p> <ul style="list-style-type: none"><li>• <i>Exclusions.</i> The mastectomy exclusions must be applied. Value sets and logic may not be changed.</li><li>• <i>Numerator.</i> Value sets and logic may not be changed.</li></ul>
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## Documented Assessment After Mammogram (DBM-E)

Measure title	Documented Assessment After Mammogram*	Measure ID	DBM-E
<b>Description</b>	The percentage of episodes of mammograms documented in the form of a BI-RADS assessment within 14 days of the mammogram for persons 40–74 years of age.		
<b>Measurement period</b>	January 1–December 31.		
<b>Copyright and disclaimer notice</b>	<p><i>*This measure was supported by Cooperative Award NU380T000303 from the Centers for Disease Control and Prevention and the National Network of Public Health Institutes (NNPHI). Its contents are the sole responsibility of the authors (NCQA) and do not necessarily represent the official position of the Centers for Disease Control and Prevention, the US Department of Health and Human Services, the US government, or the NNPHI.</i></p> <p>Refer to the complete copyright and disclaimer information at the front of this publication.</p> <p>NCQA website: <a href="http://www.ncqa.org">www.ncqa.org</a>.</p> <p>Submit policy clarification support questions via My NCQA (<a href="https://my.ncqa.org">https://my.ncqa.org</a>).</p>		
<b>Clinical recommendation statement/ rationale</b>	<p>The National Comprehensive Cancer Network (NCCN) recommends breast cancer screening follow-up actions in alignment with the Breast Imaging Reporting and Data System (BI-RADS) scoring categories. The BI-RADS categorization offers specific recommendations for different findings.</p> <ul style="list-style-type: none"> <li>• Category 0: Incomplete—Need Additional Imaging Evaluation and/or Prior Mammograms for Comparison, advises additional imaging.</li> <li>• Category 1: Negative or Category 2: Benign advises resuming routine screening.</li> <li>• Category 3: Probably Benign, recommends diagnostic mammograms at 6 months, followed by repeat screenings every 6–12 months for 1–2 years, if appropriate.</li> <li>• Category 4: Suspicious and Category 5: Highly Suggestive of Malignancy, the recommendation is for tissue diagnosis using core needle biopsy (preferred) or needle localization excisional biopsy with specimen radiograph. When a needle biopsy (aspiration or core needle biopsy) is performed, obtaining concordance between the pathology report and the imaging finding is crucial.</li> <li>• For Category 6: Known Biopsy-Proven Malignancy, the recommendation depends on the primary tumor, size of the invasive component, estimated disease volume, histological grade and other relevant characteristics.</li> </ul> <p>All recommendations are Category 2A recommendations. Based on lower-level evidence, there is uniform NCCN consensus that the intervention is appropriate.</p>		

<b>Citations</b>	Sickles, E.A., C.J. D'Orsi, L.W. Bassett, C.M. Appleton, W.A. Berg, and E.S. Burnside. "ACR Bi-Rads® Mammography." ACR BI-RADS® Atlas, Breast Imaging Reporting and Data System 5 (2013): 2013.  Gradishar, W.J., M.S. Moran, J. Abraham, et al. 2022. "Breast Cancer, Version 3.2022, NCCN Clinical Practice Guidelines in Oncology." <i>J Natl Compr Canc Netw</i> 20(6):691–722. doi:10.6004/jnccn.2022.0030.
<b>Characteristics</b>	
<b>Scoring</b>	Proportion.
<b>Type</b>	Process.
<b>Product lines</b>	<ul style="list-style-type: none"> <li>• Commercial.</li> <li>• Medicaid.</li> <li>• Medicare.</li> </ul>
<b>Stratifications</b>	None.
<b>Risk adjustment</b>	None.
<b>Improvement notation</b>	Increased score indicates improvement.
<b>Guidance</b>	<p><b>Data collection methodology:</b> ECDS. Refer to <a href="#">General Guideline: Data Collection Methods</a> for additional information.</p> <p><b>Date specificity:</b> Dates must be specific enough to determine the event occurred in the period being measured.</p> <p><b>What services count?</b> When using claims, include all paid, suspended, pending and denied claims.</p> <p><b>Other guidance:</b> The measure is based on episodes; therefore, it is possible for the denominator to include multiple events for the same person.</p>
<b>Definitions</b>	
<b>BI-RADS assessment</b>	Clinically documented BI-RADS score. BI-RADS is a standardized classification system proposed by the American College of Radiology, used for imaging of mammography, ultrasound and MRI of the breast.
<b>Episode date</b>	The date of service for an eligible encounter during the intake period with a mammogram procedure.
<b>Intake period</b>	December 18 of the prior measurement period to December 17 of the measurement period. The intake period is used to capture the episode date.
<b>Initial population</b>	<p><b>Measure item count:</b> Episode.</p> <p><b>Attribution basis:</b> Enrollment.</p> <ul style="list-style-type: none"> <li>• <b>Benefits:</b> Medical.</li> <li>• <b>Continuous enrollment:</b> Date of episode through 14 days after episode.</li> <li>• <b>Allowable gap:</b> None.</li> </ul>

	<p><b>Ages:</b> 40–74 years of age as of the episode date.</p> <p><b>Event: Mammogram.</b></p> <p>Episodes of mammograms (<u>Mammography Value Set</u>) during the intake period.</p>																		
<b>Denominator exclusions</b>	<p><b>Persons with a date of death.</b> Death in the measurement period, identified using data sources determined by the organization. Method and data sources are subject to review during the HEDIS audit.</p> <p><b>Persons in hospice or using hospice services.</b> Persons who use hospice services (<u>Hospice Encounter Value Set</u>; <u>Hospice Intervention Value Set</u>) or elect to use a hospice benefit any time during the measurement period. Organizations that use the Monthly Membership Detail Data File to identify these persons must use only the run date of the file.</p>																		
<b>Denominator</b>	The initial population minus denominator exclusions.																		
<b>Numerator</b>	<p><b>BI-RADS score.</b> Episodes of mammograms that receive a BI-RADS score (<u>BIRADS Assessment Value Set</u>) on or within 14 days after the episode date (15 total days).</p>																		
<b>Summary of changes</b>	<ul style="list-style-type: none"> <li>Removed the definitions of “participation” and “participation period.”</li> <li>Removed the SSoR data elements from the data elements tables.</li> </ul>																		
<b>Data element tables</b>	<p>Organizations that submit HEDIS data to NCQA must provide the following data elements.</p> <p><b>Table DBM-E-A-1/2/3: Data Elements for Documented Assessment After Mammogram</b></p> <table border="1"> <thead> <tr> <th>Metric</th> <th>Data Element</th> <th>Reporting Instructions</th> </tr> </thead> <tbody> <tr> <td>DocumentedMammogramAssessment</td> <td>InitialPopulation</td> <td>Report once</td> </tr> <tr> <td></td> <td>Exclusions</td> <td>Report once</td> </tr> <tr> <td></td> <td>Denominator</td> <td>Report once</td> </tr> <tr> <td></td> <td>Numerator</td> <td>Report once</td> </tr> <tr> <td></td> <td>Rate</td> <td>(Percent)</td> </tr> </tbody> </table>	Metric	Data Element	Reporting Instructions	DocumentedMammogramAssessment	InitialPopulation	Report once		Exclusions	Report once		Denominator	Report once		Numerator	Report once		Rate	(Percent)
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	Rate	(Percent)																	
<b>Rules for Allowable Adjustments</b>	<p><b>Copyright and use:</b> The “Rules for Allowable Adjustments of HEDIS” (the “Rules”) describe how NCQA’s HEDIS measure specifications can be adjusted for other populations, if applicable. The Rules, reviewed and approved by NCQA measure experts, provide for expanded use of HEDIS measures without changing their clinical intent.</p> <p><b>Adjusted HEDIS measures may not be used for HEDIS health plan reporting.</b></p> <p><b>ADJUSTMENTS ALLOWED</b></p> <ul style="list-style-type: none"> <li><b>Product lines.</b> Organizations are not required to use product line criteria; product lines may be combined, and all (or no) product line criteria may be used.</li> </ul>																		

- *Ages.* The denominator age may be expanded. Age determination dates may be changed (e.g., select, “age as of June 30”).
- *Attribution.* Organizations are not required to use enrollment criteria.
- *Benefits.* Organizations are not required to use a benefit.
- *Other.* Organizations may use additional initial population criteria to focus on an area of interest defined by gender, race, ethnicity, socioeconomic or sociodemographic characteristics, geographic region or another characteristic.
- *Measurement period adjustments.* Organizations may adjust the measurement period.
- *Exclusions.* Hospice and deceased persons exclusions are not required.
- *Telehealth.* Services/events that allow the use of synchronous telehealth visits, telephone visits and asynchronous telehealth (e-visits, virtual check-ins) may be stratified to identify services performed via telehealth. This adjustment is not allowed for events, numerators and exclusions that do not allow the use of telehealth.

**ADJUSTMENTS NOT ALLOWED**

- *Initial population:* Event. Value sets and logic may not be changed.
- *Numerator.* Value sets and logic may not be changed.

## Follow-Up After Abnormal Mammogram Assessment (FMA-E)

<b>Measure title</b>	Follow-Up After Abnormal Mammogram Assessment*	<b>Measure ID</b>	FMA-E
<b>Description</b>	The percentage of episodes for persons 40–74 years of age with inconclusive or high-risk BI-RADS assessments that received appropriate follow-up within 90 days of the assessment.		
<b>Measurement period</b>	January 1–December 31.		
<b>Copyright and disclaimer notice</b>	<p><i>*This measure was supported by Cooperative Award NU380T000303 from the Centers for Disease Control and Prevention and the National Network of Public Health Institutes (NNPHI). Its contents are the sole responsibility of the authors (NCQA) and do not necessarily represent the official position of the Centers for Disease Control and Prevention, the US Department of Health and Human Services, the US government, or the NNPHI.</i></p> <p>Refer to the complete copyright and disclaimer information at the front of this publication.</p> <p>NCQA website: <a href="http://www.ncqa.org">www.ncqa.org</a>.</p> <p>Submit policy clarification support questions via My NCQA (<a href="https://my.ncqa.org">https://my.ncqa.org</a>).</p>		
<b>Clinical recommendation statement/rationale</b>	<p>The National Comprehensive Cancer Network (NCCN) recommends breast cancer screening follow-up, in alignment with the Breast Imaging Reporting and Data System (BI-RADS) scoring categories, which offer recommendations for different findings:</p> <ul style="list-style-type: none"> <li>• Category 0: Incomplete—Need Additional Imaging Evaluation and/or Prior Mammograms for Comparison, advises additional imaging.</li> <li>• Category 1: Negative Finding or Category 2: Benign, advises resuming routine screening.</li> <li>• Category 3: Probably Benign, the recommendation is for diagnostic mammograms at 6 months, followed by repeat screenings every 6–12 months for 1–2 years, if appropriate.</li> <li>• Category 4: Suspicious and Category 5: Highly Suggestive of Malignancy, the recommendation is for tissue diagnosis using core needle biopsy (preferred) or needle localization excisional biopsy with specimen radiograph. When a needle biopsy (aspiration or core needle biopsy) is performed, obtaining concordance between the pathology report and the imaging finding is crucial.</li> <li>• For Category 6: Known Biopsy-Proven Malignancy, the recommendation depends on the primary tumor, size of the invasive component, estimated disease volume, histological grade and other relevant characteristics.</li> </ul>		

	All recommendations are Category 2A recommendations—based on lower-level evidence, there is uniform NCCN consensus that the intervention is appropriate.
<b>Citations</b>	Sickles, E.A., C.J. D'Orsi, L.W. Bassett, C.M. Appleton, W.A. Berg, and E.S. Burnside. "ACR BI-RADS® Mammography." 2013. ACR BI-RADS® Atlas, Breast Imaging Reporting and Data System 5. Gradishar, W.J., M.S. Moran, J. Abraham, et al. 2022. "Breast Cancer, Version 3. NCCN Clinical Practice Guidelines in Oncology." <i>J Natl Compr Canc Netw</i> 20(6):691–722. doi:10.6004/jnccn.2022.0030.
<b>Characteristics</b>	
<b>Scoring</b>	Proportion.
<b>Type</b>	Process.
<b>Product lines</b>	<ul style="list-style-type: none"> <li>• Commercial.</li> <li>• Medicaid.</li> <li>• Medicare.</li> </ul>
<b>Stratifications</b>	None.
<b>Risk adjustment</b>	None.
<b>Improvement notation</b>	Increased score indicates improvement.
<b>Guidance</b>	<p><b>Data collection methodology:</b> ECDS. Refer to <a href="#">General Guideline: Data Collection Methods</a> for additional information.</p> <p><b>Date specificity:</b> Dates must be specific enough to determine the event occurred in the period being measured.</p> <p><b>Which services count?</b> When using claims, include all paid, suspended, pending and denied claims.</p> <p><b>Other guidance:</b> The measure is based on episodes; therefore, it is possible for the denominator to include multiple events for the same person.</p>
<b>Definitions</b>	
<b>BI-RADS assessment</b>	Clinically documented BI-RADS score. BI-RADS is a standardized classification system proposed by the American College of Radiology, used for the imaging of mammography, ultrasound and MRI of the breast.
<b>Episode date</b>	The dates of service during the intake period when a high-risk or inconclusive BI-RADS score was documented.
<b>Intake period</b>	October 3 of the year prior to the measurement period to October 2 of the measurement period. The intake period is used to capture the episode date.

<b>Initial population</b>	<p><b>Measure item count:</b> Episode.</p> <p><b>Attribution basis:</b> Enrollment.</p> <ul style="list-style-type: none"> <li>• <b>Benefits:</b> Medical.</li> <li>• <b>Continuous enrollment:</b> Date of episode through 90 days after episode.</li> <li>• <b>Allowable gap:</b> None.</li> </ul> <p><b>Ages:</b> 40-74 years of age as of the episode date.</p> <p><b>Event: Episodes of high-risk or inconclusive BI-RADS assessment.</b> Episodes with a high-risk (<a href="#">High Risk BIRADS Value Set</a>) or inconclusive (<a href="#">Inconclusive BIRADS Value Set</a>) BI-RADS assessment during the intake period.</p>
<b>Denominator exclusions</b>	<p><b>Persons with a date of death.</b> Death in the measurement period, identified using data sources determined by the organization. Method and data sources are subject to review during the HEDIS audit.</p> <p><b>Persons in hospice or using hospice services.</b> Persons who use hospice services (<a href="#">Hospice Encounter Value Set</a>; <a href="#">Hospice Intervention Value Set</a>) or elect to use a hospice benefit any time during the measurement period. Organizations that use the Monthly Membership Detail Data File to identify these persons must use only the run date of the file.</p>
<b>Denominator</b>	The initial population minus denominator exclusions.
<b>Numerator</b>	<p><b>Appropriate follow-up for high-risk or inconclusive BI-RADS assessment.</b> High-risk and inconclusive BI-RADS assessment during the intake period that received appropriate follow-up. Appropriate follow-up is defined as either of the following:</p> <ul style="list-style-type: none"> <li>• A high-risk BI-RADS assessment (<a href="#">High Risk BIRADS Value Set</a>) result (Category 4: Suspicious—Category 5: Highly Suggestive of Malignancy), that received a breast biopsy (<a href="#">Breast Biopsy Value Set</a>) on or within 90 days after the episode date (91 days total).</li> <li>• An inconclusive BI-RADS assessment (BI-RADS 0: Incomplete—Need Additional Imaging Evaluation and/or Prior Mammograms for Comparison), (<a href="#">Inconclusive BIRADS Value Set</a>) that received a mammogram (<a href="#">Mammography Value Set</a>) or ultrasound (<a href="#">Breast Ultrasound Value Set</a>) on or within 90 days after the episode date (91 days total).</li> </ul>
<b>Summary of changes</b>	<ul style="list-style-type: none"> <li>• Removed the definitions of “participation” and “participation period.”</li> <li>• Removed the SSoR data elements from the data elements tables.</li> </ul>

<b>Data element tables</b>	<p>Organizations that submit HEDIS data to NCQA must provide the following data elements.</p> <p><b>Table FMA-E-A-1/2/3: Data Elements for Follow-Up after Abnormal Mammogram Assessment</b></p> <table border="1" data-bbox="491 361 1470 635"> <thead> <tr> <th>Metric</th><th>Data Element</th><th>Reporting Instructions</th></tr> </thead> <tbody> <tr> <td rowspan="5">FollowUpMammogramAssessment</td><td>InitialPopulation</td><td>Report once</td></tr> <tr> <td>Exclusions</td><td>Report once</td></tr> <tr> <td>Denominator</td><td>Report once</td></tr> <tr> <td>Numerator</td><td>Report once</td></tr> <tr> <td>Rate</td><td>(Percent)</td></tr> </tbody> </table>	Metric	Data Element	Reporting Instructions	FollowUpMammogramAssessment	InitialPopulation	Report once	Exclusions	Report once	Denominator	Report once	Numerator	Report once	Rate	(Percent)
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<b>Rules for Allowable Adjustments</b>	<p><b>Copyright and use:</b> The “Rules for Allowable Adjustments of HEDIS” (the “Rules”) describe how NCQA’s HEDIS measure specifications can be adjusted for other populations, if applicable. The Rules, reviewed and approved by NCQA measure experts, provide for expanded use of HEDIS measures without changing their clinical intent.</p> <p><b>Adjusted HEDIS measures may not be used for HEDIS health plan reporting.</b></p> <p><b>ADJUSTMENTS ALLOWED</b></p> <ul style="list-style-type: none"> <li>• <i>Product lines.</i> Organizations are not required to use product line criteria; product lines may be combined, and all (or no) product line criteria may be used.</li> <li>• <i>Ages.</i> The denominator age may be expanded. Age determination dates may be changed (e.g., select, “age as of June 30”).</li> <li>• <i>Attribution.</i> Organizations are not required to use enrollment criteria.</li> <li>• <i>Benefits.</i> Organizations are not required to use a benefit.</li> <li>• <i>Other.</i> Organizations may use additional initial population criteria to focus on an area of interest defined by gender, race, ethnicity, socioeconomic or sociodemographic characteristics, geographic region or another characteristic.</li> <li>• <i>Measurement period adjustments.</i> Organizations may adjust the measurement period.</li> <li>• <i>Exclusions.</i> Hospice and deceased persons exclusions are not required.</li> <li>• <i>Telehealth.</i> Services/events that allow the use of synchronous telehealth visits, telephone visits and asynchronous telehealth (e-visits, virtual check-ins) may be stratified to identify services performed via telehealth. This adjustment is not allowed for events, numerators and exclusions that do not allow the use of telehealth.</li> </ul> <p><b>ADJUSTMENTS NOT ALLOWED</b></p> <ul style="list-style-type: none"> <li>• <i>Initial population:</i> Event. Value sets and logic may not be changed.</li> <li>• <i>Numerator.</i> Value sets and logic may not be changed.</li> </ul>														

## Cervical Cancer Screening (CCS-E)

Measure title	Cervical Cancer Screening	Measure ID	CCS-E
<b>Description</b>	<p>The percentage of persons 21–64 years of age who were recommended for routine cervical cancer screening and were screened for cervical cancer using any of the following criteria:</p> <ul style="list-style-type: none"> <li>• Persons 21–64 years of age who were recommended for routine cervical cancer screening and had cervical cytology performed within the last 3 years.</li> <li>• Persons 30–64 years of age who were recommended for routine cervical cancer screening and had cervical high-risk human papillomavirus (hrHPV) testing performed within the last 5 years.</li> <li>• Persons 30–64 years of age who were recommended for routine cervical cancer screening and had cervical cytology/high-risk human papillomavirus (hrHPV) cotesting within the last 5 years.</li> </ul>		
<b>Measurement period</b>	January 1–December 31.		
<b>Copyright and disclaimer notice</b>	<p>Refer to the complete copyright and disclaimer information at the front of this publication.  NCQA website: <a href="http://www.ncqa.org">www.ncqa.org</a>.  Submit policy clarification support questions via My NCQA (<a href="https://my.ncqa.org">https://my.ncqa.org</a>).</p>		
<b>Clinical recommendation statement/ rationale</b>	<p>The U.S. Preventive Services Task Force (USPSTF) recommends screening for cervical cancer every 3 years with cervical cytology alone in women aged 21–29 years. This recommendation statement applies to all asymptomatic individuals with a cervix. (A recommendation)</p> <p>The USPSTF recommends screening every 3 years with cervical cytology alone, every 5 years with hrHPV testing alone or every 5 years with hrHPV testing in combination with cytology (cotesting) in women aged 30–65 years. This recommendation statement applies to all asymptomatic individuals with a cervix. (A recommendation)</p> <p>The USPSTF recommends against screening for cervical cancer in women younger than 21 years. This recommendation statement applies to all asymptomatic individuals with a cervix. (D recommendation)</p> <p>The USPSTF recommends against screening for cervical cancer in women older than 65 years who have had adequate prior screening and are not otherwise at high risk for cervical cancer. This recommendation statement applies to all asymptomatic individuals with a cervix. (D recommendation).</p> <p>The USPSTF recommends against screening for cervical cancer in women who have had a hysterectomy with removal of the cervix, and do not have a history of a high-grade precancerous lesion or cervical cancer. (D recommendation)</p>		

	<p>The American Cancer Society recommends that individuals with a cervix initiate cervical cancer screening at age 25 years, and undergo primary HPV testing every 5 years through age 65 years (preferred). If primary HPV testing is not available, individuals aged 25–65 years should be screened with cotesting (HPV testing in combination with cytology) every 5 years, or cytology alone every 3 years (acceptable). The recommendations apply to all asymptomatic individuals with a cervix, regardless of their sexual history or HPV vaccination status, including those who have undergone supracervical hysterectomy and transgender men who retain their cervix. (Strong Recommendation)</p> <p>The Fenway Institute recommends that transgender and gender diverse patients who have a cervix have regular cervical pap tests, as per the published guidelines for cisgender women.</p> <p>The University of California San Francisco Center of Excellence for Transgender Health recommends that cervical cancer screening for transgender men, including intervals of screening and age to begin and end screening, follows recommendations for non-transgender women as endorsed by the American Cancer Society, the American Society of Colposcopy and Cervical Pathology, the American Society of Clinical Pathologists, the U.S. Preventive Services Task Force and the World Health Organization.</p> <p>The World Professional Association for Transgender Health recommends that health care professionals offer cervical cancer screening to transgender and gender diverse people who currently have or previously had a cervix, following local guidelines for cisgender women.</p>
<b>Citations</b>	<p>American Cancer Society. 2020. <i>Cervical Cancer Screening for Individuals at Average Risk: 2020 Guideline Update From the American Cancer Society</i>. <a href="https://acsjournals.onlinelibrary.wiley.com/doi/full/10.3322/caac.21628">https://acsjournals.onlinelibrary.wiley.com/doi/full/10.3322/caac.21628</a></p> <p>Fenway Health. 2021. <i>Medical Care of Trans and Gender Diverse Adults</i>. <a href="https://fenwayhealth.org/wp-content/uploads/Medical-Care-of-Trans-and-Gender-Diverse-Adults-Spring-2021-1.pdf">https://fenwayhealth.org/wp-content/uploads/Medical-Care-of-Trans-and-Gender-Diverse-Adults-Spring-2021-1.pdf</a></p> <p>University of California San Francisco Center of Excellence for Transgender Health. 2016. <i>Guidelines for the Primary and Gender-Affirming Care of Transgender and Gender Nonbinary People</i>. <a href="https://transcare.ucsf.edu/sites/transcare.ucsf.edu/files/Transgender-PGACG-6-17-16.pdf">https://transcare.ucsf.edu/sites/transcare.ucsf.edu/files/Transgender-PGACG-6-17-16.pdf</a></p> <p>U.S. Preventive Services Task Force. 2018. “Screening for Cervical Cancer: U.S. Preventive Services Task Force Recommendation Statement.” <i>JAMA</i> 320(7): 674–86.</p> <p>World Professional Association for Transgender Health. 2022. <i>Standards of Care for the Health of Transgender and Gender Diverse People, Version 8</i>. <a href="https://www.tandfonline.com/doi/pdf/10.1080/26895269.2022.2100644">https://www.tandfonline.com/doi/pdf/10.1080/26895269.2022.2100644</a></p>
<b>Characteristics</b>	
<b>Scoring</b>	Proportion.
<b>Type</b>	Process.

<b>Product lines</b>	<ul style="list-style-type: none"> <li>Commercial.</li> <li>Medicaid.</li> </ul>
<b>Stratifications</b>	<p>Race. (Refer to <a href="#">General Guideline: Race and Ethnicity Stratification</a>.)</p> <ul style="list-style-type: none"> <li>American Indian or Alaska Native.</li> <li>Asian.</li> <li>Black or African American.</li> <li>Middle Eastern or North African.</li> <li>Native Hawaiian or Pacific Islander.</li> <li>White.</li> <li>Some Other Race.</li> <li>Two or More Races.</li> <li>Asked But No Answer.</li> <li>Unknown.</li> </ul> <p>Ethnicity. (Refer to <a href="#">General Guideline: Race and Ethnicity Stratification</a>.)</p> <ul style="list-style-type: none"> <li>Hispanic or Latino.</li> <li>Not Hispanic or Latino.</li> <li>Asked But No Answer.</li> <li>Unknown.</li> </ul>
<b>Risk adjustment</b>	None.
<b>Improvement notation</b>	Increased score indicates improvement.
<b>Guidance</b>	<p><b>Data collection methodology:</b> ECDS. Refer to <a href="#">General Guideline: Data Collection Methods</a> for additional information.</p> <p><b>Date specificity:</b> Dates must be specific enough to determine the event occurred in the period being measured.</p> <p><b>What services count?</b> When using claims, include all paid, suspended, pending and denied claims.</p>
<b>Initial population</b>	<p><i>Measure item count:</i> Person.</p> <p><i>Attribution basis:</i> Enrollment.</p> <ul style="list-style-type: none"> <li><i>Benefits:</i> Medical.</li> <li><i>Continuous enrollment:</i> <ul style="list-style-type: none"> <li><i>Commercial:</i> The measurement period and the 730 days prior to the measurement period.</li> <li><i>Medicaid:</i> The measurement period.</li> </ul> </li> <li><i>Allowable gap:</i> No more than one gap of ≤45 days each year of continuous enrollment. No gaps on the last day of the measurement period.</li> </ul> <p><i>Ages:</i> 24–64 years of age as of the last day of the measurement period.</p>

	<p><i>Gender/sex criteria (persons recommended for routine cervical cancer screening):</i></p> <ul style="list-style-type: none"> <li>• Administrative Gender of Female (AdministrativeGender code female) any time in the person's history.</li> <li>• Sex Assigned at Birth (LOINC code 76689-9) of Female (<u>Female Value Set</u>) any time in the person's history.</li> <li>• Sex Parameter for Clinical Use of Female (SexParameterForClinicalUse code female-typical) during the measurement period.</li> </ul> <p><i>Event:</i> None.</p>
<b>Denominator exclusions</b>	<p><b>Persons with a date of death.</b> Death in the measurement period, identified using data sources determined by the organization. Method and data sources are subject to review during the HEDIS audit.</p> <p><b>Persons in hospice or using hospice services.</b> Persons who use hospice services (<u>Hospice Encounter Value Set</u>; <u>Hospice Intervention Value Set</u>) or elect to use a hospice benefit any time during the measurement period. Organizations that use the Monthly Membership Detail Data File to identify these persons must use only the run date of the file.</p> <p><b>Persons receiving palliative care.</b> Persons receiving palliative care (<u>Palliative Care Assessment Value Set</u>; <u>Palliative Care Encounter Value Set</u>; <u>Palliative Care Intervention Value Set</u>) or who had an encounter for palliative care (ICD-10-CM code Z51.5*) any time during the measurement period.</p> <p><b>Persons with a hysterectomy with no residual cervix, cervical agenesis, or acquired absence of cervix.</b> Hysterectomy with no residual cervix (<u>Hysterectomy With No Residual Cervix Value Set</u>) or cervical agenesis or acquired absence of cervix (<u>Absence of Cervix Diagnosis Value Set*</u>) any time during the person's history through the last day of the measurement period.</p> <p><b>Persons with sex assigned at birth of male.</b> Sex Assigned at Birth (LOINC code 76689-9) of Male (<u>Male Value Set</u>) any time during the person's history through the last day of the measurement period.</p> <p><b>Coding Guidance</b> *Do not include laboratory claims (claims with POS code 81).</p>
<b>Denominator</b>	The initial population minus denominator exclusions.
<b>Numerator</b>	<p><b>Persons recommended for routine cervical cancer screening who were screened for cervical cancer.</b> Either of the following meets criteria:</p> <ul style="list-style-type: none"> <li>• Persons 24–64 years of age by the last day of the measurement period who were recommended for routine cervical cancer screening and had cervical cytology (<u>Cervical Cytology Lab Test Value Set</u>; <u>Cervical Cytology Result or Finding Value Set</u>) during the measurement period or the 2 years prior to the measurement period.</li> </ul>

	<ul style="list-style-type: none"> <li>Persons 30–64 years of age by the last day of the measurement period who were recommended for routine cervical cancer screening and had cervical high-risk human papillomavirus (hrHPV) testing (<a href="#">High Risk HPV Lab Test Value Set</a>; SNOMED CT code 718591004) during the measurement period or the 4 years prior to the measurement period, and who were 30 years of age or older on the test date.</li> </ul> <p><i>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.</i></p>																																																														
<b>Summary of changes</b>	<ul style="list-style-type: none"> <li>Updated the race and ethnicity stratification categories to align with OMB SPD 15 2024.</li> <li>Removed the definitions of “participation” and “participation period.”</li> <li>Removed the SSoR data elements from the data element tables.</li> <li>Added instructions on allowable adjustments to the race and ethnicity stratifications.</li> </ul>																																																														
<b>Data element tables</b>	<p>Organizations that submit HEDIS data to NCQA must provide the following data elements.</p> <p><b>Table CCS-E-A-1/2: Metadata Elements for Cervical Cancer Screening</b></p> <table border="1"> <thead> <tr> <th>Metric</th><th>Data Element</th><th>Reporting Instructions</th></tr> </thead> <tbody> <tr> <td>CervicalCancerScreening</td><td>InitialPopulation</td><td>Report once</td></tr> <tr> <td></td><td>Exclusions</td><td>Report once</td></tr> <tr> <td></td><td>Denominator</td><td>Report once</td></tr> <tr> <td></td><td>Numerator</td><td>Report once</td></tr> <tr> <td></td><td>Rate</td><td>(Percent)</td></tr> </tbody> </table> <p><b>Table CCS-E-B-1/2: Data Elements for Cervical Cancer Screening: Stratifications by Race</b></p> <table border="1"> <thead> <tr> <th>Metric</th><th>Race</th><th>Data Element</th><th>Reporting Instructions</th></tr> </thead> <tbody> <tr> <td>CervicalCancerScreening</td><td>AmericanIndianOrAlaskaNative</td><td>InitialPopulation</td><td>For each Stratification</td></tr> <tr> <td></td><td>Asian</td><td>Exclusions</td><td>For each Stratification</td></tr> <tr> <td></td><td>BlackOrAfricanAmerican</td><td>Denominator</td><td>For each Stratification</td></tr> <tr> <td></td><td>MiddleEasternOrNorthAfrican</td><td>Numerator</td><td>For each Stratification</td></tr> <tr> <td></td><td>NativeHawaiianOrPacificIslander</td><td>Rate</td><td>(Percent)</td></tr> <tr> <td></td><td>White</td><td></td><td></td></tr> <tr> <td></td><td>SomeOtherRace</td><td></td><td></td></tr> <tr> <td></td><td>TwoOrMoreRaces</td><td></td><td></td></tr> <tr> <td></td><td>AskedButNoAnswer</td><td></td><td></td></tr> <tr> <td></td><td>Unknown</td><td></td><td></td></tr> </tbody> </table>	Metric	Data Element	Reporting Instructions	CervicalCancerScreening	InitialPopulation	Report once		Exclusions	Report once		Denominator	Report once		Numerator	Report once		Rate	(Percent)	Metric	Race	Data Element	Reporting Instructions	CervicalCancerScreening	AmericanIndianOrAlaskaNative	InitialPopulation	For each Stratification		Asian	Exclusions	For each Stratification		BlackOrAfricanAmerican	Denominator	For each Stratification		MiddleEasternOrNorthAfrican	Numerator	For each Stratification		NativeHawaiianOrPacificIslander	Rate	(Percent)		White				SomeOtherRace				TwoOrMoreRaces				AskedButNoAnswer				Unknown		
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<b>Table CCS-E-C-1/2: Data Elements for Cervical Cancer Screening: Stratifications by Ethnicity</b>				
Metric	Ethnicity	Data Element	Reporting Instructions	
CervicalCancerScreening	HispanicOrLatino	InitialPopulation	For each Stratification	
	NotHispanicOrLatino	Exclusions	For each Stratification	
	AskedButNoAnswer	Denominator	For each Stratification	
	Unknown	Numerator	For each Stratification	
		Rate	(Percent)	

<b>Rules for Allowable Adjustments</b>	<p><b>Copyright and use:</b> The “Rules for Allowable Adjustments of HEDIS” (the “Rules”) describe how NCQA’s HEDIS measure specifications can be adjusted for other populations, if applicable. The Rules, reviewed and approved by NCQA measure experts, provide for expanded use of HEDIS measures without changing their clinical intent.</p> <p><b>Adjusted HEDIS measures may not be used for HEDIS health plan reporting.</b></p> <p><b>ADJUSTMENTS ALLOWED</b></p> <ul style="list-style-type: none"> <li>• <b>Product lines.</b> Organizations are not required to use product line criteria; product lines may be combined, and all (or no) product line criteria may be used.</li> <li>• <b>Attribution.</b> Organizations are not required to use enrollment criteria.</li> <li>• <b>Benefits.</b> Organizations are not required to use a benefit.</li> <li>• <b>Other.</b> Organizations may use additional eligible population criteria to focus on an area of interest defined by gender, race, ethnicity, socioeconomic or sociodemographic characteristics, geographic region or another characteristic.</li> <li>• <b>Measurement period adjustments.</b> Organizations may adjust the measurement period.</li> <li>• <b>Stratifications:</b> Race and ethnicity stratification. The race and ethnicity stratification is not required. Organizations may adjust this stratification as needed.</li> <li>• <b>Exclusions.</b> Hospice, deceased persons and palliative care exclusions are not required.</li> <li>• <b>Telehealth.</b> Services/events that allow the use of synchronous telehealth visits, telephone visits and asynchronous telehealth (e-visits, virtual check-ins) may be stratified to identify services performed via telehealth. This adjustment is not allowed for events, numerators and exclusions that do not allow the use of telehealth.</li> </ul>
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	<p><b>ADJUSTMENTS ALLOWED WITH LIMITS</b></p> <ul style="list-style-type: none"><li>• <i>Ages.</i> Age determination dates may be changed (e.g., select, “age as of June 30”). The denominator age may not be expanded.</li></ul> <p><b>ADJUSTMENTS NOT ALLOWED</b></p> <ul style="list-style-type: none"><li>• <i>Exclusions.</i> Hysterectomy, cervical agenesis or acquired absence of cervix and male sex assigned at birth exclusions must be applied. Value sets may not be changed.</li><li>• <i>Numerator.</i> Value sets and logic may not be changed.</li></ul>
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## Colorectal Cancer Screening (COL-E)

<b>Measure title</b>	Colorectal Cancer Screening	<b>Measure ID</b>	COL-E
<b>Description</b>	The percentage of persons 45–75 years of age who had appropriate screening for colorectal cancer.		
<b>Measurement period</b>	January 1–December 31.		
<b>Copyright and disclaimer notice</b>	<p>Refer to the complete copyright and disclaimer information at the front of this publication.</p> <p>NCQA website: <a href="http://www.ncqa.org">www.ncqa.org</a>.</p> <p>Submit policy clarification support questions via My NCQA (<a href="https://my.ncqa.org">https://my.ncqa.org</a>).</p>		
<b>Clinical recommendation statement/ rationale</b>	<p>The U.S. Preventive Services Task Force “recommends screening for colorectal cancer in all adults aged 50 to 75 years (A recommendation) and all adults aged 45 to 49 years (B recommendation).” Potential screening methods include an annual guaiac-based fecal occult blood test (gFOBT), annual fecal immunochemical test (FIT), multitargeted stool DNA with FIT test (sDNA FIT) every 3 years, colonoscopy every 10 years, CT colonography every 5 years, flexible sigmoidoscopy every 5 years or flexible sigmoidoscopy every 10 years, with FIT every year.</p>		
<b>Citations</b>	<p>USPSTF. 2021. “Screening for Colorectal Cancer: US Preventive Services Task Force Recommendation Statement.” <i>JAMA</i> 325(19): 1965–77. doi:10.1001/jama.2021.6238.</p>		
<b>Characteristics</b>			
<b>Scoring</b>	Proportion.		
<b>Type</b>	Process.		
<b>Product lines</b>	<ul style="list-style-type: none"> <li>• Commercial.</li> <li>• Medicaid.</li> <li>• Medicare.</li> </ul>		
<b>Stratifications</b>	<p>Age as of the last day of the measurement period.</p> <ul style="list-style-type: none"> <li>• 46–50 years.</li> <li>• 51–75 years.</li> </ul> <p>Race. (Refer to <a href="#">General Guideline: Race and Ethnicity Stratification</a>.)</p> <ul style="list-style-type: none"> <li>• American Indian or Alaska Native.</li> <li>• Asian.</li> <li>• Black or African American.</li> <li>• Middle Eastern or North African.</li> </ul>		

	<ul style="list-style-type: none"> <li>• Native Hawaiian or Pacific Islander.</li> <li>• White.</li> <li>• Some Other Race.</li> <li>• Two or More Races.</li> <li>• Asked But No Answer.</li> <li>• Unknown.</li> </ul> <p>Ethnicity. (Refer to <a href="#">General Guideline: Race and Ethnicity Stratification</a>.)</p> <ul style="list-style-type: none"> <li>• Hispanic or Latino.</li> <li>• Not Hispanic or Latino.</li> <li>• Asked But No Answer.</li> <li>• Unknown.</li> </ul> <p>SES (Medicare only). (Refer to <a href="#">General Guideline: Medicare Socioeconomic Status Stratification</a>.)</p> <ul style="list-style-type: none"> <li>• Non-LIS/DE, Nondisability.</li> <li>• LIS/DE.</li> <li>• Disability.</li> <li>• LIS/DE and Disability.</li> <li>• Other.</li> <li>• Unknown.</li> </ul>
<b>Risk adjustment</b>	None.
<b>Improvement notation</b>	Increased score indicates improvement.
<b>Guidance</b>	<p><b>Data collection methodology:</b> ECDS. Refer to <a href="#">General Guideline: Data Collection Methods</a> for additional information.</p> <p><b>Date specificity:</b> Dates must be specific enough to determine the event occurred in the period being measured.</p> <p><b>Which services count?</b> When using claims, include all paid, suspended, pending and denied claims.</p>
<b>Initial population</b>	<p><b>Measure item count:</b> Person.</p> <p><b>Attribution basis:</b> Enrollment.</p> <ul style="list-style-type: none"> <li>• <b>Benefits:</b> Medical.</li> <li>• <b>Continuous enrollment:</b> The measurement period and the year prior to the measurement period.</li> <li>• <b>Allowable gap:</b> No more than one gap of ≤45 days during each year of the continuous enrollment period. No gaps on the last day of the measurement period.</li> </ul> <p><b>Ages:</b> 46–75 years of age as of the last day of the measurement period.</p> <p><b>Event:</b> None.</p>

<b>Denominator exclusions</b>	<p><b>Persons with a date of death.</b> Death in the measurement period, identified using data sources determined by the organization. Method and data sources are subject to review during the HEDIS audit.</p> <p><b>Persons in hospice or using hospice services.</b> Persons who use hospice services (<u>Hospice Encounter Value Set</u>; <u>Hospice Intervention Value Set</u>) or elect to use a hospice benefit any time during the measurement period. Organizations that use the Monthly Membership Detail Data File to identify these persons must use only the run date of the file.</p> <p><b>Persons receiving palliative care.</b> Persons receiving palliative care (<u>Palliative Care Assessment Value Set</u>; <u>Palliative Care Encounter Value Set</u>; <u>Palliative Care Intervention Value Set</u>) or who had an encounter for palliative care (ICD-10-CM code Z51.5*) any time during the measurement period.</p> <p><b>Medicare enrollees, 66 years of age and older by the last day of the measurement period, in an institutional SNP (I-SNP) or living long-term in an institution (LTI).</b></p> <ul style="list-style-type: none"> <li>• Enrolled in an Institutional SNP (I-SNP) any time during the measurement period.</li> <li>• Living long-term in an institution any time during the measurement period as identified by the LTI flag in the Monthly Membership Detail Data File. Use the run date of the file to determine if a member had an LTI flag during the measurement period.</li> </ul> <p><b>Persons 66 years of age or older by the last day of the measurement period, with both frailty and advanced illness.</b></p> <ol style="list-style-type: none"> <li>1. <b>Frailty.</b> At least two indications of frailty (<u>Frailty Device Value Set</u>; <u>Frailty Diagnosis Value Set*</u>; <u>Frailty Encounter Value Set</u>; <u>Frailty Symptom Value Set*</u>) with different dates of service during the measurement period.</li> <li>2. <b>Advanced illness.</b> Either of the following during the measurement period or the year prior to the measurement period: <ul style="list-style-type: none"> <li>– Advanced illness (<u>Advanced Illness Value Set*</u>) on at least two different dates of service.</li> <li>– Dispensed dementia medication (<u>Dementia Medications List</u>).</li> </ul> </li> </ol> <p><b>History of colorectal cancer and/or total colectomy.</b> Colorectal cancer (<u>Colorectal Cancer and History of Colorectal Cancer Value Set*</u>) or a total colectomy (<u>Total Colectomy Value Set</u>; SNOMED CT code 119771000119101) any time during the person's history through the last day of the measurement period.</p> <p><b>Coding Guidance</b> *Do not include laboratory claims (claims with POS code 81).</p>
<b>Denominator</b>	The initial population minus denominator exclusions.

<b>Numerator</b>	<p><b>Persons with one or more screenings for colorectal cancer.</b></p> <p>Any of the following meet criteria:</p> <ul style="list-style-type: none"> <li>• Fecal occult blood test (<a href="#">FOBT Lab Test Value Set</a>; <a href="#">FOBT Test Result or Finding Value Set</a>) during the measurement period. For administrative data, assume the required number of samples were returned, regardless of FOBT type.</li> <li>• Stool DNA (sDNA) with FIT test (<a href="#">sDNA FIT Lab Test Value Set</a>; SNOMED CT code 708699002) during the measurement period or the 2 years prior to the measurement period.</li> <li>• Flexible sigmoidoscopy (<a href="#">Flexible Sigmoidoscopy Value Set</a>; SNOMED CT code 841000119107) during the measurement period or the 4 years prior to the measurement period.</li> <li>• CT colonography (<a href="#">CT Colonography Value Set</a>) during the measurement period or the 4 years prior to the measurement period.</li> <li>• Colonoscopy (<a href="#">Colonoscopy Value Set</a>; SNOMED CT code 851000119109) during the measurement period or the 9 years prior to the measurement period.</li> </ul>																																		
<b>Summary of changes</b>	<ul style="list-style-type: none"> <li>• Updated the race and ethnicity stratification categories to align with OMB SPD 15 2024.</li> <li>• Removed the definitions of “participation” and “participation period.”</li> <li>• Removed the SSoR data elements from the data elements tables.</li> <li>• Added instructions on allowable adjustments to the race and ethnicity and SES stratifications.</li> </ul>																																		
<b>Data element tables</b>	<p>Organizations that submit HEDIS data to NCQA must provide the following data elements.</p> <p><b>Table COL-E-A-1/2/3: Metadata Elements for Colorectal Cancer Screening</b></p> <table border="1"> <thead> <tr> <th>Metric</th> <th>Age</th> <th>Data Element</th> <th>Reporting Instructions</th> </tr> </thead> <tbody> <tr> <td rowspan="5">ColorectalCancerScreening</td> <td>46-50</td> <td>InitialPopulation</td> <td>For each Stratification</td> </tr> <tr> <td>51-75</td> <td>Exclusions</td> <td>For each Stratification</td> </tr> <tr> <td>Total</td> <td>Denominator</td> <td>For each Stratification</td> </tr> <tr> <td></td> <td>Numerator</td> <td>For each Stratification</td> </tr> <tr> <td></td> <td>Rate</td> <td>(Percent)</td> </tr> </tbody> </table> <p><b>Table COL-E-B-3: Data Elements for Colorectal Cancer Screening: SES Stratifications</b></p> <table border="1"> <thead> <tr> <th>Metric</th> <th>SES Stratifications</th> <th>Data Element</th> <th>Reporting Instructions</th> </tr> </thead> <tbody> <tr> <td rowspan="3">ColorectalCancerScreening</td> <td>NonLisDeNondisability</td> <td>InitialPopulation</td> <td>For each Stratification</td> </tr> <tr> <td>LisDe</td> <td>Exclusions</td> <td>For each Stratification</td> </tr> <tr> <td>Disability</td> <td>Denominator</td> <td>For each Stratification</td> </tr> </tbody> </table>	Metric	Age	Data Element	Reporting Instructions	ColorectalCancerScreening	46-50	InitialPopulation	For each Stratification	51-75	Exclusions	For each Stratification	Total	Denominator	For each Stratification		Numerator	For each Stratification		Rate	(Percent)	Metric	SES Stratifications	Data Element	Reporting Instructions	ColorectalCancerScreening	NonLisDeNondisability	InitialPopulation	For each Stratification	LisDe	Exclusions	For each Stratification	Disability	Denominator	For each Stratification
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	LisDe	Exclusions	For each Stratification																																
	Disability	Denominator	For each Stratification																																

Metric	SES Stratifications	Data Element	Reporting Instructions
	LisDeAndDisability	Numerator	For each stratification
	Other	Rate	(Percent)
	Unknown		

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

Metric	Race	Data Element	Reporting Instructions
ColorectalCancerScreening	AmericanIndianOrAlaskaNative	InitialPopulation	For each Stratification
	Asian	Exclusions	For each Stratification
	BlackOrAfricanAmerican	Denominator	For each Stratification
	MiddleEasternOrNorthAfrican	Numerator	For each Stratification
	NativeHawaiianOrPacificIslander	Rate	(Percent)
	White		
	SomeOtherRace		
	TwoOrMoreRaces		
	AskedButNoAnswer		
	Unknown		

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

Metric	Ethnicity	Data Element	Reporting Instructions
ColorectalCancerScreening	HispanicOrLatino	InitialPopulation	For each Stratification
	NotHispanicOrLatino	Exclusions	For each Stratification
	AskedButNoAnswer	Denominator	For each Stratification
	Unknown	Numerator	For each Stratification
		Rate	(Percent)

## Rules for Allowable Adjustments

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

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

### ADJUSTMENTS ALLOWED

- *Product lines.* Organizations are not required to use product line criteria; product lines may be combined, and all (or no) product line criteria may be used.
- *Attribution.* Organizations are not required to use enrollment criteria.
- *Benefits.* Organizations are not required to use a benefit.
- *Other.* Organizations may use additional initial population criteria to focus on an area of interest defined by gender, race, ethnicity, socioeconomic or sociodemographic characteristics, geographic region or another characteristic.
- *Measurement period adjustments.* Organizations may adjust the measurement period.
- *Stratifications:* Race and ethnicity stratification. The race and ethnicity stratification is not required. Organizations may adjust this stratification as needed.
- *Exclusions.* Hospice, deceased persons, palliative care, I-SNP, LTI, frailty or advanced illness exclusions are not required.
- *Telehealth.* Services/events that allow the use of synchronous telehealth visits, telephone visits and asynchronous telehealth (e-visits, virtual check-ins) may be stratified to identify services performed via telehealth. This adjustment is not allowed for events, numerators and exclusions that do not allow the use of telehealth.

### ADJUSTMENTS ALLOWED WITH LIMITS

- *Ages.* The age determination dates may be changed (e.g., select, “age as of June 30”). The initial population age may be expanded to 45–85 years of age.
- *Socioeconomic stratification.* The socioeconomic stratification is not required, but if it is applied, no adjustments may be made.

### ADJUSTMENTS NOT ALLOWED

- *Exclusions.* The colorectal cancer and colectomy exclusions must be applied. Value sets may not be changed.
- *Numerator.* The value sets, direct reference codes and logic may not be changed.

## **Follow-Up After Acute and Urgent Care Visits for Asthma (AAF-E)**

<b>Measure title</b>	Follow-Up After Acute and Urgent Care Visits for Asthma	<b>Measure ID</b>	AAF-E
<b>Description</b>	The percentage of persons 5-64 years of age with an urgent care visit, acute inpatient discharge, observation stay discharge or ED visit with a diagnosis of asthma that had a corresponding outpatient follow-up visit with a diagnosis of asthma within 30 days.		
<b>Measurement period</b>	January 1–December 31.		
<b>Copyright and disclaimer notice</b>	<p>Refer to the complete copyright and disclaimer information at the front of this publication.</p> <p>NCQA website: <a href="http://www.ncqa.org">www.ncqa.org</a>.</p> <p>Submit policy clarification support questions via My NCQA (<a href="https://my.ncqa.org">https://my.ncqa.org</a>).</p>		
<b>Clinical recommendation statement/ rationale</b>	<p>Non-clinical factors (e.g., socioeconomic status, environmental exposures, access to care) can limit individual efficacy in managing chronic conditions such as asthma, leading to higher use of urgent care, emergency departments, and hospitalizations instead of preventive care. An accountability mechanism that drives individuals towards non-acute care may help to improve poor and disparate asthma outcomes.</p>		
<b>Citations</b>	<p>McIvor A., Kaplan A. 2020. “A Call to Action for Improving Clinical Outcomes in Patients with Asthma.” Primary Care Respiratory Medicine 30(54).</p> <p>National Asthma Education and Prevention Program (NAEPP) Coordinating Committee Expert Working Group. 2020. 2020 Focused Updates to the Asthma Management Guidelines. <a href="https://www.nhlbi.nih.gov/resources/2020-focused-updatesasthma-management-guidelines">https://www.nhlbi.nih.gov/resources/2020-focused-updatesasthma-management-guidelines</a></p> <p>Global Initiative for Asthma (GINA). 2024. Global Strategy for Asthma Management and Prevention. <a href="https://ginasthma.org/wp-content/uploads/2024/05/GINA-2024- Strategy-Report-24_05_22_WMS.pdf">https://ginasthma.org/wp-content/uploads/2024/05/GINA-2024- Strategy-Report-24_05_22_WMS.pdf</a></p>		
<b>Characteristics</b>			
<b>Scoring</b>	Proportion.		
<b>Type</b>	Process.		
<b>Product lines</b>	<ul style="list-style-type: none"> <li>• Commercial.</li> <li>• Medicaid.</li> </ul>		

<b>Stratifications</b>	<p>Age as of the episode date.</p> <ul style="list-style-type: none"> <li>• 5–11 years.</li> <li>• 12–17 years.</li> <li>• 18–50 years.</li> <li>• 51–64 years.</li> </ul> <p>COPD diagnosis.</p> <ul style="list-style-type: none"> <li>• Persons diagnosed with COPD (<a href="#">COPD Value Set*</a>) any time during the person's history through the last day of the measurement period.</li> <li>• Persons who did not meet criteria for the stratification above (i.e., did not have a diagnosis of COPD any time during the person's history through the last day of the measurement period).</li> </ul> <p><b>Coding Guidance</b></p> <p>*Do not include laboratory claims (claims with POS code 81).</p>
<b>Risk adjustment</b>	None.
<b>Improvement notation</b>	Increased score indicates improvement.
<b>Guidance</b>	<p><b>Data collection methodology:</b> ECDS. Refer to <a href="#">General Guideline: Data Collection Methods</a> for additional information.</p> <p><b>Date specificity:</b> Dates must be specific enough to determine the episode occurred in the period being measured.</p> <p><b>Observation stays:</b> For observation stays (<a href="#">Observation Stay Value Set</a>) that do not have a recorded admission or discharge date, set the admission date to the earliest date of service on the claim and set the discharge date to the last date of service on the claim.</p> <p><b>Which services count?</b> When using claims, include all paid, suspended, pending and denied claims.</p> <p><b>Other guidance:</b> The measure is based on episodes; therefore, it is possible for the denominator to include multiple events for the same person.</p>

<b>Definitions</b>	
<b>Asthma episode</b>	<p>An encounter between January 1 and December 1 with a diagnosis of asthma.</p> <p><i>For urgent care visits that result in an ED visit</i>, the ED visit is the episode.</p> <p><i>For urgent care or ED visits that result in a nonacute inpatient stay</i>, the urgent care or ED visit is the episode.</p> <p><i>For acute inpatient or observation stays that result in a nonacute inpatient stay</i>, the acute inpatient or observation stay discharge is the episode.</p>
<b>Asthma episode date</b>	<p>The date of service for the asthma episode.</p> <p><i>For acute inpatient or observation stay discharges</i>, the episode date is the date of discharge.</p>

<b>Direct transfer</b>	<p><i>For direct transfers</i>, the episode date is the discharge date from the last transfer admission.</p> <p><i>For ED or urgent care visits</i>, the episode date is the date of service.</p> <p>When the discharge date from the initial stay precedes the admission date to a subsequent stay by one calendar day or less.</p> <ul style="list-style-type: none"> <li>• <i>For example:</i> <ul style="list-style-type: none"> <li>– An inpatient discharge on June 1, followed by an admission to another inpatient setting on June 1, is a direct transfer.</li> <li>– An inpatient discharge on June 1, followed by an admission to an inpatient setting on June 2, is a direct transfer.</li> <li>– An inpatient discharge on June 1, followed by an admission to another inpatient setting on June 3, is not a direct transfer; these are two distinct inpatient stays.</li> </ul> </li> </ul> <p>Direct transfers may occur between different facilities and between inpatient and observation stays.</p>
<b>Initial population</b>	<p><i>Measure item count:</i> Episode.</p> <p><i>Attribution basis:</i> Enrollment.</p> <ul style="list-style-type: none"> <li>• <i>Benefits:</i> Medical.</li> <li>• <i>Continuous enrollment:</i> Episode date through 30 days after episode date (31 total days).</li> <li>• <i>Allowable gap:</i> None.</li> </ul> <p><i>Ages:</i> 5–64 years of age as of the episode date.</p> <p><i>Event:</i> Acute visits for asthma on or between January 1 and December 1 of the measurement period.</p> <p><b>Step 1.</b> Identify all urgent care visits, ED visits, acute inpatient discharges and observation stay discharges on or between January 1 and December 1 of the measurement period:</p> <ul style="list-style-type: none"> <li>• An urgent care visit (<u>Outpatient and Telehealth Value Set</u> <b>with</b> POS code 20) <b>with</b> a diagnosis of asthma (<u>Asthma Value Set</u>).</li> <li>• An ED visit (<u>ED Value Set</u>) <b>with</b> a diagnosis of asthma (<u>Asthma Value Set</u>).</li> <li>• Acute inpatient or observation discharges with a diagnosis of asthma (<u>Asthma Value Set</u>) on the discharge claim. To identify an acute inpatient or observation discharge: <ol style="list-style-type: none"> <li>1. Identify all acute and nonacute inpatient stays (<u>Inpatient Stay Value Set</u>) and observation stays (<u>Observation Stay Value Set</u>).</li> <li>2. Exclude nonacute inpatient stays (<u>Nonacute Inpatient Stay Value Set</u>).</li> <li>3. Identify the discharge date for the stay.</li> </ol> </li> </ul> <p><b>Step 2.</b> Exclude ED and urgent care visits followed by admission to an acute inpatient or observation stay care setting on the date of the ED or urgent care visit, or within 30 days after the ED or urgent care visit (31 total days), regardless of diagnosis for the admission.</p>

	<p>To identify admissions to an acute inpatient or observation stay care setting:</p> <ol style="list-style-type: none"> <li>1. Identify all acute and nonacute inpatient stays (<u>Inpatient Stay Value Set</u>) and observation stays (<u>Observation Stay Value Set</u>).</li> <li>2. Exclude nonacute inpatient stays (<u>Nonacute Inpatient Stay Value Set</u>).</li> <li>3. Identify the admission date for the stay.</li> </ol> <p><b>Step 3.</b> Determine all asthma episode dates. Multiple visits/discharges that occur on the same date count as one episode.</p> <p><b>Step 4.</b> Test for direct transfers.</p> <p>For discharges with one or more direct transfers, use the last discharge. Exclude the episode if the direct transfer's discharge date occurs after December 1 of the measurement period.</p> <p>For episodes with a direct transfer to an acute setting for any diagnosis, the episode date is the discharge date from the last admission.</p> <p>To identify admissions to and discharges from acute inpatient settings:</p> <ol style="list-style-type: none"> <li>1. Identify all acute and nonacute inpatient stays (<u>Inpatient Stay Value Set</u>) and observation stays (<u>Observation Stay Value Set</u>).</li> <li>2. Exclude nonacute inpatient stays (<u>Nonacute Inpatient Stay Value Set</u>).</li> <li>3. Identify the discharge date for the stay.</li> </ol> <p><b>Note:</b> For acute inpatient or observation stays where there was a direct transfer, use the original stay and any direct transfer stays to identify eligible episode dates in this step.</p> <p><b>Step 5.</b> Calculate continuous enrollment.</p> <p><b>Step 6.</b> Multiple episodes within a 31-day period.</p> <p>Identify ED or urgent care visits chronologically, including only the first episode in each 31-day period.</p> <ul style="list-style-type: none"> <li>• For example, consider the following events:       <ul style="list-style-type: none"> <li>– ED visit: January 1.</li> <li>– Urgent care visit: January 15.</li> <li>– ED visit: January 20.</li> </ul>       Include the ED visit on January 1 as a denominator event. Exclude the urgent care visit on January 15 and the ED visit on January 20.     </li> </ul> <p>Identify acute inpatient or observation stay discharges chronologically, including only the last discharge in each 31-day period.</p> <ul style="list-style-type: none"> <li>• For example, consider the following events:       <ul style="list-style-type: none"> <li>– Acute inpatient discharge: March 5.</li> <li>– Observation stay discharge: March 9.</li> <li>– Acute inpatient discharge: March 22.</li> </ul>       Include the acute inpatient discharge on March 22 as a denominator event. Exclude the discharges on March 5 and March 9.     </li> </ul> <p>For 31-day periods that include an eligible acute inpatient or observation stay discharge followed by an ED or urgent care visit, include only the acute inpatient or observation stay discharge.</p>
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	<ul style="list-style-type: none"> <li>• <i>For example</i>, consider the following events:           <ul style="list-style-type: none"> <li>– Acute inpatient discharge: March 5.</li> <li>– ED visit: March 12.</li> <li>– Urgent care visit: March 20.</li> </ul> </li> </ul> <p>Include the acute inpatient discharge on March 5 as a denominator event. Exclude the ED visit on March 12 and urgent care visit on March 20.</p> <p><b>Note:</b> Removal of multiple episodes in a 31-day period is based on eligible episode dates. Assess each episode for eligibility before removing multiple episodes in a 31-day period.</p>
<b>Denominator exclusions</b>	<p><b>Persons with a date of death.</b> Death in the measurement period, identified using data sources determined by the organization. Method and data sources are subject to review during the HEDIS audit.</p> <p><b>Persons in hospice or using hospice services.</b> Persons who use hospice services (<u>Hospice Encounter Value Set</u>; <u>Hospice Intervention Value Set</u>) or elect to use a hospice benefit any time during the measurement period. Organizations that use the Monthly Membership Detail Data File to identify these persons must use only the run date of the file.</p> <p><b>Persons with a diagnosis of cystic fibrosis.</b> Persons with a diagnosis of cystic fibrosis (<u>Cystic Fibrosis Value Set*</u>) at any time in the person's history through the last day of the measurement period.</p> <p><b>Coding Guidance</b> *Do not include laboratory claims (claims with POS code 81).</p>
<b>Denominator</b>	The initial population minus denominator exclusions.
<b>Numerator</b>	<p><b>30-day follow-up.</b> An outpatient visit, telephone visit, e-visit or virtual check-in (<u>Outpatient and Telehealth Value Set</u>) with a diagnosis of asthma (<u>Asthma Value Set</u>) within 30 days after the asthma episode. Do not include visits that occur on the same day as the asthma episode. Do not include services provided in an urgent care setting (POS code 20).</p>
<b>Summary of changes</b>	<ul style="list-style-type: none"> <li>• This is a first-year measure.</li> </ul>
<b>Data element tables</b>	Organizations that submit HEDIS data to NCQA must provide the following data elements.

<b>Table AAF-E-1/2: Data Elements for Follow-Up After Acute and Urgent Care Visits for Asthma</b>					
Metric	Age	Diagnosis	Data Element	Reporting Instructions	
FollowUpVisit	5-11	COPDDiagnosed	InitialPopulation	For each Stratification	
	12-17		Exclusions	For each Stratification	
	18-50		Denominator	For each Stratification	
	51-64		Numerator	For each Stratification	
	Total		Rate	(Percent)	
<b>Rules for Allowable Adjustments</b>	<p><b>Copyright and use:</b> The “Rules for Allowable Adjustments of HEDIS” (the “Rules”) describe how NCQA’s HEDIS measure specifications can be adjusted for other populations, if applicable. The Rules, reviewed and approved by NCQA measure experts, provide for expanded use of HEDIS measures without changing their clinical intent.</p> <p><b>Adjusted HEDIS measures may not be used for HEDIS health plan reporting.</b></p> <p><b>ADJUSTMENTS ALLOWED</b></p> <ul style="list-style-type: none"> <li>• <b>Product lines.</b> Organizations are not required to use product line criteria; product lines may be combined, and all (or no) product line criteria may be used.</li> <li>• <b>Attribution.</b> Organizations are not required to use enrollment criteria.</li> <li>• <b>Benefits.</b> Organizations are not required to use a benefit.</li> <li>• <b>Ages.</b> The denominator age range may be expanded. The age determination dates may be changed (e.g., select, “age as of June 30”).</li> <li>• <b>Other.</b> Organizations may use additional initial population criteria to focus on a population of interest such as gender, race, ethnicity, socioeconomic or sociodemographic characteristics, geographic region or another characteristic.</li> <li>• <b>Measurement period adjustments.</b> Organizations may adjust the measurement period.</li> <li>• <b>Exclusions.</b> Hospice and deceased persons exclusions are not required.</li> <li>• <b>Telehealth.</b> Services/events that allow the use of synchronous telehealth visits, telephone visits and asynchronous telehealth (e-visits, virtual check-ins) may be stratified to identify services performed via telehealth. This adjustment is not allowed for events, numerators and exclusions that do not allow the use of telehealth.</li> </ul> <p><b>ADJUSTMENTS ALLOWED WITH LIMITS</b></p> <ul style="list-style-type: none"> <li>• <b>Numerator.</b> The timing of the follow-up period can be shortened (e.g., assessing for follow-up visits that occur within 7 days or within 14 days). Value sets and logic may not be changed.</li> </ul>				

**ADJUSTMENTS NOT ALLOWED**

- *Exclusions.* The cystic fibrosis exclusions must be applied. Value sets and logic may not be changed.
- *Initial population:* Event. Only events or diagnoses that contain (or map to) codes in the value sets may be used to identify visits. Value sets and logic may not be changed.

## Blood Pressure Control for Patients With Hypertension (BPC-E)

Measure title	Blood Pressure Control for Patients With Hypertension	Measure ID	BPC-E
<b>Description</b>	The percentage of persons 18–85 years of age who had a diagnosis of hypertension (HTN) and whose most recent blood pressure (BP) was <140/90 mm Hg during the measurement period.		
<b>Measurement period</b>	January 1–December 31.		
<b>Copyright and disclaimer notice</b>	<p>Refer to the complete copyright and disclaimer information at the front of this publication.</p> <p>NCQA website: <a href="http://www.ncqa.org">www.ncqa.org</a>.</p> <p>Submit policy clarification support questions via My NCQA (<a href="https://my.ncqa.org">https://my.ncqa.org</a>).</p>		
<b>Clinical recommendation statement/rationale</b>	<p>The American Academy of Family Physicians (AAFP) strongly recommends clinicians treat adults who have hypertension to a standard blood pressure target (&lt;140/90 mm Hg) to reduce the risk of all-cause and cardiovascular mortality.</p> <p>The Joint National Committee recommends that pharmacologic treatment be initiated in the general population &lt;60 years, to lower systolic BP ≥140 mm Hg (and treat to a goal of systolic BP &lt;140 mm Hg) and to lower diastolic BP ≥90 mm Hg (and treat to a goal of diastolic BP &lt;90 mm Hg).</p> <p>The American College of Cardiology (ACC) and American Heart Association (AHA) recommend a target BP of less than 130/80 mm Hg for adults with confirmed hypertension and known cardiovascular disease (CVD) or 10-year atherosclerotic CVD event risk of 10% or higher. In addition, they have determined that a reasonable target BP for adults with confirmed hypertension, without additional markers of increased CVD risk, is less than 130/80 mm Hg.</p>		
<b>Citations</b>	<p>Coles, S., L. Fisher, K. Lin, C. Lyon, A. Vosooney, and M. Bird. November 14, 2022. <i>Blood Pressure Targets in Adults With Hypertension: A Clinical Practice Guideline From the AAFP</i>.</p> <p>James, P.A., S. Oparil, B.L. Carter, W.C. Cushman, C. Dennison-Himmelfarb, J. Handler, D.T. Lackland, et al. February 5, 2014. "2014 Evidence-Based Guideline for the Management of High Blood Pressure in Adults: Report From the Panel Members Appointed to the Eighth Joint National Committee (JNC 8)." <i>JAMA</i> 311, no. 5: 507–20. <a href="https://doi.org/10.1001/jama.2013.284427">https://doi.org/10.1001/jama.2013.284427</a></p> <p>Whelton, P.K., R.M. Carey, W.S. Aronow, D.E. Casey, K.J. Collins, C. Dennison Himmelfarb, S.M. DePalma, et al. June 2018. "2017 ACC/AHA/ AAPA/ABC/ACPM/AGS/APhA/ASH/ASPC/NMA/PCNA Guideline for the Prevention, Detection, Evaluation, and Management of High Blood Pressure in Adults: A Report of the American College of Cardiology/American Heart Association Task Force on Clinical Practice Guidelines." <i>Hypertension</i> 71, no. 6: e13–115. <a href="https://doi.org/10.1161/HYP.0000000000000065">https://doi.org/10.1161/HYP.0000000000000065</a></p>		

Characteristics	
<b>Scoring</b>	Proportion.
<b>Type</b>	Outcome.
<b>Product lines</b>	<ul style="list-style-type: none"> <li>• Commercial.</li> <li>• Medicaid.</li> <li>• Medicare.</li> </ul>
<b>Stratifications</b>	<p>Race. (Refer to <a href="#">General Guideline: Race and Ethnicity Stratification</a>.)</p> <ul style="list-style-type: none"> <li>• American Indian or Alaska Native.</li> <li>• Asian.</li> <li>• Black or African American.</li> <li>• Middle Eastern or North African.</li> <li>• Native Hawaiian or Pacific Islander.</li> <li>• White.</li> <li>• Some Other Race.</li> <li>• Two or More Races.</li> <li>• Asked But No Answer.</li> <li>• Unknown.</li> </ul> <p>Ethnicity. (Refer to <a href="#">General Guideline: Race and Ethnicity Stratification</a>.)</p> <ul style="list-style-type: none"> <li>• Hispanic or Latino.</li> <li>• Not Hispanic or Latino.</li> <li>• Asked But No Answer.</li> <li>• Unknown.</li> </ul>
<b>Risk adjustment</b>	None.
<b>Improvement notation</b>	Increased score indicates improvement.
<b>Guidance</b>	<p><b>Data collection methodology:</b> ECDS. Refer to <a href="#">General Guideline: Data Collection Methods</a> for additional information.</p> <p><b>Date specificity:</b> Dates must be specific enough to determine the event occurred in the period being measured.</p> <p><b>Which services count?</b> When using claims, include all paid, suspended, pending and denied claims.</p>
<b>Initial population</b>	<p><b>Measure item count:</b> Person.</p> <p><b>Attribution basis:</b> Enrollment.</p> <ul style="list-style-type: none"> <li>• <b>Benefits:</b> Medical.</li> <li>• <b>Continuous enrollment:</b> The measurement period.</li> </ul>

	<ul style="list-style-type: none"> <li>• <b>Allowable gap:</b> No more than one gap of ≤45 days during the measurement period. No gaps on the last day of the measurement period.</li> </ul> <p><b>Ages:</b> 18–85 years of age as of the last day of the measurement period.</p> <p><b>Event:</b> Persons with a diagnosis of hypertension.</p> <p>Persons who meet either of the following criteria:</p> <ul style="list-style-type: none"> <li>• At least two outpatient visits, telephone visits, e-visits or virtual check-ins (<a href="#">Outpatient and Telehealth Without UBREV Value Set</a>) on different dates of service with a diagnosis of hypertension (<a href="#">Essential Hypertension Value Set</a>) on or between January 1 of the year prior to the measurement period and June 30 of the measurement period.</li> <li>• At least one outpatient visit, telephone visit, e-visit or virtual check-in (<a href="#">Outpatient and Telehealth Without UBREV Value Set</a>) with a diagnosis of hypertension (<a href="#">Essential Hypertension Value Set</a>) and at least one dispensed antihypertensive medication (<a href="#">Antihypertensive Medications List</a>) on or between January 1 of the year prior to the measurement period and June 30 of the measurement period.</li> </ul>
<b>Denominator exclusions</b>	<p><b>Persons with a date of death.</b> Death in the measurement period, identified using data sources determined by the organization. Method and data sources are subject to review during the HEDIS audit.</p> <p><b>Persons in hospice or using hospice services.</b> Persons who use hospice services (<a href="#">Hospice Encounter Value Set</a>; <a href="#">Hospice Intervention Value Set</a>) or elect to use a hospice benefit any time during the measurement period. Organizations that use the Monthly Membership Detail Data File to identify these persons must use only the run date of the file.</p> <p><b>Persons receiving palliative care.</b> Persons receiving palliative care (<a href="#">Palliative Care Assessment Value Set</a>; <a href="#">Palliative Care Encounter Value Set</a>; <a href="#">Palliative Care Intervention Value Set</a>) or who had an encounter for palliative care (ICD-10-CM code Z51.5*) any time during the measurement period.</p> <p><b>Medicare enrollees, 66 years of age and older by the last day of the measurement period, in an institutional SNP (I-SNP) or living long-term in an institution (LTI).</b></p> <ul style="list-style-type: none"> <li>• Enrolled in an Institutional SNP (I-SNP) any time during the measurement period.</li> <li>• Living long-term in an institution any time during the measurement period as identified by the LTI flag in the Monthly Membership Detail Data File. Use the run date of the file to determine if a member had an LTI flag during the measurement period.</li> </ul> <p><b>Persons 66–80 years of age by the last day of the measurement period, with both frailty and advanced illness.</b></p> <ol style="list-style-type: none"> <li>1. <b>Frailty.</b> At least two indications of frailty (<a href="#">Frailty Device Value Set</a>; <a href="#">Frailty Diagnosis Value Set*</a>; <a href="#">Frailty Encounter Value Set</a>; <a href="#">Frailty Symptom Value Set*</a>) with different dates of service during the measurement period.</li> </ol>

	<p>2. <b>Advanced illness.</b> Either of the following during the measurement period or the year prior to the measurement period:</p> <ul style="list-style-type: none"> <li>– Advanced illness (<a href="#">Advanced Illness Value Set*</a>) on at least two different dates of service.</li> <li>– Dispensed dementia medication (<a href="#">Dementia Medications List</a>).</li> </ul> <p><b>Persons 81 years of age or older by the last day of the measurement period, with frailty.</b></p> <p>Persons 81 years of age and older as of the last day of the measurement period with at least two indications of frailty (<a href="#">Frailty Device Value Set</a>; <a href="#">Frailty Diagnosis Value Set*</a>; <a href="#">Frailty Encounter Value Set</a>; <a href="#">Frailty Symptom Value Set*</a>) with different dates of service during the measurement period.</p> <p><b>End-stage renal disease (ESRD).</b></p> <p>Persons with any of the following during their history on or prior to the last day of the measurement period:</p> <ul style="list-style-type: none"> <li>• Diagnosis that indicates end-stage renal disease (ESRD) (<a href="#">ESRD Diagnosis Value Set*</a>; <a href="#">History of Nephrectomy or Kidney Transplant Value Set*</a>).</li> <li>• Procedure that indicates ESRD: dialysis (<a href="#">Dialysis Procedure Value Set</a>), nephrectomy (<a href="#">Total Nephrectomy Value Set</a>; <a href="#">Partial Nephrectomy Value Set</a>) or kidney transplant (<a href="#">Kidney Transplant Value Set</a>).</li> </ul> <p><b>Diagnosis of pregnancy.</b></p> <p>Persons with a diagnosis of pregnancy (<a href="#">Pregnancy Value Set*</a>) any time during the measurement period.</p> <p><b>Nonacute inpatient admission.</b></p> <p>Persons with a nonacute inpatient admission during the measurement period. To identify nonacute inpatient admissions:</p> <ol style="list-style-type: none"> <li>1. Identify all acute and nonacute inpatient stays (<a href="#">Inpatient Stay Value Set</a>).</li> <li>2. Confirm the stay was for nonacute care based on the presence of a nonacute code (<a href="#">Nonacute Inpatient Stay Value Set</a>) on the claim.</li> <li>3. Identify the admission date for the stay.</li> </ol> <p><b>Coding Guidance</b> *Do not include laboratory claims (claims with POS code 81).</p>
<b>Denominator</b>	The initial population minus denominator exclusions.
<b>Numerator</b>	<p><b>Both a systolic and diastolic reading &lt;140/90 mm Hg.</b></p> <p>Identify the most recent systolic and diastolic BP readings (<a href="#">Systolic Blood Pressure Value Set</a>; <a href="#">Diastolic Blood Pressure Value Set</a>) taken during the measurement period <i>on or after</i> the second diagnosis of hypertension event (identified using the initial population criteria). Do not include CPT Category II codes (<a href="#">Systolic and Diastolic Result Value Set</a>) with a modifier (<a href="#">CPT CAT II Modifier Value Set</a>). Do not include BPs taken in an acute inpatient setting (<a href="#">Acute Inpatient Value Set</a>; <a href="#">Acute Inpatient POS Value Set</a>) or ED visit (<a href="#">ED Value Set</a>; POS code 23).</p> <p>If multiple readings were recorded for a single date, use the lowest systolic and lowest diastolic BP on that date as the representative BP. The systolic and diastolic results do not need to be from the same reading.</p>

	<ul style="list-style-type: none"> <li>• <b>Compliant:</b> BP is &lt;140/90 mm Hg.</li> <li>• <b>Non-compliant:</b> BP is ≥140/90 mm Hg; no BP reading during the measurement period; or if the reading is incomplete (e.g., the systolic or diastolic level is missing).</li> </ul> <p>If the most recent blood pressure was identified based on a CPT Category II code (<u>Systolic and Diastolic Result Value Set</u>) use the following to determine compliance:</p> <ul style="list-style-type: none"> <li>• <b>Systolic compliant:</b> <u>Systolic Less Than 140 Value Set</u>.</li> <li>• <b>Systolic not compliant:</b> CPT-CAT-II code 3077F.</li> <li>• <b>Diastolic compliant:</b> <u>Diastolic Less Than 90 Value Set</u>.</li> <li>• <b>Diastolic not compliant:</b> CPT-CAT-II code 3080F.</li> </ul>																																														
<b>Summary of changes</b>	<ul style="list-style-type: none"> <li>• Updated the race and ethnicity stratification categories to align with OMB SPD 15 2024.</li> <li>• Removed the definitions of participation and participation period.</li> <li>• Removed the SSoR data elements from the data element tables.</li> <li>• Stratifications: Race and ethnicity stratification. The race and ethnicity stratification is not required. Organizations may adjust this stratification as needed.</li> </ul>																																														
<b>Data element tables</b>	<p>Organizations that submit HEDIS data to NCQA must provide the following data elements.</p> <p><b>Table BPC-E-A-1/2/3: Data Elements for Blood Pressure Control for Patients With Hypertension</b></p> <table border="1"> <thead> <tr> <th>Metric</th> <th>Data Element</th> <th>Reporting Instructions</th> </tr> </thead> <tbody> <tr> <td>BPUnder140Over90</td> <td>InitialPopulation</td> <td>Report once</td> </tr> <tr> <td></td> <td>Exclusions</td> <td>Report once</td> </tr> <tr> <td></td> <td>Denominator</td> <td>Report once</td> </tr> <tr> <td></td> <td>Numerator</td> <td>Report once</td> </tr> <tr> <td></td> <td>Rate</td> <td>(Percent)</td> </tr> </tbody> </table> <p><b>Table BPC-E-B-1/2/3: Data Elements for Blood Pressure Control for Patients With Hypertension: Stratifications by Race</b></p> <table border="1"> <thead> <tr> <th>Metric</th> <th>Race</th> <th>Data Element</th> <th>Reporting Instructions</th> </tr> </thead> <tbody> <tr> <td>BPUnder140Over90</td> <td>AmericanIndianOrAlaskaNative</td> <td>InitialPopulation</td> <td>For each Stratification</td> </tr> <tr> <td></td> <td>Asian</td> <td>Exclusions</td> <td>For each Stratification</td> </tr> <tr> <td></td> <td>BlackOrAfricanAmerican</td> <td>Denominator</td> <td>For each Stratification</td> </tr> <tr> <td></td> <td>MiddleEasternOrNorthAfrican</td> <td>Numerator</td> <td>For each Stratification</td> </tr> <tr> <td></td> <td>NativeHawaiianOrPacificIslander</td> <td>Rate</td> <td>(Percent)</td> </tr> <tr> <td></td> <td>White</td> <td></td> <td></td> </tr> </tbody> </table>	Metric	Data Element	Reporting Instructions	BPUnder140Over90	InitialPopulation	Report once		Exclusions	Report once		Denominator	Report once		Numerator	Report once		Rate	(Percent)	Metric	Race	Data Element	Reporting Instructions	BPUnder140Over90	AmericanIndianOrAlaskaNative	InitialPopulation	For each Stratification		Asian	Exclusions	For each Stratification		BlackOrAfricanAmerican	Denominator	For each Stratification		MiddleEasternOrNorthAfrican	Numerator	For each Stratification		NativeHawaiianOrPacificIslander	Rate	(Percent)		White		
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	White																																														

Metric	Race	Data Element	Reporting Instructions
	SomeOtherRace		
	TwoOrMoreRaces		
	AskedButNoAnswer		
	Unknown		

**Table BPC-E-C-1/2/3: Data Elements for Blood Pressure Control for Patients With Hypertension: Stratifications by Ethnicity**

Metric	Ethnicity	Data Element	Reporting Instructions
BPUnder140Over90	HispanicOrLatino	InitialPopulation	For each Stratification
	NotHispanicOrLatino	Exclusions	For each Stratification
	AskedButNoAnswer	Denominator	For each Stratification
	Unknown	Numerator	For each Stratification
		Rate	(Percent)

### Rules for Allowable Adjustments

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

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

#### ADJUSTMENTS ALLOWED

- **Product lines.** Organizations are not required to use product line criteria; product lines may be combined, and all (or no) product line criteria may be used.
- **Attribution.** Organizations are not required to use enrollment criteria.
- **Benefits.** Organizations are not required to use a benefit.
- **Other.** Organizations may use additional initial population criteria to focus on an area of interest defined by gender, race, ethnicity, socioeconomic or sociodemographic characteristics, geographic region or another characteristic.
- **Measurement period adjustments.** Organizations may adjust the measurement period.
- **Stratifications:** Race and ethnicity stratification. The race and ethnicity stratification is not required. Organizations may adjust this stratification as needed.
- **Exclusions.** The hospice, deceased person, palliative care, I-SNP, LTI, frailty or advanced illness exclusions are not required.
- **Telehealth.** Services/events that allow the use of synchronous telehealth visits, telephone visits and asynchronous telehealth (e-visits, virtual check-ins) may be stratified to identify services performed via telehealth. This adjustment is not allowed for events, numerators and exclusions that do not allow the use of telehealth.

**ADJUSTMENTS ALLOWED WITH LIMITS**

- *Ages.* Age determination dates may be changed (e.g., select, “age as of June 30”). The denominator age range may be changed if the range is within the specified age range (18–85 years of age).

**ADJUSTMENTS NOT ALLOWED**

- *Initial population:* Event. Value sets, medication lists and logic may not be changed.
- *Exclusions.* The ESRD and pregnancy exclusions must be applied. The value sets and logic may not be changed.
- *Numerator.* Value sets and logic may not be changed.

## ***Statin Therapy for Patients With Cardiovascular Disease (SPC-E)***

<b>Measure title</b>	Statin Therapy for Patients With Cardiovascular Disease	<b>Measure ID</b>	SPC-E
<b>Description</b>	<p>The percentage of persons 21–75 years of age during the measurement period who were identified as having clinical atherosclerotic cardiovascular disease (ASCVD) and met the following criteria. Two rates are reported:</p> <ol style="list-style-type: none"> <li>1. <i>Received Statin Therapy.</i> Persons who were dispensed at least one high-intensity or moderate-intensity statin medication during the measurement period.</li> <li>2. <i>Statin Adherence 80%.</i> Persons who remained on a high-intensity or moderate-intensity statin medication for at least 80% of the treatment period.</li> </ol>		
<b>Measurement period</b>	January 1–December 31.		
<b>Copyright and disclaimer notice</b>	<p>Refer to the complete copyright and disclaimer information at the front of this publication.</p> <p>NCQA website: <a href="http://www.ncqa.org">www.ncqa.org</a>.</p> <p>Submit policy clarification support questions via My NCQA (<a href="https://my.ncqa.org">https://my.ncqa.org</a>).</p>		
<b>Clinical recommendation statement/ rationale</b>	<p>Guidelines from the American Heart Association (AHA) recommend high-intensity statin therapy for men and women 21–75 years of age with a diagnosis of clinical ASCVD.</p> <p>If high-intensity therapy is contraindicated, or when adverse effects are present, moderate-intensity statin therapy should be used. Adherence to both medication and lifestyle regimens are required for ASCVD risk reduction.</p>		
<b>Citations</b>	<p>Grundy, S.M., N.J. Stone, A.L. Bailey, C. Beam, K.K. Birtcher, R.S. Blumenthal, L.T. Braun, S. de Ferranti, J. Faiella-Tomasino, D.E. Forman, R. Goldberg, P.A. Heidenreich, M.A. Hlatky, D.W. Jones, D.M. Lloyd-Jones, N. Lopez-Pajares, C.E. Ndumele, C.E. Orringer, C.A. Peralta,... J. Yeboah. "2018 AHA/ACC/AACVPR/AAPA/ABC/ACPM/ADA/AGS/Apha/ASPC/NLA/PCNA Guideline on the Management of Blood Cholesterol." <i>Journal of the American College of Cardiology</i> 73(24).</p>		
<b>Characteristics</b>			
<b>Scoring</b>	Proportion.		
<b>Type</b>	Process.		
<b>Product lines</b>	<ul style="list-style-type: none"> <li>• Commercial.</li> <li>• Medicaid.</li> <li>• Medicare.</li> </ul>		

<b>Stratifications</b>	None.
<b>Risk adjustment</b>	None.
<b>Improvement notation</b>	Increased score indicates improvement.
<b>Guidance</b>	<p><b>Data collection methodology:</b> ECDS. Refer to <a href="#">General Guideline: Data Collection Methods</a> for additional information.</p> <p><b>Date specificity:</b> Dates must be specific enough to determine the event occurred in the period being measured.</p> <p><b>Which services count?</b> When using claims, include all paid, suspended, pending and denied claims.</p> <p><b>Medication lists:</b> If an organization uses both pharmacy data (NDC codes) and clinical data (RxNorm codes) for reporting, and there are both NDC and RxNorm codes on the same date of service, use only one data source for the date of service.</p> <p><b>Other guidance:</b> All persons who are numerator compliant for Rate 1 must be used as the denominator for Rate 2.</p>
<b>Definitions</b>	
<b>Calculating number of days covered for multiple prescriptions</b>	<p>If multiple prescriptions for <i>different medications are dispensed on the same day</i>, calculate the number of days covered by a statin medication (for the numerator) using the prescriptions with the longest days supply.</p> <p>For multiple <i>different prescriptions dispensed on different days with overlapping days supply</i>, count each day in the treatment period only once toward the numerator.</p> <p>If multiple prescriptions for the <i>same medication are dispensed on the same day or on different days</i>, sum the days supply and use the total to calculate the number of days covered by a statin medication (for the numerator). For example, three prescriptions for the same medication are dispensed on the same day, each with a 30-days supply.</p> <p>Sum the days supply for a total of 90 days covered by a statin. Subtract any days supply that extends beyond December 31 of the measurement period.</p> <p>Use the medication lists to determine if drugs are the same or different. <i>Drugs in different medication lists are considered different drugs.</i> For example, a dispensing event from the <a href="#">Amlodipine Atorvastatin High Intensity Medications List</a> and a dispensing event from the <a href="#">Amlodipine Atorvastatin Moderate Intensity Medications List</a> are dispensing events for different medications.</p>
<b>IPSD</b>	Index prescription start date. The earliest prescription dispensing date for any statin medication of at least moderate intensity during the measurement period.
<b>PDC</b>	Proportion of days covered. The number of days the person is covered by at least one statin medication prescription of appropriate intensity, divided by the number of days in the treatment period.
<b>Treatment period</b>	The period of time beginning on the IPSD through the last day of the measurement period.

<b>Initial population</b>	<p><b>Measure item count:</b> Person.</p> <p><b>Attribution basis:</b> Enrollment.</p> <ul style="list-style-type: none"> <li>• <b>Benefits:</b> Medical Pharmacy during the measurement period.</li> <li>• <b>Continuous enrollment:</b> The measurement period and the year prior to the measurement period.</li> <li>• <b>Allowable gap:</b> No more than one gap of ≤45 days during each year of continuous enrollment. No gaps on the last day of the measurement period.</li> </ul> <p><b>Ages:</b> 21–75 years of age as of the last day of the measurement period.</p> <p><b>Event: Persons with clinical atherosclerotic cardiovascular disease.</b> To identify persons with ASCVD, persons must meet either of the following criteria:</p> <ul style="list-style-type: none"> <li>• Any of the following during the year prior to the measurement period meet criteria: <ul style="list-style-type: none"> <li>– Discharged from an inpatient setting with an MI (<a href="#">MI Value Set</a>; <a href="#">Old Myocardial Infarction Value Set</a>) on the discharge claim. To identify discharges: <ol style="list-style-type: none"> <li>1. Identify all acute and nonacute inpatient stays (<a href="#">Inpatient Stay Value Set</a>).</li> <li>2. Identify the discharge date for the stay.</li> </ol> </li> <li>– CABG (<a href="#">CABG Value Set</a>) in any setting.</li> <li>– PCI (<a href="#">PCI Value Set</a>) in any setting.</li> <li>– Any other revascularization procedures (<a href="#">Other Revascularization Value Set</a>) in any setting.</li> </ul> </li> <li>• At least two diagnoses of ASCVD (<a href="#">Atherosclerotic Cardiovascular Disease Value Set*</a>) on different dates of service during the measurement period or the year prior to the measurement period.</li> </ul> <p><b>Coding Guidance</b> *Do not include laboratory claims (claims with POS code 81).</p>
<b>Denominator exclusions</b>	<p><b>Persons with a date of death.</b> Death in the measurement period, identified using data sources determined by the organization. Method and data sources are subject to review during the HEDIS audit.</p> <p><b>Persons in hospice or using hospice services.</b> Persons who use hospice services (<a href="#">Hospice Encounter Value Set</a>; <a href="#">Hospice Intervention Value Set</a>) or elect to use a hospice benefit any time during the measurement period. Organizations that use the Monthly Membership Detail Data File to identify these persons must use only the run date of the file.</p> <p><b>Persons receiving palliative care.</b> Persons receiving palliative care (<a href="#">Palliative Care Assessment Value Set</a>; <a href="#">Palliative Care Encounter Value Set</a>; <a href="#">Palliative Care Intervention Value Set</a>) or who had an encounter for palliative care (ICD-10-CM code Z51.5*) any time during the measurement period.</p>

	<p><b>Persons 66 years of age or older by the last day of the measurement period, with both frailty and advanced illness.</b></p> <ol style="list-style-type: none"> <li>1. <b>Frailty.</b> At least two indications of frailty (<a href="#">Frailty Device Value Set</a>; <a href="#">Frailty Diagnosis Value Set*</a>; <a href="#">Frailty Encounter Value Set</a>; <a href="#">Frailty Symptom Value Set*</a>) with different dates of service during the measurement period.</li> <li>2. <b>Advanced Illness.</b> Either of the following during the measurement period or the year prior to the measurement period: <ul style="list-style-type: none"> <li>– Advanced illness (<a href="#">Advanced Illness Value Set*</a>) on at least two different dates of service.</li> <li>– Dispensed dementia medication (<a href="#">Dementia Medications List</a>).</li> </ul> </li> </ol> <p><b>In vitro fertilization, pregnancy, or a prescription of clomiphene.</b> Persons who received in vitro fertilization (<a href="#">IVF Value Set</a>), had a diagnosis of (<a href="#">Pregnancy Value Set*</a>), or were dispensed at least one prescription for clomiphene (<a href="#">Estrogen Agonists Medications List</a>) during the measurement period or the year prior to the measurement period.</p> <p><b>ESRD, cirrhosis, or dialysis.</b> Persons with a diagnosis of ESRD (<a href="#">ESRD Diagnosis Value Set*</a>) or cirrhosis (<a href="#">Cirrhosis Value Set*</a>), or who received dialysis (<a href="#">Dialysis Procedure Value Set</a>) during the measurement period or the year prior to the measurement period.</p> <p><b>Myalgia, myositis, myopathy or rhabdomyolysis.</b> Persons with myalgia, myositis, myopathy or rhabdomyolysis (<a href="#">Muscular Pain and Disease Value Set*</a>) during the measurement period.</p> <p><b>Myalgia or rhabdomyolysis caused by a statin.</b> Persons with myalgia or rhabdomyolysis caused by a statin (<a href="#">Muscular Reactions to Statins Value Set</a>) any time during the person's history through the last day of the measurement period.</p> <p><b>Coding Guidance</b> *Do not include laboratory claims (claims with POS code 81).</p>					
<b>Denominator</b>	<p><b>Denominator 1: Received statin therapy.</b> Initial population minus denominator exclusions.</p> <p><b>Denominator 2: Statin adherence 80%.</b> Persons who meet numerator 1 criteria.</p>					
<b>Numerator</b>	<p><b>Numerator 1: Received statin therapy.</b> At least one dispensing event for a high-intensity or moderate-intensity statin medication (<a href="#">High and Moderate Intensity Statin Medications List</a>) during the measurement period.</p> <p><b>High- and Moderate-Intensity Statin Medications</b></p> <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="text-align: center; background-color: black; color: white;">Medication Lists</th> </tr> </thead> <tbody> <tr> <td style="padding: 2px;"><a href="#">Atorvastatin High Intensity Medications List</a></td> </tr> <tr> <td style="padding: 2px;"><a href="#">Amlodipine Atorvastatin High Intensity Medications List</a></td> </tr> <tr> <td style="padding: 2px;"><a href="#">Rosuvastatin High Intensity Medications List</a></td> </tr> <tr> <td style="padding: 2px;"><a href="#">Simvastatin High Intensity Medications List</a></td> </tr> </tbody> </table>	Medication Lists	<a href="#">Atorvastatin High Intensity Medications List</a>	<a href="#">Amlodipine Atorvastatin High Intensity Medications List</a>	<a href="#">Rosuvastatin High Intensity Medications List</a>	<a href="#">Simvastatin High Intensity Medications List</a>
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<a href="#">Simvastatin High Intensity Medications List</a>						

<b>Medication Lists</b>	
<a href="#">Ezetimibe Simvastatin High Intensity Medications List</a>	
<a href="#">Atorvastatin Moderate Intensity Medications List</a>	
<a href="#">Amlodipine Atorvastatin Moderate Intensity Medications List</a>	
<a href="#">Rosuvastatin Moderate Intensity Medications List</a>	
<a href="#">Simvastatin Moderate Intensity Medications List</a>	
<a href="#">Ezetimibe Simvastatin Moderate Intensity Medications List</a>	
<a href="#">Pravastatin Moderate Intensity Medications List</a>	
<a href="#">Lovastatin Moderate Intensity Medications List</a>	
<a href="#">Fluvastatin Moderate Intensity Medications List</a>	
<a href="#">Pitavastatin Moderate Intensity Medications List</a>	
<b>Numerator 2: Statin adherence 80%.</b> PDC of at least 80% during the treatment period. Follow the steps below to identify numerator compliance.	
<b>Step 1.</b> Identify the IPSD. Use the High- and Moderate-Intensity Statin Medications table to identify statin medication dispensing events.	
<b>Step 2.</b> Determine the treatment period. Calculate the number of days beginning on the IPSD through the last day of the measurement period.	
<b>Step 3.</b> Count the days covered by at least one prescription for any high-intensity or moderate-intensity statin medication during the treatment period. Subtract any days supply that extends beyond December 31 of the measurement period to ensure that it is not counted.	
<b>Step 4.</b> Calculate the person's PDC using the following equation. Multiply the equation by 100 and round (using the .5 rule) to the nearest whole number. $\frac{\text{Total Days Covered by a Statin Medication in the Treatment Period (step 3)}}{\text{Total Days in Treatment Period (step 2)}} \times 100$ <ul style="list-style-type: none"> <li>For example, if a person has 291 total days covered by a medication during a 365-day treatment period, this calculates to 0.7972. Multiply this number by 100, convert it to 79.72% and round it to 80%, the nearest whole number.</li> </ul> <b>Step 5.</b> Sum the number of persons whose PDC is ≥80% for the treatment period.	
<b>Summary of changes</b>	<ul style="list-style-type: none"> <li>This is the first year the measure is reported using ECDS.</li> <li>Removed the Administrative Data Collection Method.</li> <li>Removed sex-specific age bands.</li> <li>Removed the requirement to use the same data source for rate 1 and rate 2.</li> </ul>

	<ul style="list-style-type: none"> <li>Updated the initial population criteria to identify persons with ASCVD diagnosis.</li> <li>Expanded ASCVD diagnosis criteria in the initial population to allow diagnosis in the measurement period or the year prior to the measurement period.</li> <li>Removed denominator exclusion for persons enrolled in an I-SNP or LTI.</li> </ul>																					
<b>Data element tables</b>	<p>Organizations that submit HEDIS data to NCQA must provide the following data elements.</p> <p><b>Table SPC-E-1/2/3: Data Elements for Statin Therapy for Patients With Cardiovascular Disease</b></p> <table border="1"> <thead> <tr> <th>Metric</th> <th>Data Element</th> <th>Reporting Instructions</th> </tr> </thead> <tbody> <tr> <td>ReceivedTherapy</td> <td>Benefit</td> <td>Metadata</td> </tr> <tr> <td>Adherence</td> <td>InitialPopulation</td> <td>For each Metric</td> </tr> <tr> <td></td> <td>Exclusions</td> <td>Only for ReceivedTherapy Metric</td> </tr> <tr> <td></td> <td>Denominator</td> <td>For each Metric</td> </tr> <tr> <td></td> <td>Numerator</td> <td>For each Metric</td> </tr> <tr> <td></td> <td>Rate</td> <td>(Percent)</td> </tr> </tbody> </table>	Metric	Data Element	Reporting Instructions	ReceivedTherapy	Benefit	Metadata	Adherence	InitialPopulation	For each Metric		Exclusions	Only for ReceivedTherapy Metric		Denominator	For each Metric		Numerator	For each Metric		Rate	(Percent)
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<b>Rules for Allowable Adjustments</b>	<p><b>Copyright and use:</b> The “Rules for Allowable Adjustments of HEDIS” (the “Rules”) describe how NCQA’s HEDIS measure specifications can be adjusted for other populations, if applicable. The Rules, reviewed and approved by NCQA measure experts, provide for expanded use of HEDIS measures without changing their clinical intent.</p> <p><b>Adjusted HEDIS measures may not be used for HEDIS health plan reporting.</b></p> <p><b>ADJUSTMENTS ALLOWED</b></p> <ul style="list-style-type: none"> <li><b>Product lines.</b> Organizations are not required to use product line criteria; product lines may be combined, and all (or no) product line criteria may be used.</li> <li><b>Attribution.</b> Organizations are not required to use enrollment criteria.</li> <li><b>Benefits.</b> Organizations are not required to use a benefit.</li> <li><b>Other.</b> Organizations may use additional initial population criteria to focus on an area of interest defined by gender, race, ethnicity, socioeconomic or sociodemographic characteristics, geographic region or another characteristic.</li> <li><b>Measurement period adjustments.</b> Organizations may adjust the measurement period.</li> <li><b>Exclusions.</b> The hospice, deceased persons, palliative care, frailty or advanced illness exclusions are not required.</li> </ul>																					

- *Telehealth.* Services/events that allow the use of synchronous telehealth visits, telephone visits and asynchronous telehealth (e-visits, virtual check-ins) may be stratified to identify services performed via telehealth. This adjustment is not allowed for events, numerators and exclusions that do not allow the use of telehealth.
- *Supplemental data.* Supplemental data may be used to identify initial population, denominator, exclusion and numerator events.

#### **ADJUSTMENTS ALLOWED WITH LIMITS**

- *Ages.* Age determination dates may be changed (e.g., select, "age as of January 1"). The denominator age may be changed if the range is within the specified age range. The denominator age may not be expanded.

#### **ADJUSTMENTS NOT ALLOWED**

- *Initial population:* Event. Only events that contain (or map to) codes in the value sets may be used to identify discharges. Medication lists, value sets and logic may not be changed.
- *Exclusions.* The pregnancy, IVF, clomiphene, ESRD, dialysis, cirrhosis, myalgia, myositis, myopathy or rhabdomyolysis exclusions must be applied. Medication lists, value sets and logic may not be changed.
- *Numerator.* Medication lists, value sets and logic may not be changed.

## Blood Pressure Control for Patients With Diabetes (BPD-E)

Measure title	Blood Pressure Control for Patients With Diabetes		Measure ID	BPDE
Description	The percentage of persons 18–75 years of age with diabetes (type 1 or 2) whose most recent blood pressure (BP) was <140/90 mm Hg during the measurement period.			
Measurement period	January 1–December 31.			
Copyright and disclaimer notice	<p>Refer to the complete copyright and disclaimer information at the front of this publication.</p> <p>NCQA website: <a href="http://www.ncqa.org">www.ncqa.org</a>.</p> <p>Submit policy clarification support questions via My NCQA (<a href="https://my.ncqa.org">https://my.ncqa.org</a>).</p>			
Clinical recommendation statement/rationale	<p>American Diabetes Association (2025)</p> <ul style="list-style-type: none"> <li>The on-treatment target blood pressure goal is &lt;130/80 mmHg, if it can be safely attained. Level of evidence: A</li> <li>The ADA recognizes that there has been no randomized controlled trial to specifically demonstrate a decreased incidence of cardiovascular events in people with diabetes by targeting a blood pressure &lt;130/80 mmHg.</li> </ul> <p>Joslin Diabetes Center (2020)</p> <ul style="list-style-type: none"> <li>Blood pressure goal for each patient aged &gt;18 years is ≤140/90 mmHg. Grade of recommendation: 1B</li> <li>Systolic blood pressure &lt;130 mmHg may be appropriate for individuals without CVD or without multiple risk factors. Grade of recommendation: 1B</li> </ul>			
Citations	<p>American Diabetes Association Professional Practice Committee. 2025. “10. Cardiovascular Disease and Risk Management: Standards of Care in Diabetes—2025. <i>Diabetes Care</i> 48(Suppl. 1):S207–38.</p> <p>Joslin Diabetes Center. 2020. <i>Joslin Diabetes Center Clinical Guidelines for Management of Adults with Diabetes</i>. Joslin Diabetes Center. <a href="https://www.ajmc.com/view/chapter-1-clinical-guideline-for-adults-with-diabetes">https://www.ajmc.com/view/chapter-1-clinical-guideline-for-adults-with-diabetes</a></p>			
<b>Characteristics</b>				
Scoring	Proportion.			
Type	Outcome.			
Product lines	<ul style="list-style-type: none"> <li>Commercial.</li> <li>Medicaid.</li> <li>Medicare.</li> </ul>			
Stratifications	None.			
Risk adjustment	None.			

<b>Improvement notation</b> <b>Guidance</b>	<p>Increased score indicates improvement.</p> <p><b>Data collection methodology:</b> ECDS. Refer to the <a href="#">General Guideline: Data Collection Methods</a> for additional information.</p> <p><b>Date specificity:</b> Dates must be specific enough to determine the event occurred in the period being measured.</p> <p><b>Which services count?</b> When using claims, include all paid, suspended, pending and denied claims.</p>
<b>Initial population</b>	<p><b>Measure item count:</b> Person.</p> <p><b>Attribution basis:</b> Enrollment.</p> <ul style="list-style-type: none"> <li>• <b>Benefits:</b> Medical.</li> <li>• <b>Continuous enrollment:</b> The measurement period.</li> <li>• <b>Allowable gap:</b> No more than one gap of ≤45 days during the measurement period. No gaps on the last day of the measurement period.</li> </ul> <p><b>Ages:</b> 18–75 years of age as of the last day of the measurement period.</p> <p><b>Event: Identify persons with a diagnosis of diabetes.</b></p> <p>Either of the following meets criteria:</p> <ul style="list-style-type: none"> <li>• <b>Claim/encounter data.</b> At least two diagnoses of diabetes (<a href="#">Diabetes Value Set*</a>) on different dates of service during the measurement period or the year prior to the measurement period.</li> <li>• <b>Pharmacy data.</b> At least one diagnosis of diabetes (<a href="#">Diabetes Value Set*</a>) <b>and</b> at least one diabetes medication dispensing event of insulin or a hypoglycemic/antihyperglycemic medication (<a href="#">Diabetes Medications List</a>) during the measurement period or the year prior to the measurement period.</li> </ul> <p><b>Coding Guidance</b>  *Do not include laboratory claims (claims with POS code 81).</p>
<b>Denominator exclusions</b>	<p><b>Persons with a date of death.</b>  Death in the measurement period, identified using data sources determined by the organization. Method and data sources are subject to review during the HEDIS audit.</p> <p><b>Persons in hospice or using hospice services.</b>  Persons who use hospice services (<a href="#">Hospice Encounter Value Set</a>; <a href="#">Hospice Intervention Value Set</a>) or elect to use a hospice benefit any time during the measurement period. Organizations that use the Monthly Membership Detail Data File to identify these persons must use only the run date of the file.</p> <p><b>Persons receiving palliative care.</b>  Persons receiving palliative care (<a href="#">Palliative Care Assessment Value Set</a>; <a href="#">Palliative Care Encounter Value Set</a>; <a href="#">Palliative Care Intervention Value Set</a>) or who had an encounter for palliative care (ICD-10-CM code Z51.5*) any time during the measurement period.</p>

	<p><b>Medicare enrollees, 66 years of age and older by the last day of the measurement period, in an institutional SNP (I-SNP) or living long-term in an institution (LTI).</b></p> <ul style="list-style-type: none"> <li>Enrolled in an Institutional SNP (I-SNP) any time during the measurement period.</li> <li>Living long-term in an institution any time during the measurement period as identified by the LTI flag in the Monthly Membership Detail Data File. Use the run date of the file to determine if a member had an LTI flag during the measurement period.</li> </ul> <p><b>Persons 66 years of age or older by the last day of the measurement period, with both frailty and advanced illness.</b></p> <ol style="list-style-type: none"> <li><b>Frailty.</b> At least two indications of frailty (<a href="#">Frailty Device Value Set</a>; <a href="#">Frailty Diagnosis Value Set*</a>; <a href="#">Frailty Encounter Value Set</a>; <a href="#">Frailty Symptom Value Set*</a>) with different dates of service during the measurement period.</li> <li><b>Advanced Illness.</b> Either of the following during the measurement period or the year prior to the measurement period: <ul style="list-style-type: none"> <li>Advanced illness (<a href="#">Advanced Illness Value Set*</a>) on at least two different dates of service.</li> <li>Dispensed dementia medication (<a href="#">Dementia Medications List</a>).</li> </ul> </li> </ol> <p><b>Coding Guidance</b> *Do not include laboratory claims (claims with POS code 81).</p>
<b>Denominator</b>	The initial population minus denominator exclusions.
<b>Numerator</b>	<p><b>Both a systolic and diastolic reading &lt;140/90 mm Hg.</b></p> <p>Identify the most recent systolic and diastolic BP readings (<a href="#">Systolic Blood Pressure Value Set</a>; <a href="#">Diastolic Blood Pressure Value Set</a>) taken during the measurement period. Do not include CPT Category II codes (<a href="#">Systolic and Diastolic Result Value Set</a>) with a modifier (<a href="#">CPT CAT II Modifier Value Set</a>). Do not include BPs taken in an acute inpatient setting (<a href="#">Acute Inpatient Value Set</a>; <a href="#">Acute Inpatient POS Value Set</a>) or during an ED visit (<a href="#">ED Value Set</a>; POS code 23).</p> <ul style="list-style-type: none"> <li><i>Compliant:</i> BP is &lt;140/90 mm Hg.</li> <li><i>Non-compliant:</i> BP is ≥140/90 mm Hg; no BP reading during the measurement period, or if the reading is incomplete (e.g., the systolic or diastolic level is missing).</li> </ul> <p>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.</p> <p>If the most recent BP was identified based on a CPT Category II code (<a href="#">Systolic and Diastolic Result Value Set</a>), use the following to determine compliance:</p> <ul style="list-style-type: none"> <li><i>Systolic Compliant:</i> <a href="#">Systolic Less Than 140 Value Set</a>.</li> <li><i>Systolic Not Compliant:</i> CPT-CAT-II code 3077F.</li> <li><i>Diastolic Compliant:</i> <a href="#">Diastolic Less Than 90 Value Set</a>.</li> <li><i>Diastolic Not Compliant:</i> CPT-CAT-II code 3080F.</li> </ul>

<b>Summary of changes</b>	<ul style="list-style-type: none"> <li>This is the first year this measure is reported using ECDS and the measure will be in first year status for measurement year 2026.</li> </ul>																		
<b>Data element tables</b>	<p>Organizations that submit HEDIS data to NCQA must provide the following data elements.</p> <p><b>Table BPD-E-1/2/3: Data Elements for Blood Pressure Control for Patients With Diabetes</b></p> <table border="1"> <thead> <tr> <th>Metric</th> <th>Data Element</th> <th>Reporting Instructions</th> </tr> </thead> <tbody> <tr> <td>BPUnder140Over90</td> <td>InitialPopulation</td> <td>Report once</td> </tr> <tr> <td></td> <td>Exclusions</td> <td>Report once</td> </tr> <tr> <td></td> <td>Denominator</td> <td>Report once</td> </tr> <tr> <td></td> <td>Numerator</td> <td>Report once</td> </tr> <tr> <td></td> <td>Rate</td> <td>(Percent)</td> </tr> </tbody> </table>	Metric	Data Element	Reporting Instructions	BPUnder140Over90	InitialPopulation	Report once		Exclusions	Report once		Denominator	Report once		Numerator	Report once		Rate	(Percent)
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<b>Rules for Allowable Adjustments</b>	<p><b>Copyright and use:</b> The “Rules for Allowable Adjustments of HEDIS” (the “Rules”) describe how NCQA’s HEDIS measure specifications can be adjusted for other populations, if applicable. The Rules, reviewed and approved by NCQA measure experts, provide for expanded use of HEDIS measures without changing their clinical intent.</p> <p><b>Adjusted HEDIS measures may not be used for HEDIS health plan reporting.</b></p> <p><b>ADJUSTMENTS ALLOWED</b></p> <ul style="list-style-type: none"> <li><b>Product lines.</b> Organizations are not required to use product line criteria; product lines may be combined, and all (or no) product line criteria may be used.</li> <li><b>Attribution.</b> Organizations are not required to use enrollment criteria.</li> <li><b>Benefits.</b> Organizations are not required to use a benefit.</li> <li><b>Other.</b> Organizations may use additional initial population criteria to focus on an area of interest defined by gender, race, ethnicity, socioeconomic or sociodemographic characteristics, geographic region or another characteristic.</li> <li><b>Measurement period adjustments.</b> Organizations may adjust the measurement period.</li> <li><b>Exclusions.</b> The hospice, deceased persons, palliative care, I-SNP, LTI, frailty or advanced illness exclusions are not required.</li> <li><b>Telehealth.</b> Services/events that allow the use of synchronous telehealth visits, telephone visits and asynchronous telehealth (e-visits, virtual check-ins) may be stratified to identify services performed via telehealth. This adjustment is not allowed for events/diagnoses, numerators and exclusions that do not allow the use of telehealth.</li> </ul> <p><b>ADJUSTMENTS ALLOWED WITH LIMITS</b></p> <ul style="list-style-type: none"> <li><b>Ages.</b> Age determination dates may be changed (e.g., select, “age as of June 30”). Changing the denominator age range is allowed within a specified age range (ages 18–75 years). The denominator age may not be expanded.</li> </ul>																		

**ADJUSTMENTS NOT ALLOWED**

- *Initial population:* Event. Only events or diagnoses that contain (or map to) codes in the medication lists and value sets may be used to identify visits. Medication lists, value sets and logic may not be changed.
- *Numerator.* Value sets and logic may not be changed.

## ***Statin Therapy for Patients With Diabetes (SPD-E)***

Measure title	Statin Therapy for Patients With Diabetes	Measure ID	SPD-E
<b>Description</b>	<p>The percentage of persons 40–75 years of age during the measurement period with diabetes who do not have clinical atherosclerotic cardiovascular disease (ASCVD) and met the following criteria. Two rates are reported:</p> <ol style="list-style-type: none"> <li>1. <i>Received Statin Therapy.</i> Persons who were dispensed at least one statin medication of any intensity during the measurement period.</li> <li>2. <i>Statin Adherence 80%.</i> Persons who remained on a statin medication of any intensity for at least 80% of the treatment period.</li> </ol>		
<b>Measurement period</b>	January 1–December 31.		
<b>Copyright and disclaimer notice</b>	<p>Refer to the complete copyright and disclaimer information at the front of this publication.  NCQA website: <a href="http://www.ncqa.org">www.ncqa.org</a>.  Submit policy clarification support questions via My NCQA (<a href="https://my.ncqa.org">https://my.ncqa.org</a>).</p>		
<b>Clinical recommendation statement and rationale</b>	<p>American Diabetes Association (2025)</p> <ul style="list-style-type: none"> <li>• For people with diabetes aged 40–75 years without ASCVD, use moderate-intensity statin therapy in addition to lifestyle therapy. Level of evidence: A</li> <li>• For people with diabetes aged 40–75 years at higher cardiovascular risk, including those with one or more ASCVD risk factors, high-intensity statin therapy is recommended to reduce LDL cholesterol by <math>\geq 50\%</math> of baseline and to obtain an LDL cholesterol goal of <math>&lt; 70 \text{ mg/dL}</math> (<math>1.8 \text{ mmol/L}</math>). Level of evidence: A</li> <li>• For people of all ages with diabetes and ASCVD, high-intensity statin therapy should be added to lifestyle therapy. Level of evidence: A</li> </ul> <p>US Preventive Services Task Force (2022)</p> <ul style="list-style-type: none"> <li>• Adults ages 40–75 years who have 1 or more cardiovascular risk factors (i.e., dyslipidemia, diabetes, hypertension, or smoking) and an estimated 10-year cardiovascular risk of 10% or greater—Initiate a statin. Grade: B</li> </ul> <p>American College of Cardiology (2018)</p> <ul style="list-style-type: none"> <li>• In adults 40 to 75 years of age with diabetes mellitus, regardless of estimated 10-year ASCVD risk, moderate statin therapy is indicated. Class I. Level of evidence: A</li> </ul>		
<b>Citations</b>	<p>American Diabetes Association Professional Practice Committee. 2025. “11. Chronic Kidney Disease and Risk Management: Standards of Care in Diabetes—2025.” <i>Diabetes Care</i> 48(Suppl. 1):S239–51.</p> <p>Grundy, S.M., N.J. Stone, A.L. Bailey, C. Beam, K.K. Birtcher, R.S. Blumenthal, L.T. Braun, et al. 2019. “2018 AHA/ACC/AACVPR/AAPA/ABC/ACPM/ADA/AGS/APhA/ASPC/NLA/PCNA Guideline on the Management of Blood</p>		

	<p>Cholesterol." Journal of the American College of Cardiology 73 (24): e285–350. <a href="https://doi.org/10.1016/j.jacc.2018.11.003">https://doi.org/10.1016/j.jacc.2018.11.003</a></p> <p>US Preventive Services Task Force. 2022. "Statin Use for the Primary Prevention of Cardiovascular Disease in Adults: US Preventive Services Task Force Recommendation Statement." JAMA 328(8), 746–53. <a href="https://doi.org/10.1001/jama.2022.13044">https://doi.org/10.1001/jama.2022.13044</a></p> <p>American Heart Association (AHA). 2014. <i>Drug Therapy for Cholesterol</i>. <a href="http://www.heart.org/HEARTORG/Conditions/Cholesterol/PreventionTreatmentofHighCholesterol/Drug-Therapy-for-Cholesterol_UCM_305632_Article.jsp">http://www.heart.org/HEARTORG/Conditions/Cholesterol/PreventionTreatmentofHighCholesterol/Drug-Therapy-for-Cholesterol_UCM_305632_Article.jsp</a>.</p>
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<b>Characteristics</b>	
<b>Scoring</b>	Proportion.
<b>Type</b>	Process.
<b>Product lines</b>	<ul style="list-style-type: none"> <li>• Commercial.</li> <li>• Medicaid.</li> <li>• Medicare.</li> </ul>
<b>Stratifications</b>	None.
<b>Risk adjustment</b>	None.
<b>Improvement notation</b>	Increased score indicates improvement.
<b>Guidance</b>	<p><b>Data collection methodology:</b> ECDS. Refer to <a href="#">General Guideline: Data Collection Methods</a> for additional information.</p> <p><b>Date specificity:</b> Dates must be specific enough to determine the event occurred in the period being measured.</p> <p><b>Which services count?</b> When using claims, include all paid, suspended, pending and denied claims.</p> <p><b>Medication lists:</b> If an organization uses both pharmacy data (NDC codes) and clinical data (RxNorm codes) for reporting, and there are both NDC and RxNorm codes on the same date of service, use only one data source for the date of service.</p> <p><b>Other guidance:</b> All persons who are numerator compliant for Rate 1 must be used as the denominator for Rate 2.</p>
<b>Definitions</b>	
<b>Calculating number of days covered for multiple prescriptions</b>	<p>If multiple prescriptions for different medications are dispensed on the same day, calculate number of days covered by a statin medication (for the numerator) using the prescriptions with the longest days supply.</p> <p>If multiple prescriptions for different medications are dispensed on different days, with overlapping days supply, count each day within the treatment period only once toward the numerator.</p>

	<p>If multiple prescriptions for the same medication are dispensed on the same or different days, sum the days supply and use the total to calculate the number of days covered by a statin medication (for the numerator).</p> <ul style="list-style-type: none"> <li>• <i>For example</i>, if three prescriptions for the same medication are dispensed on the same day, each with a 30-days supply, sum the days supply for a total of 90 days covered by a statin. Subtract any days supply that extends beyond December 31 of the measurement period.</li> </ul> <p>Use the medication lists to determine if drugs are the same or different. <i>Drugs in different lists are considered different drugs.</i></p> <ul style="list-style-type: none"> <li>• <i>For example</i>, a dispensing event from the <u>Amlodipine Atorvastatin High Intensity Medications List</u> and a dispensing event from the <u>Amlodipine Atorvastatin Moderate Intensity Medications List</u> are dispensing events for different medications.</li> </ul>
<b>IPSD</b>	Index prescription start date. The earliest prescription dispensing date for any statin medication, of any intensity, during the measurement period.
<b>PDC</b>	Proportion of days covered. The number of days the person is covered by at least one statin medication prescription of appropriate intensity, divided by the number of days in the treatment period.
<b>Treatment period</b>	The period beginning on the PSD through the last day of the measurement period.
<b>Initial population</b>	<p><b>Measure item count:</b> Person.</p> <p><b>Attribution basis:</b> Enrollment.</p> <ul style="list-style-type: none"> <li>• <b>Benefits:</b> Medical. Pharmacy during the measurement period.</li> <li>• <b>Continuous enrollment:</b> The measurement period and the year prior to the measurement period.</li> <li>• <b>Allowable gap:</b> No more than one gap of ≤45 days during each year of continuous enrollment. No gaps on the last day of the measurement period.</li> </ul> <p><b>Ages:</b> 40–75 years of age as of last day of the measurement period.</p> <p><b>Event:</b> <b>Identify persons with a diagnosis of diabetes.</b></p> <p>Either of the following meets criteria:</p> <ul style="list-style-type: none"> <li>• <b>Claim/encounter data.</b> At least two diagnoses of diabetes (<u>Diabetes Value Set*</u>) on different dates of service during the measurement period or the year prior to the measurement period.</li> <li>• <b>Pharmacy data.</b> At least one diagnosis of diabetes (<u>Diabetes Value Set*</u>) and at least one diabetes medication dispensing event of insulin or a hypoglycemic/antihyperglycemic medication (<u>Diabetes Medications List</u>) during the measurement period or the year prior to the measurement period.</li> </ul> <p><b>Coding Guidance</b></p> <p>*Do not include laboratory claims (claims with POS code 81).</p>

<b>Denominator exclusions</b>	<p><b>Persons with a date of death.</b> Death in the measurement period, identified using data sources determined by the organization. Method and data sources are subject to review during the HEDIS audit.</p> <p><b>Persons in hospice or using hospice services.</b> Persons who use hospice services (<a href="#">Hospice Encounter Value Set</a>; <a href="#">Hospice Intervention Value Set</a>) or elect to use a hospice benefit any time during the measurement period. Organizations that use the Monthly Membership Detail Data File to identify these persons must use only the run date of the file.</p> <p><b>Persons receiving palliative care.</b> Persons receiving palliative care (<a href="#">Palliative Care Assessment Value Set</a>; <a href="#">Palliative Care Encounter Value Set</a>; <a href="#">Palliative Care Intervention Value Set</a>) or who had an encounter for palliative care (ICD-10-CM code Z51.5*) any time during the measurement period.</p> <p><b>Persons 66 years of age or older by the last day of the measurement period, with both frailty and advanced illness.</b></p> <ol style="list-style-type: none"> <li>1. <b>Frailty.</b> At least two indications of frailty (<a href="#">Frailty Device Value Set</a>; <a href="#">Frailty Diagnosis Value Set*</a>; <a href="#">Frailty Encounter Value Set</a>; <a href="#">Frailty Symptom Value Set*</a>) with different dates of service during the measurement period.</li> <li>2. <b>Advanced illness.</b> Either of the following during the measurement period or the year prior to the measurement period: <ul style="list-style-type: none"> <li>– Advanced illness (<a href="#">Advanced Illness Value Set*</a>) on at least two different dates of service.</li> <li>– Dispensed dementia medication (<a href="#">Dementia Medications List</a>).</li> </ul> </li> </ol> <p><b>In vitro fertilization, pregnancy or a prescription of clomiphene.</b> Persons who received in vitro fertilization (<a href="#">IVF Value Set</a>), had a diagnosis of (<a href="#">Pregnancy Value Set*</a>), or were dispensed at least one prescription for clomiphene (<a href="#">Estrogen Agonists Medications List</a>) during the measurement period or the year prior to the measurement period.</p> <p><b>ESRD, cirrhosis or dialysis.</b> Persons with a diagnosis of ESRD (<a href="#">ESRD Diagnosis Value Set*</a>) or cirrhosis (<a href="#">Cirrhosis Value Set*</a>), or who received dialysis (<a href="#">Dialysis Procedure Value Set</a>) during the measurement period or the year prior to the measurement period.</p> <p><b>Myalgia, myositis, myopathy or rhabdomyolysis.</b> Persons with myalgia, myositis, myopathy or rhabdomyolysis (<a href="#">Muscular Pain and Disease Value Set*</a>) during the measurement period.</p> <p><b>Myalgia or rhabdomyolysis caused by a statin.</b> Persons with myalgia or rhabdomyolysis caused by a statin (<a href="#">Muscular Reactions to Statins Value Set</a>) any time during the person's history through the last day of the measurement period.</p> <p><b>MI, CABG, PCI or other revascularization during the year prior to the measurement period.</b></p> <ul style="list-style-type: none"> <li>• Persons discharged from an inpatient setting with an MI (<a href="#">MI Value Set</a>; <a href="#">Old Myocardial Infarction Value Set</a>) on the discharge claim. To identify discharges: <ol style="list-style-type: none"> <li>1. Identify all acute and nonacute inpatient stays (<a href="#">Inpatient Stay Value Set</a>).</li> </ol> </li> </ul>
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	<p>2. Identify the discharge date for the stay.</p> <ul style="list-style-type: none"> <li>Persons with CABG (<a href="#">CABG Value Set</a>), PCI (<a href="#">PCI Value Set</a>) or other revascularization procedures (<a href="#">Other Revascularization Value Set</a>) in any setting.</li> </ul> <p><b>ASCVD during the measurement period or the year prior to the measurement period.</b></p> <p>Persons who had at least two diagnoses of ASCVD (<a href="#">Atherosclerotic Cardiovascular Disease Value Set*</a>) on different dates of service during the measurement period or the year prior to the measurement period.</p> <p><b>Coding Guidance</b></p> <p>*Do not include laboratory claims (claims with POS code 81).</p>																				
<b>Denominator</b>	<p><b>Denominator 1: Received statin therapy.</b> Initial population minus denominator exclusions.</p> <p><b>Denominator 2: Statin adherence 80%.</b> Persons who meet numerator 1 criteria.</p>																				
<b>Numerator</b>	<p><b>Numerator 1: Received statin therapy.</b> At least one dispensing event for a high-intensity, moderate-intensity or low-intensity statin medication (<a href="#">High, Moderate and Low Intensity Statin Medications List</a>) during the measurement period.</p> <p><b>High, Moderate and Low-Intensity Statin Medications</b></p> <table border="1"> <thead> <tr> <th>Medication Lists</th></tr> </thead> <tbody> <tr><td><a href="#">Atorvastatin High Intensity Medications List</a></td></tr> <tr><td><a href="#">Amlodipine Atorvastatin High Intensity Medications List</a></td></tr> <tr><td><a href="#">Rosuvastatin High Intensity Medications List</a></td></tr> <tr><td><a href="#">Simvastatin High Intensity Medications List</a></td></tr> <tr><td><a href="#">Ezetimibe Simvastatin High Intensity Medications List</a></td></tr> <tr><td><a href="#">Atorvastatin Moderate Intensity Medications List</a></td></tr> <tr><td><a href="#">Amlodipine Atorvastatin Moderate Intensity Medications List</a></td></tr> <tr><td><a href="#">Rosuvastatin Moderate Intensity Medications List</a></td></tr> <tr><td><a href="#">Simvastatin Moderate Intensity Medications List</a></td></tr> <tr><td><a href="#">Ezetimibe Simvastatin Moderate Intensity Medications List</a></td></tr> <tr><td><a href="#">Pravastatin Moderate Intensity Medications List</a></td></tr> <tr><td><a href="#">Lovastatin Moderate Intensity Medications List</a></td></tr> <tr><td><a href="#">Fluvastatin Moderate Intensity Medications List</a></td></tr> <tr><td><a href="#">Pitavastatin Moderate Intensity Medications List</a></td></tr> <tr><td><a href="#">Ezetimibe Simvastatin Low Intensity Medications List</a></td></tr> <tr><td><a href="#">Fluvastatin Low Intensity Medications List</a></td></tr> <tr><td><a href="#">Lovastatin Low Intensity Medications List</a></td></tr> <tr><td><a href="#">Pravastatin Low Intensity Medications List</a></td></tr> <tr><td><a href="#">Simvastatin Low Intensity Medications List</a></td></tr> </tbody> </table>	Medication Lists	<a href="#">Atorvastatin High Intensity Medications List</a>	<a href="#">Amlodipine Atorvastatin High Intensity Medications List</a>	<a href="#">Rosuvastatin High Intensity Medications List</a>	<a href="#">Simvastatin High Intensity Medications List</a>	<a href="#">Ezetimibe Simvastatin High Intensity Medications List</a>	<a href="#">Atorvastatin Moderate Intensity Medications List</a>	<a href="#">Amlodipine Atorvastatin Moderate Intensity Medications List</a>	<a href="#">Rosuvastatin Moderate Intensity Medications List</a>	<a href="#">Simvastatin Moderate Intensity Medications List</a>	<a href="#">Ezetimibe Simvastatin Moderate Intensity Medications List</a>	<a href="#">Pravastatin Moderate Intensity Medications List</a>	<a href="#">Lovastatin Moderate Intensity Medications List</a>	<a href="#">Fluvastatin Moderate Intensity Medications List</a>	<a href="#">Pitavastatin Moderate Intensity Medications List</a>	<a href="#">Ezetimibe Simvastatin Low Intensity Medications List</a>	<a href="#">Fluvastatin Low Intensity Medications List</a>	<a href="#">Lovastatin Low Intensity Medications List</a>	<a href="#">Pravastatin Low Intensity Medications List</a>	<a href="#">Simvastatin Low Intensity Medications List</a>
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	<p><b>Numerator 2: Statin adherence 80%.</b> PDC of at least 80% during the treatment period. Follow the steps below to identify numerator compliance.</p> <p><b>Step 1.</b> Identify the IPSD. The IPSD is the earliest dispensing event for any high-intensity, moderate-intensity or low-intensity statin medication during the measurement period. Use the medication list table in Rate 1 to identify dispensing events.</p> <p><b>Step 2.</b> To determine the treatment period, calculate the number of days beginning on the IPSD through the last day of the measurement period.</p> <p><b>Step 3.</b> Count the days covered by at least one prescription for any high-intensity, moderate-intensity or low-intensity statin medication during the treatment period. To ensure the days supply that extends beyond the measurement period is not counted, subtract any days supply that extends beyond December 31 of the measurement period.</p> <p><b>Step 4.</b> Calculate the PDC using the following equation. Multiply the equation by 100 and round (using the .5 rule) to the nearest whole number.</p> $\frac{\text{Total Days Covered by a Statin Medication in the Treatment Period (step 3)}}{\text{Total Days in Treatment Period (step 2)}}$ <ul style="list-style-type: none"> <li>• <i>For example</i>, if a person has 291 total days covered by a medication during a 365-day treatment period, this calculates to 0.7972. Multiply this number by 100, convert it to 79.72% and round it to 80%, the nearest whole number.</li> </ul> <p><b>Step 5.</b> Sum the number of persons whose PDC is ≥80% for the treatment period.</p>
<b>Summary of changes</b>	<ul style="list-style-type: none"> <li>• This is the first year this measure is reported using ECDS.</li> <li>• Removed the Administrative Data Collection Method.</li> <li>• Removed the requirement to use the same data source for rate 1 and rate 2.</li> <li>• Updated the ASCVD diagnosis criteria in the denominator exclusions to allow diagnoses to occur in the measurement period or the year prior to the measurement period.</li> <li>• Removed denominator exclusion for persons enrolled in an I-SNP or living long-term in an institution.</li> <li>• Updated the denominator exclusion to remove persons with an ASCVD diagnosis.</li> </ul>

<b>Data element tables</b>	<p>Organizations that submit HEDIS data to NCQA must provide the following data elements.</p> <p><b>Table SPD-E-1/2/3: Data Elements for Statin Therapy for Patients With Diabetes</b></p> <table border="1" data-bbox="491 333 1470 663"> <thead> <tr> <th>Metric</th><th>Data Element</th><th>Reporting Instructions</th></tr> </thead> <tbody> <tr> <td>ReceivedTherapy</td><td>Benefit</td><td>Metadata</td></tr> <tr> <td>Adherence</td><td>InitialPopulation</td><td>For each Metric</td></tr> <tr> <td></td><td>Exclusions</td><td>Only for ReceivedTherapy Metric</td></tr> <tr> <td></td><td>Denominator</td><td>For each Metric</td></tr> <tr> <td></td><td>Numerator</td><td>For each Metric</td></tr> <tr> <td></td><td>Rate</td><td>(Percent)</td></tr> </tbody> </table>	Metric	Data Element	Reporting Instructions	ReceivedTherapy	Benefit	Metadata	Adherence	InitialPopulation	For each Metric		Exclusions	Only for ReceivedTherapy Metric		Denominator	For each Metric		Numerator	For each Metric		Rate	(Percent)
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<b>Rules for Allowable Adjustments</b>	<p><b>Copyright and use:</b> The “Rules for Allowable Adjustments of HEDIS” (the “Rules”) describe how NCQA’s HEDIS measure specifications can be adjusted for other populations, if applicable. The Rules, reviewed and approved by NCQA measure experts, provide for expanded use of HEDIS measures without changing their clinical intent.</p> <p><b>Adjusted HEDIS measures may not be used for HEDIS health plan reporting.</b></p> <p><b>ADJUSTMENTS ALLOWED</b></p> <ul style="list-style-type: none"> <li>• <b>Product lines.</b> Organizations are not required to use product line criteria; product lines may be combined, and all (or no) product line criteria may be used.</li> <li>• <b>Attribution.</b> Organizations are not required to use enrollment criteria.</li> <li>• <b>Benefits.</b> Organizations are not required to use enrollment criteria.</li> <li>• <b>Other.</b> Organizations may use additional initial population criteria to focus on an area of interest defined by gender, race, ethnicity, socioeconomic or sociodemographic characteristics, geographic region or another characteristic.</li> <li>• <b>Measurement period adjustments.</b> Organizations may adjust the measurement period.</li> <li>• <b>Exclusions.</b> The hospice, deceased persons, palliative care, I-SNP, LTI, frailty or advanced illness exclusions are not required.</li> <li>• <b>Telehealth.</b> Services/events that allow the use of synchronous telehealth visits, telephone visits and asynchronous telehealth (e-visits, virtual check-ins) may be stratified to identify services performed via telehealth. This adjustment is not allowed for events, numerators and exclusions that do not allow the use of telehealth.</li> </ul> <p><b>ADJUSTMENTS ALLOWED WITH LIMITS</b></p> <ul style="list-style-type: none"> <li>• <b>Ages.</b> Age determination dates may be changed (e.g., select “age as of January 1”). The denominator age may be changed if the range is within the specified age range. The denominator age may not be expanded.</li> </ul>																					

	<b>ADJUSTMENTS NOT ALLOWED</b>
	<ul style="list-style-type: none"><li>• <i>Initial population.</i> Event. Only events or diagnoses that contain (or map to) codes in the medication lists and value sets may be used to identify visits. Medication lists, value sets and logic may not be changed.</li><li>• <i>Exclusions.</i> The MI, CABG, PCR, other revascularization, IVD, pregnancy, IVF, clomiphene, ESRD, dialysis, cirrhosis, myalgia, myositis, myopathy and rhabdomyolysis exclusions must be applied. Value sets and logic may not be changed.</li><li>• <i>Numerator.</i> Medication lists, value sets and logic may not be changed.</li></ul>

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

<b>Measure title</b>	Follow-Up Care for Children Prescribed ADHD Medication	<b>Measure ID</b>	ADD-E
<b>Description</b>	<p>The percentage of persons newly prescribed attention-deficit/hyperactivity disorder (ADHD) medication who had at least three follow-up care visits within a 300-day (10 month) period, one of which was within 30 days of when the first ADHD medication was dispensed. Two rates are reported:</p> <ul style="list-style-type: none"> <li>• <i>Initiation Phase.</i> The percentage of persons 6–12 years of age with a prescription dispensed for ADHD medication who had one follow-up visit with a practitioner with prescribing authority during the 30-day initiation phase.</li> <li>• <i>Continuation and Maintenance (C&amp;M) Phase.</i> The percentage of persons 6–12 years of age with a prescription dispensed for ADHD medication, who remained on the medication for at least 210 days and who, in addition to the visit in the initiation phase, had at least two follow-up visits with a practitioner within 270 days (9 months) after the initiation phase ended.</li> </ul>		
<b>Measurement period</b>	January 1–December 31.		
<b>Copyright and disclaimer notice</b>	<p>Refer to the complete copyright and disclaimer information at the front of this publication.</p> <p>NCQA website: <a href="http://www.ncqa.org">www.ncqa.org</a>.</p> <p>Submit policy clarification support questions via My NCQA (<a href="https://my.ncqa.org">https://my.ncqa.org</a>).</p>		
<b>Clinical recommendation statement/ rationale</b>	<p>American Academy of Child and Adolescent Psychiatry (AACAP) Practice Parameter for the Assessment and Treatment of Children and Adolescents with ADHD</p> <ul style="list-style-type: none"> <li>• <i>Recommendation 6:</i> A well-thought-out and comprehensive treatment plan should be developed for the patient with ADHD. The treatment plan should be reviewed regularly and modified if the patient's symptoms do not respond. Minimal Standard [MS]</li> <li>• <i>Recommendation 9:</i> During a psychopharmacological intervention for ADHD, the patient should be monitored for treatment-emergent side effects. Minimal Standard [MS]</li> <li>• <i>Recommendation 12:</i> Patients should be assessed periodically to determine whether there is continued need for treatment or if symptoms have remitted. Treatment of ADHD should continue as long as symptoms remain present and cause impairment. Minimal Standard [MS]</li> </ul>		

	<p>American Academy of Pediatrics Clinical Practice Guideline for the Diagnosis, Evaluation and Treatment of ADHD in Children and Adolescents</p> <ul style="list-style-type: none"> <li>• <b>Action Statement 4:</b> The primary care clinician should recognize ADHD as a chronic condition and, therefore, consider children and adolescents with ADHD as children and youth with special health care needs. Management of children and youth with special health care needs should follow the principles of the chronic care model and the medical home (Grade B: Strong Recommendation).</li> </ul>
<b>Citations</b>	<p>American Academy of Child and Adolescent Psychiatry (AACAP). 2007. "Practice Parameter for the Assessment and Treatment of Children and Adolescents with ADHD." <i>J. Am. Acad. Child Adolesc. Psychiatry</i> 46(7): 894Y921.</p> <p>American Academy of Pediatrics. November 2011. "ADHD: Clinical Practice Guideline for the Diagnosis, Evaluation, and Treatment of Attention-Deficit/Hyperactivity Disorder in Children and Adolescents." Subcommittee on Attention-Deficit/Hyperactivity Disorder, Steering Committee on Quality Improvement and Management. <i>Pediatrics</i> 128 (5) 1007–22. doi: 10.1542/peds.2011-2654</p>
<b>Characteristics</b>	
<b>Scoring</b>	Proportion.
<b>Type</b>	Process.
<b>Product lines</b>	<ul style="list-style-type: none"> <li>• Commercial.</li> <li>• Medicaid.</li> </ul>
<b>Stratifications</b>	None.
<b>Risk adjustment</b>	None.
<b>Improvement notation</b>	Increased score indicates improvement.
<b>Guidance</b>	<p><b>Data collection methodology:</b> ECDS. Refer to <a href="#">General Guideline: Data Collection Methods</a> for additional information.</p> <p><b>Date specificity:</b> Dates must be specific enough to determine that the event occurred in the period being measured.</p> <p><b>Which services count?</b> When using claims, include all paid, suspended, pending and denied claims.</p> <p><b>Medication lists:</b> If an organization uses both pharmacy data (NDC codes) and clinical data (RxNorm codes) for reporting, and there are both NDC and RxNorm codes on the same date of service, use only one data source for the date of service.</p> <p><b>Other guidance:</b> Persons who switch product lines or products between rate 1 and rate 2 enrollment periods are only included in rate 1. However, if an organization reports products combined, then a member who switches between</p>

	<p>those products (e.g., the products included in the HEDIS reporting entity) is included in both rates.</p> <ul style="list-style-type: none"> <li>• <i>For example</i>, if an organization reports HMO and POS products combined and a person switches from HMO to POS between rate 1 and rate 2 enrollment periods, the person is included in both rate 1 and rate 2.</li> </ul>
<b>Definitions</b>	
<b>C&amp;M phase</b>	The 300 days following the IPSD.
<b>Continuous medication treatment</b>	<p>There must be ≥210 treatment days during the 301-day period, with allowed gaps in medication of up to a total of 91 days.</p> <p>Gaps may include either washout period gaps to change medication or treatment gaps to refill the same medication.</p> <p>Regardless of the number of gaps, there may not be more than 91 total gap days. Count any combination of gaps (e.g., one washout gap of 14 days and numerous weekend drug holidays).</p>
<b>Identifying same or different drugs</b>	<p>Dispensing events from different medication value sets are considered different drugs; dispensing events from the same medication value set are considered the same drug. Use all of the medication lists below to identify ADHD dispensing events.</p> <ul style="list-style-type: none"> <li>• <a href="#">Dexmethylphenidate Medications List</a>.</li> <li>• <a href="#">Dextroamphetamine Medications List</a>.</li> <li>• <a href="#">Lisdexamfetamine Medications List</a>.</li> <li>• <a href="#">Methylphenidate Medications List</a>.</li> <li>• <a href="#">Methamphetamine Medications List</a>.</li> <li>• <a href="#">Clonidine Medications List</a>.</li> <li>• <a href="#">Guanfacine Medications List</a>.</li> <li>• <a href="#">Atomoxetine Medications List</a>.</li> <li>• <a href="#">Viloxazine Medications List</a>.</li> </ul>
<b>Initiation phase</b>	The 30 days following the IPSD.
<b>Intake period</b>	March 1 of the year prior to the measurement period through the last calendar day of February of the measurement period.
<b>IPSD</b>	Index prescription start date. The earliest prescription dispensing date for an ADHD medication where the date is in the intake period and there is a negative medication history.
<b>Negative medication history</b>	A period of 120 days prior to the IPSD when the person had no ADHD medications dispensed for either new or refill prescriptions.
<b>Treatment days (covered days)</b>	<p>The actual number of calendar days covered by prescriptions during the 301-day period.</p> <p>Use the following steps to identify and calculate covered days.</p>

	<p><b>Step 1.</b> Identify dispensing events where multiple prescriptions for the same medication are dispensed with overlapping days supply (i.e., dispensed on the same day or dispensed on different days with overlapping days supply). Sum the days supply for these dispensing events.</p> <p>Identify the start and end dates. The start date is the date of service of the earliest dispensing event, and the end date is the start date plus the summed days supply minus 1. The start date through the end date are considered covered days.</p> <ul style="list-style-type: none"> <li>• <i>For example:</i> <ul style="list-style-type: none"> <li>– If there are three 7 days supply dispensing events for the same medication on January 1, the start date is January 1 and the end date is January 21. Covered days include January 1–21.</li> <li>– If there are two 7 days supply dispensing events for the same medication on January 1 and January 5, the start date is January 1 and the end date is January 14. Covered days include January 1–14.</li> <li>– If there are three 7 days supply dispensing events for the same medication on January 1, a 7 days supply dispensing event on January 20 and a 7 days supply dispensing event on January 28, the start date is January 1 and the end date is February 4. Covered days include January 1–February 4.</li> </ul> </li> </ul> <p><i>Note: This step assumes that the person will take one prescription at a time (and start taking the next prescription after exhausting the previous prescription).</i></p> <p><b>Step 2.</b> For all other dispensing events (multiple prescriptions for the same medication on different days without overlap; multiple prescriptions for different medications on the same or different days, with or without overlap), identify the start and end dates for each dispensing event individually. The start date through the end date are considered covered days.</p> <p><i>Note: This step assumes the person will take the different medications concurrently.</i></p> <p><b>Step 3.</b> Count the covered days. Consider each calendar day covered by one or more medications to be 1 covered day.</p>
<b>Initial population</b>	<p><i>Measure item count:</i> Person.</p> <p><i>Attribution basis:</i> Enrollment.</p> <ul style="list-style-type: none"> <li>• <i>Benefits:</i> Medical and pharmacy.</li> <li>• <i>Continuous enrollment:</i> <ul style="list-style-type: none"> <li>– <i>Initial population 1:</i> 120 days prior to the IPSD through 30 days after the IPSD.</li> <li>– <i>Initial population 2:</i> 120 days prior to the IPSD through 300 days after the IPSD.</li> </ul> </li> <li>• <i>Allowable gap:</i> <ul style="list-style-type: none"> <li>– <i>Initial population 1:</i> None.</li> <li>– <i>Initial population 2:</i> No more than one gap of ≤45 days between 31 days after the IPSD through 300 days after the IPSD.</li> </ul> </li> </ul>

	<p><b>Ages:</b> 6 years of age as of March 1 of the year prior to the measurement period to 12 years as of the last calendar day of February of the measurement period.</p> <p><b>Event: Persons newly prescribed ADHD medication.</b></p> <p>Refer to additional initial population criteria for each rate.</p> <p><b>Additional Initial Population Criteria:</b></p> <p><b>Initial population 1: Initiation Phase.</b></p> <p><b>Step 1.</b> Identify all persons in the specified age range who were dispensed an ADHD medication (<a href="#">ADHD Medications List</a>) during the 12-month intake period.</p> <p><b>Step 2.</b> For each person identified in step 1, identify the IPSD.</p> <p><b>Step 3.</b> Calculate continuous enrollment.. The person must be enrolled throughout 120 days prior to the IPSD through 30 days after the IPSD..</p> <p><b>Step 4.</b> Remove persons who had an acute inpatient encounter for a mental, behavioral or neurodevelopmental disorder during the initiation phase. Either of the following meets criteria:</p> <ul style="list-style-type: none"> <li>• Acute inpatient encounter (<a href="#">Acute Inpatient Value Set</a>) <b>with</b> a principal diagnosis of mental, behavioral or neurodevelopmental disorder (<a href="#">Mental, Behavioral and Neurodevelopmental Disorders Value Set</a>).</li> <li>• Acute inpatient admission <b>with</b> a principal diagnosis of mental, behavioral or neurodevelopmental disorder (<a href="#">Mental, Behavioral and Neurodevelopmental Disorders Value Set</a>) on the discharge claim. To identify an acute inpatient admission:           <ol style="list-style-type: none"> <li>1. Identify all acute and nonacute inpatient stays (<a href="#">Inpatient Stay Value Set</a>).</li> <li>2. Exclude nonacute inpatient stays (<a href="#">Nonacute Inpatient Stay Value Set</a>).</li> <li>3. Identify the admission date for the stay.</li> </ol> </li> </ul> <p><b>Initial population 2: C&amp;M Phase.</b></p> <p><b>Step 1.</b> Identify all persons from initial population 1.</p> <p><b>Step 2.</b> Calculate continuous enrollment. The person must be enrolled throughout the 120 days prior to the IPSD through 300 days after the IPSD..</p> <p><b>Step 3.</b> Calculate treatment days (covered days) to determine continuous medication treatment. Using the persons in step 2, determine if the person was dispensed a sufficient number of prescriptions to provide continuous medication treatment beginning on the IPSD through 300 days after the IPSD. The definition of “continuous medication treatment” allows gaps in medication treatment, up to a total of 91 days during the 301-day period.</p> <p><b>Step 4.</b> Remove persons who had an acute inpatient encounter for a mental, behavioral or neurodevelopmental disorder during the C&amp;M phase. Either of the following meets criteria:</p> <ul style="list-style-type: none"> <li>• Acute inpatient encounter (<a href="#">Acute Inpatient Value Set</a>) with a principal diagnosis of mental, behavioral or neurodevelopmental disorder (<a href="#">Mental, Behavioral and Neurodevelopmental Disorders Value Set</a>).</li> </ul>
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	<ul style="list-style-type: none"> <li>• Acute inpatient admission with a principal diagnosis of mental, behavioral or neurodevelopmental disorder (<a href="#">Mental, Behavioral and Neurodevelopmental Disorders Value Set</a>) on the discharge claim. To identify an acute inpatient admission:           <ol style="list-style-type: none"> <li>1. Identify all acute and nonacute inpatient stays (<a href="#">Inpatient Stay Value Set</a>).</li> <li>2. Exclude nonacute inpatient stays (<a href="#">Nonacute Inpatient Stay Value Set</a>).</li> <li>3. Identify the admission date for the stay.</li> </ol> </li> </ul>
<b>Denominator exclusions</b>	<p><b>Persons with a date of death.</b> Death in the measurement period, identified using data sources determined by the organization. Method and data sources are subject to review during the HEDIS audit.</p> <p><b>Persons in hospice or using hospice services.</b> Persons who use hospice services (<a href="#">Hospice Encounter Value Set</a>; <a href="#">Hospice Intervention Value Set</a>) or elect to use a hospice benefit any time during the measurement period. Organizations that use the Monthly Membership Detail Data File to identify these persons must use only the run date of the file.</p> <p><b>Persons with a diagnosis of narcolepsy.</b> Diagnosis of narcolepsy (<a href="#">Narcolepsy Value Set</a>*) any time during the person's history through the last day of the measurement period.</p> <p><b>Coding Guidance</b> *Do not include laboratory claims (claims with POS code 81).</p>
<b>Denominator</b>	<p><b>Denominator 1:</b> The initial population and additional initial population 1 criteria minus denominator exclusions.</p> <p><b>Denominator 2:</b> The initial population and additional initial population 2 criteria minus denominator exclusions.</p>
<b>Numerator</b>	<p><b>Numerator 1: Initiation phase.</b> Persons who had a follow-up visit with a practitioner with prescribing authority within 30 days after the IPSD. Do not include visits on the IPSD.</p> <p>Any of the following code combinations meet criteria for a visit; the visit must be with a provider with prescribing authority.</p> <ul style="list-style-type: none"> <li>• An outpatient visit (<a href="#">Visit Setting Unspecified Value Set with Outpatient POS Value Set</a>).</li> <li>• An outpatient visit (<a href="#">BH Outpatient Value Set</a>).</li> <li>• A health and behavior assessment or intervention (<a href="#">Health and Behavior Assessment or Intervention Value Set</a>).</li> <li>• An intensive outpatient encounter or partial hospitalization (<a href="#">Visit Setting Unspecified Value Set with POS code 52</a>).</li> <li>• An intensive outpatient encounter or partial hospitalization (<a href="#">Partial Hospitalization or Intensive Outpatient Value Set</a>).</li> <li>• A community mental health center visit (<a href="#">Visit Setting Unspecified Value Set with POS Code 53</a>).</li> </ul>

	<ul style="list-style-type: none"> <li>• A telehealth visit (<u>Visit Setting Unspecified Value Set with Telehealth POS Value Set</u>).</li> <li>• A telephone visit (<u>Telephone Visits Value Set</u>).</li> </ul> <p><b>Numerator 2: C&amp;M phase.</b> Persons numerator who meet the following:</p> <ul style="list-style-type: none"> <li>• Numerator compliant for Rate 1—Initiation Phase, <b>and</b></li> <li>• At least two follow-up visits on different dates of service with any provider, from 31–300 days after the IPSD.</li> </ul> <p>Any of the following code combinations meet criteria for follow-up visits:</p> <ul style="list-style-type: none"> <li>• An outpatient visit (<u>Visit Setting Unspecified Value Set with Outpatient POS Value Set</u>).</li> <li>• An outpatient visit (<u>BH Outpatient Value Set</u>).</li> <li>• A health and behavior assessment or intervention (<u>Health and Behavior Assessment or Intervention Value Set</u>).</li> <li>• An intensive outpatient encounter or partial hospitalization (<u>Visit Setting Unspecified Value Set with POS code 52</u>).</li> <li>• An intensive outpatient encounter or partial hospitalization (<u>Partial Hospitalization or Intensive Outpatient Value Set</u>).</li> <li>• A community mental health center visit (<u>Visit Setting Unspecified Value Set with POS Code 53</u>).</li> <li>• A telehealth visit (<u>Visit Setting Unspecified Value Set with Telehealth POS Value Set</u>).</li> <li>• A telephone visit (<u>Telephone Visits Value Set</u>).</li> <li>• An e-visit or virtual check-in (<u>Online Assessments Value Set</u>). <ul style="list-style-type: none"> <li>– Only one of the two visits (during the 31–300 days after the IPSD) may be an e-visit or virtual check-in (<u>Online Assessments Value Set</u>).</li> </ul> </li> </ul>																					
<b>Summary of changes</b>	<ul style="list-style-type: none"> <li>• Removed the definitions of “participation” and “participation period.”</li> <li>• Removed the SSoR data elements from the data element tables.</li> </ul>																					
<b>Data element tables</b>	<p>Organizations that submit HEDIS data to NCQA must provide the following data elements.</p> <p><b>Table ADD-E-1/2: Data Elements for Follow-Up Care for Children Prescribed ADHD Medication Dispensed</b></p> <table border="1"> <thead> <tr> <th>Metric</th> <th>Data Element</th> <th>Reporting Instructions</th> </tr> </thead> <tbody> <tr> <td>Initiation</td> <td>Benefit</td> <td>Metadata</td> </tr> <tr> <td>Continuation</td> <td>InitialPopulation</td> <td>For each Metric</td> </tr> <tr> <td></td> <td>Exclusions</td> <td>For each Metric</td> </tr> <tr> <td></td> <td>Denominator</td> <td>For each Metric</td> </tr> <tr> <td></td> <td>Numerator</td> <td>For each Metric</td> </tr> <tr> <td></td> <td>Rate</td> <td>(Percent)</td> </tr> </tbody> </table>	Metric	Data Element	Reporting Instructions	Initiation	Benefit	Metadata	Continuation	InitialPopulation	For each Metric		Exclusions	For each Metric		Denominator	For each Metric		Numerator	For each Metric		Rate	(Percent)
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**Rules for Allowable Adjustments**

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

**ADJUSTMENTS ALLOWED**

- *Product lines.* Organizations are not required to use product line criteria; product lines may be combined, and all (or no) product line criteria may be used.
- *Ages.* The denominator age range may be expanded. The age determination dates may be changed (e.g., select, “age as of June 30”).
- *Attribution.* Organizations are not required to use enrollment criteria.
- *Benefits.* Organizations are not required to use a benefit.
- *Other.* Organizations may use additional initial population criteria to focus on an area of interest defined by gender, race, ethnicity, socioeconomic or sociodemographic characteristics, geographic region or another characteristic.
- *Measurement period adjustments.* Organizations may adjust the measurement period.
- *Exclusions.* Hospice and deceased person exclusions are not required.
- *Telehealth.* Services/events that allow the use of synchronous telehealth visits, telephone visits and asynchronous telehealth (e-visits, virtual check-ins) may be stratified to identify services performed via telehealth. This adjustment is not allowed for events, numerators and exclusions that do not allow the use of telehealth.

**ADJUSTMENTS NOT ALLOWED**

- *Initial population:* Event. Medication lists, value sets and logic may not be changed.
- *Exclusions.* The narcolepsy exclusion must be applied. The value sets and logic may not be changed.
- *Numerator.* Value sets, direct reference codes and logic may not be changed.

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

<b>Measure title</b>	Metabolic Monitoring for Children and Adolescents on Antipsychotics*	<b>Measure ID</b>	APM-E
<b>Description</b>	<p>The percentage of persons 1–17 years of age who had two or more antipsychotic prescriptions and had metabolic testing. Three rates are reported:</p> <ul style="list-style-type: none"> <li>• The percentage of persons on antipsychotics who received blood glucose testing.</li> <li>• The percentage of persons on antipsychotics who received cholesterol testing.</li> <li>• The percentage of persons on antipsychotics who received blood glucose and cholesterol testing.</li> </ul>		
<b>Measurement period</b>	January 1–December 31.		
<b>Copyright and disclaimer notice</b>	<p><i>*Developed with financial support from the Agency for Healthcare Research and Quality (AHRQ) and the Centers for Medicare &amp; Medicaid Services (CMS) under the CHIPRA Pediatric Quality Measures Program Centers of Excellence grant number U18 HS020503.</i></p> <p>Refer to the complete copyright and disclaimer information at the front of this publication.</p> <p>NCQA website: <a href="http://www.ncqa.org">www.ncqa.org</a>.</p> <p>Submit policy clarification support questions via My NCQA (<a href="https://my.ncqa.org">https://my.ncqa.org</a>).</p>		
<b>Clinical recommendation statement/ rationale</b>	<p>The American Academy of Child &amp; Adolescent Psychiatry (AACAP) practice parameters endorse the American Psychiatric Association and American Diabetes Association recommendations for laboratory monitoring, including a fasting glucose and fasting lipid profile at baseline, 3 and 12 months.</p> <p>The Canadian Alliance for Monitoring Effectiveness and Safety of Antipsychotics in Children calls for more frequent monitoring in youth at baseline, 3, 6 and 12 months, and additional monitoring of fasting insulin.</p>		
<b>Citations</b>	<p>Findling, R.L., S.S. Drury, P.S. Jensen, J.L. Rapoport, O.G. Bukstein, H.J. Walter, S. Benson, et al. 2011. "Practice Parameter for the Use of Atypical Antipsychotic Medications in Children and Adolescents." <i>J Am Acad Child Adolesc Psychiatry</i>.</p> <p>Pringsheim, T., C. Panagiotopoulos, J. Davidson, J. Ho, and Canadian Alliance for Monitoring Effectiveness and Safety of Antipsychotics in Children (CAMESA) guideline group. 2011. "Evidence-Based Recommendations for Monitoring Safety of Second-Generation Antipsychotics in Children and Youth." <i>Paediatrics &amp; Child Health</i> 16, no. 9: 581–9.</p>		

Characteristics	
<b>Scoring</b>	Proportion.
<b>Type</b>	Process.
<b>Product lines</b>	<ul style="list-style-type: none"> <li>• Commercial.</li> <li>• Medicaid.</li> </ul>
<b>Stratifications</b>	<p>Age as of the last day of the measurement period.</p> <ul style="list-style-type: none"> <li>• 1–11 years.</li> <li>• 12–17 years.</li> </ul>
<b>Risk adjustment</b>	None.
<b>Improvement notation</b>	Increased score indicates improvement.
<b>Guidance</b>	<p><b>Data collection methodology:</b> ECDS. Refer to <a href="#">General Guideline: Data Collection Methods</a> for additional information.</p> <p><b>Date specificity:</b> Dates must be specific enough to determine the event occurred in the period being measured.</p> <p><b>Which services count?</b> When using claims, include all paid, suspended, pending and denied claims.</p> <p><b>Medication lists:</b> If an organization uses both pharmacy data (NDC codes) and clinical data (RxNorm codes) for reporting, and there are both NDC and RxNorm codes on the same date of service, use only one data source for the date of service.</p>
<b>Initial population</b>	<p>Measure item count: Person.</p> <p>Attribution: Enrollment.</p> <ul style="list-style-type: none"> <li>• <b>Benefits:</b> Medical and pharmacy.</li> <li>• <b>Continuous enrollment:</b> The measurement period.</li> <li>• <b>Allowable gap:</b> No more than one gap of ≤45 days during the measurement period. No gaps on the last day of the measurement period.</li> </ul> <p><b>Ages:</b> 1–17 years of age as of the last day of the measurement period.</p> <p><b>Event: Persons dispensed antipsychotic medications.</b></p> <p>Persons with at least two antipsychotic medication dispensing events (<a href="#">APM Antipsychotic Medications List</a>) of the same or different medications on different dates of service during the measurement period.</p>
<b>Denominator exclusions</b>	<p><b>Persons with a date of death.</b></p> <p>Death in the measurement period, identified using data sources determined by the organization. Method and data sources are subject to review during the HEDIS audit.</p>

	<p><b>Persons in hospice or using hospice services.</b> Persons who use hospice services (<u>Hospice Encounter Value Set</u>; <u>Hospice Intervention Value Set</u>) or elect to use a hospice benefit any time during the measurement period. Organizations that use the Monthly Membership Detail Data File to identify these persons must use only the run date of the file.</p>																												
<b>Denominator</b>	The initial population minus denominator exclusions.																												
<b>Numerator</b>	<p><b>Numerator 1: Blood glucose.</b> Persons who received at least one test for blood glucose or HbA1c (<u>Glucose Lab Test Value Set</u>, <u>Glucose Test Result or Finding Value Set</u>, <u>HbA1c Lab Test Value Set</u>, <u>HbA1c Test Result or Finding Value Set*</u>†) during the measurement period.</p> <p><b>Numerator 2: Cholesterol.</b> Persons who received at least one test for LDL-C or cholesterol (<u>Cholesterol Lab Test Value Set</u>, <u>Cholesterol Test Result or Finding Value Set</u>, <u>LDL C Lab Test Value Set</u>, <u>LDL C Test Result or Finding Value Set*</u>†) during the measurement period.</p> <p><b>Numerator 3: Blood glucose and cholesterol.</b> Persons who were compliant for both numerators 1 and 2.</p> <p><b>Coding Guidance</b></p> <p>*Do not include laboratory claims (claims with POS code 81).</p> <p>†Do not include codes with a modifier (<u>CPT CAT II Modifier Value Set</u>).</p>																												
<b>Summary of changes</b>	<ul style="list-style-type: none"> <li>Removed the definitions of “participation” and “participation period.”</li> <li>Removed the SSoR data elements from the data element tables.</li> </ul>																												
<b>Data element tables</b>	<p>Organizations that submit HEDIS data to NCQA must provide the following data elements.</p> <p><b>Table APM-E-1/2: Data Elements for Metabolic Monitoring for Children and Adolescents on Antipsychotics</b></p> <table border="1"> <thead> <tr> <th>Metric</th> <th>Age</th> <th>Data Element</th> <th>Reporting Instructions</th> </tr> </thead> <tbody> <tr> <td>BloodGlucoseTesting</td> <td>1-11</td> <td>Benefit</td> <td>Metadata</td> </tr> <tr> <td>CholesterolTesting</td> <td>12-17</td> <td>InitialPopulation</td> <td>For each Stratification, repeat per Metric</td> </tr> <tr> <td>BloodGlucoseCholesterolTesting</td> <td>Total</td> <td>Exclusions</td> <td>For each Stratification, repeat per Metric</td> </tr> <tr> <td></td> <td></td> <td>Denominator</td> <td>For each Stratification, repeat per Metric</td> </tr> <tr> <td></td> <td></td> <td>Numerator</td> <td>For each Metric and Stratification</td> </tr> <tr> <td></td> <td></td> <td>Rate</td> <td>(Percent)</td> </tr> </tbody> </table>	Metric	Age	Data Element	Reporting Instructions	BloodGlucoseTesting	1-11	Benefit	Metadata	CholesterolTesting	12-17	InitialPopulation	For each Stratification, repeat per Metric	BloodGlucoseCholesterolTesting	Total	Exclusions	For each Stratification, repeat per Metric			Denominator	For each Stratification, repeat per Metric			Numerator	For each Metric and Stratification			Rate	(Percent)
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**ADJUSTMENTS ALLOWED**

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- *Attribution.* Organizations are not required to use enrollment criteria.
- *Benefits.* Organizations are not required to use a benefit.
- *Other.* Organizations may use additional initial population criteria to focus on an area of interest defined by gender, race, ethnicity, socioeconomic or sociodemographic characteristics, geographic region or another characteristic.
- *Measurement period adjustments.* Organizations may adjust the measurement period.
- *Exclusions.* The hospice and deceased person exclusions are not required.
- *Telehealth.* Services/events that allow the use of synchronous telehealth visits, telephone visits and asynchronous telehealth (e-visits, virtual check-ins) may be stratified to identify services performed via telehealth. This adjustment is not allowed for events, numerators and exclusions that do not allow the use of telehealth.

**ADJUSTMENTS ALLOWED WITH LIMITS**

- *Ages.* The upper age range may be expanded or no upper age limit may be used. The age determination dates may be changed (e.g., select “age as of June 30”). Changing the denominator age range is allowed within a specified age range (ages 1–17+ years).

**ADJUSTMENTS NOT ALLOWED**

- *Initial population:* Event. Medication lists, value sets and logic may not be changed.
- *Numerator.* Value sets, direct reference codes and logic may not be changed.

## **Depression Screening and Follow-Up for Adolescents and Adults (DSF-E)**

<b>Measure title</b>	Depression Screening and Follow-Up for Adolescents and Adults*	<b>Measure ID</b>	DSF-E
<b>Description</b>	<p>The percentage of persons 12 years of age and older who were screened for clinical depression using a standardized instrument and, if screened positive, received follow-up care.</p> <ul style="list-style-type: none"> <li>• <i>Depression Screening.</i> The percentage of persons who were screened for clinical depression using a standardized instrument.</li> <li>• <i>Follow-Up on Positive Screen.</i> The percentage of persons who received follow-up care within 30 days of a positive depression screen finding.</li> </ul>		
<b>Measurement period</b>	January 1–December 31.		
<b>Copyright and disclaimer notice</b>	<p>*Adapted with financial support from the Centers for Medicare &amp; Medicaid Services (CMS).</p> <p>Refer to the complete copyright and disclaimer information at the front of this publication.</p> <p>NCQA website: <a href="http://www.ncqa.org">www.ncqa.org</a>.</p> <p>Submit policy clarification support questions via My NCQA (<a href="https://my.ncqa.org">https://my.ncqa.org</a>).</p>		
<b>Clinical recommendation statement/ rationale</b>	<p>The U.S. Preventive Services Task Force (USPSTF) recommends screening for depression among adolescents 12–18 years and the general adult population, including pregnant and postpartum women. (B recommendation)</p> <p>The USPSTF also recommends that screening be implemented with adequate systems in place to ensure accurate diagnosis, effective treatment and appropriate follow-up. (B recommendation)</p>		
<b>Citations</b>	<p>US Preventive Services Task Force et al. 2023. “Screening for Depression and Suicide Risk in Adults: US Preventive Services Task Force Recommendation Statement.” <i>JAMA</i> vol. 329,23: 2057–67.</p> <p>US Preventive Services Task Force et al. 2022. “Screening for Depression and Suicide Risk in Children and Adolescents: US Preventive Services Task Force Recommendation Statement.” <i>JAMA</i> vol. 328,15: 1534–42.</p>		
<b>Characteristics</b>			
<b>Scoring Type</b>	<p>Proportion.</p> <p>Process.</p>		

<b>Product lines</b>	<ul style="list-style-type: none"> <li>Commercial.</li> <li>Medicaid.</li> <li>Medicare.</li> </ul>																		
<b>Stratifications</b>	<p>Age as of the start of the measurement period.</p> <ul style="list-style-type: none"> <li>12–17 years (commercial and Medicaid only).</li> <li>18–64 years.</li> <li>65 years and older.</li> </ul>																		
<b>Risk adjustment</b>	None.																		
<b>Improvement notation</b>	Increased score indicates improvement.																		
<b>Guidance</b>	<p><b>Data collection methodology:</b> ECDS. Refer to <a href="#">General Guideline: Data Collection Methods</a> for additional information.</p> <p><b>Date specificity:</b> Dates must be specific enough to determine that the event occurred in the period being measured.</p> <p><b>Which services count?</b> When using claims, include all paid, suspended, pending and denied claims.</p> <p><b>Other guidance:</b></p> <ul style="list-style-type: none"> <li>Use the person's age to select an age-appropriate depression screening instrument.</li> <li>Depression screening captured in health risk assessments or other types of health assessments are allowed if the questions align with a specific instrument that is validated for depression screening. <ul style="list-style-type: none"> <li><i>For example</i>, a health risk assessment that includes questions from the PHQ-2 counts as screening if the questions are answered and a total score is calculated.</li> </ul> </li> </ul>																		
<b>Definitions</b>																			
<b>Depression screening instrument</b>	<p>A standard assessment instrument normalized and validated for the appropriate patient population. Eligible screening instruments with thresholds for positive findings include:</p> <table border="1"> <thead> <tr> <th>Instruments for Adolescents (≤17 Years)</th> <th>Total Score LOINC Codes</th> <th>Positive Finding</th> </tr> </thead> <tbody> <tr> <td>Patient Health Questionnaire (PHQ-9)<sup>®</sup></td> <td>44261-6</td> <td>Total score ≥10</td> </tr> <tr> <td>Patient Health Questionnaire Modified for Teens (PHQ-9M)<sup>®</sup></td> <td>89204-2</td> <td>Total score ≥10</td> </tr> <tr> <td>Patient Health Questionnaire-2 (PHQ-2)<sup>®1</sup></td> <td>55758-7</td> <td>Total score ≥3</td> </tr> <tr> <td>Beck Depression Inventory-Fast Screen (BDI-FS)<sup>®1,2</sup></td> <td>89208-3</td> <td>Total score ≥8</td> </tr> <tr> <td>Center for Epidemiologic Studies Depression Scale—Revised (CESD-R)</td> <td>89205-9</td> <td>Total score ≥17</td> </tr> </tbody> </table>	Instruments for Adolescents (≤17 Years)	Total Score LOINC Codes	Positive Finding	Patient Health Questionnaire (PHQ-9) <sup>®</sup>	44261-6	Total score ≥10	Patient Health Questionnaire Modified for Teens (PHQ-9M) <sup>®</sup>	89204-2	Total score ≥10	Patient Health Questionnaire-2 (PHQ-2) <sup>®1</sup>	55758-7	Total score ≥3	Beck Depression Inventory-Fast Screen (BDI-FS) <sup>®1,2</sup>	89208-3	Total score ≥8	Center for Epidemiologic Studies Depression Scale—Revised (CESD-R)	89205-9	Total score ≥17
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	<b>Instruments for Adolescents (≤17 Years)</b>	<b>Total Score LOINC Codes</b>	<b>Positive Finding</b>
	Edinburgh Postnatal Depression Scale (EPDS)	99046-5	Total score ≥10
	PROMIS Depression	71965-8	Total score (T Score) ≥60
	<b>Instruments for Adults (18+ Years)</b>	<b>Total Score LOINC Codes</b>	<b>Positive Finding</b>
	Patient Health Questionnaire (PHQ-9) <sup>®</sup>	44261-6	Total score ≥10
	Patient Health Questionnaire-2 (PHQ-2) <sup>®1</sup>	55758-7	Total score ≥3
	Beck Depression Inventory-Fast Screen (BDI-FS) <sup>®1,2</sup>	89208-3	Total score ≥8
	Beck Depression Inventory (BDI-II)	89209-1	Total score ≥20
	Center for Epidemiologic Studies Depression Scale—Revised (CESD-R)	89205-9	Total score ≥17
	Duke Anxiety—Depression Scale (DUKE-AD) <sup>®2</sup>	90853-3	Total score ≥30
	Geriatric Depression Scale Short Form (GDS) <sup>1</sup>	48545-8	Total score ≥5
	Geriatric Depression Scale Long Form (GDS)	48544-1	Total score ≥10
	Edinburgh Postnatal Depression Scale (EPDS)	99046-5	Total score ≥10
	My Mood Monitor (M-3) <sup>®</sup>	71777-7	Total score ≥5
	PROMIS Depression	71965-8	Total score (T Score) ≥60
	PROMIS Emotional Distress—Depression—Short Form	77861-3	Total score (T Score) ≥60
	Clinically Useful Depression Outcome Scale (CUDOS)	90221-3	Total score ≥31

<sup>1</sup>Brief screening instrument. All other instruments are full-length.

<sup>2</sup>Proprietary; may be cost or licensing requirement associated with use.

<b>Initial population</b>	<p><i>Measure item count:</i> Person.</p> <p><i>Attribution basis:</i> Enrollment.</p> <ul style="list-style-type: none"> <li>• <i>Benefits:</i> Medical.</li> <li>• <i>Continuous enrollment:</i> The measurement period.</li> <li>• <i>Allowable gap:</i> No more than one gap of ≤45 days during the measurement period. No gaps on the last day of the measurement period.</li> </ul>
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	<p><b>Ages:</b> 12 years of age and older at the start of the measurement period.</p> <p><b>Event:</b> None.</p>
<b>Denominator exclusions</b>	<p><b>Persons with a date of death.</b> Death in the measurement period, identified using data sources determined by the organization. Method and data sources are subject to review during the HEDIS audit.</p> <p><b>Persons in hospice or using hospice services.</b> Persons who use hospice services (<u>Hospice Encounter Value Set</u>; <u>Hospice Intervention Value Set</u>) or elect to use a hospice benefit any time during the measurement period. Organizations that use the Monthly Membership Detail Data File to identify these persons must use only the run date of the file.</p> <p><b>Persons with a history of bipolar disorder.</b> Persons with a history of bipolar disorder (<u>Bipolar Disorder Value Set*</u>; <u>Other Bipolar Disorder Value Set*</u>) any time during the person's history through the last day of the year prior to the measurement period.</p> <p><b>Persons with depression.</b> Persons with depression (<u>Depression Value Set*</u>) that starts during the year prior to the measurement period.</p> <p><b>Coding Guidance</b> *Do not include laboratory claims (claims with POS code 81).</p>
<b>Denominator</b>	<p><b>Denominator 1:</b> The initial population minus denominator exclusions.</p> <p><b>Denominator 2:</b> Persons from numerator 1 with a positive finding for depression between January 1 and December 1 of the measurement period.</p>
<b>Numerator</b>	<p><b>Numerator 1—Depression screening.</b> Persons with a documented result for depression screening, using an age-appropriate standardized instrument, performed between January 1 and December 1 of the measurement period.</p> <p><b>Numerator 2—Follow-up on positive screen.</b> Persons who received follow-up care on or up to 30 days after the date of the first positive screen (31 total days).</p> <p>Any of the following on or up to 30 days after the first positive screen:</p> <ul style="list-style-type: none"> <li>• An outpatient, telephone, e-visit or virtual check-in follow-up visit (<u>Follow Up Visit Value Set</u>) with a diagnosis of depression or other behavioral health condition (<u>Depression or Other Behavioral Health Condition Value Set</u>).</li> <li>• A depression case management encounter (<u>Depression Case Management Encounter Value Set</u>) that documents assessment for symptoms of depression (<u>Symptoms of Depression Value Set</u>) or a diagnosis of depression or other behavioral health condition (<u>Depression or Other Behavioral Health Condition Value Set</u>).</li> <li>• A behavioral health encounter, including assessment, therapy, collaborative care or medication management (<u>Behavioral Health Encounter Value Set</u>).</li> </ul>

	<ul style="list-style-type: none"> <li>A diagnosis of encounter for exercise counseling (ICD-10-CM code Z71.82*).</li> <li>A dispensed antidepressant medication (<a href="#">Antidepressant Medications List</a>).</li> </ul> <p><b>OR</b></p> <ul style="list-style-type: none"> <li>Documentation of additional depression screening on a full-length instrument indicating either no depression or no symptoms that require follow-up (i.e., a negative screen) on the same day as a positive screen on a brief screening instrument.           <ul style="list-style-type: none"> <li>For example, if there is a positive screen resulting from a PHQ-2 score, documentation of a negative finding from a PHQ-9 performed on the same day qualifies as evidence of follow-up.</li> </ul> </li> </ul> <p><b>Coding Guidance</b>            *Do not include laboratory claims (claims with POS code 81).</p>																																																
<b>Summary of changes</b>	<ul style="list-style-type: none"> <li>Removed the definitions of “participation” and “participation period.”</li> <li>Added the PROMIS Emotional Distress—Depression—Short Form instrument to the list of depression screening instruments for adults 18+ years of age.</li> <li>Removed the SSoR data elements from the data element tables.</li> </ul>																																																
<b>Data element tables</b>	<p>Organizations that submit HEDIS data to NCQA must provide the following data elements.</p> <p><b>Table DSF-E-1/2: Data Elements for Depression Screening and Follow-Up for Adolescents and Adults</b></p> <table border="1"> <thead> <tr> <th>Metric</th> <th>Age</th> <th>Data Element</th> <th>Reporting Instructions</th> </tr> </thead> <tbody> <tr> <td>Screening</td> <td>12-17</td> <td>InitialPopulation</td> <td>For each stratification, repeat per metric</td> </tr> <tr> <td>FollowUp</td> <td>18-64</td> <td>Exclusions</td> <td>For each stratification, repeat per metric</td> </tr> <tr> <td></td> <td>65+</td> <td>Denominator</td> <td>For each Metric and Stratification</td> </tr> <tr> <td></td> <td>Total</td> <td>Numerator</td> <td>For each Metric and Stratification</td> </tr> <tr> <td></td> <td></td> <td>Rate</td> <td>(Percent)</td> </tr> </tbody> </table> <p><b>Table DSF-E-3: Data Elements for Depression Screening and Follow-Up for Adolescents and Adults</b></p> <table border="1"> <thead> <tr> <th>Metric</th> <th>Age</th> <th>Data Element</th> <th>Reporting Instructions</th> </tr> </thead> <tbody> <tr> <td>Screening</td> <td>18-64</td> <td>InitialPopulation</td> <td>For each stratification, repeat per metric</td> </tr> <tr> <td>FollowUp</td> <td>65+</td> <td>Exclusions</td> <td>For each stratification, repeat per metric</td> </tr> <tr> <td></td> <td>Total</td> <td>Denominator</td> <td>For each Metric and Stratification</td> </tr> <tr> <td></td> <td></td> <td>Numerator</td> <td>For each Metric and Stratification</td> </tr> <tr> <td></td> <td></td> <td>Rate</td> <td>(Percent)</td> </tr> </tbody> </table>	Metric	Age	Data Element	Reporting Instructions	Screening	12-17	InitialPopulation	For each stratification, repeat per metric	FollowUp	18-64	Exclusions	For each stratification, repeat per metric		65+	Denominator	For each Metric and Stratification		Total	Numerator	For each Metric and Stratification			Rate	(Percent)	Metric	Age	Data Element	Reporting Instructions	Screening	18-64	InitialPopulation	For each stratification, repeat per metric	FollowUp	65+	Exclusions	For each stratification, repeat per metric		Total	Denominator	For each Metric and Stratification			Numerator	For each Metric and Stratification			Rate	(Percent)
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## Rules for Allowable Adjustments

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

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

### ADJUSTMENTS ALLOWED

- *Product lines.* Organizations are not required to use product line criteria; product lines may be combined, and all (or no) product line criteria may be used.
- *Attribution.* Organizations are not required to use enrollment criteria.
- *Benefits.* Organizations are not required to use a benefit.
- *Other.* Organizations may use additional initial population criteria to focus on an area of interest defined by gender, race, ethnicity, socioeconomic or sociodemographic characteristics, geographic region or another characteristic.
- *Measurement period adjustments.* Organizations may adjust the measurement period.
- *Exclusions.* Hospice and deceased person exclusions are not required.
- *Telehealth.* Services/events that allow the use of synchronous telehealth visits, telephone visits and asynchronous telehealth (e-visits, virtual check-ins) may be stratified to identify services performed via telehealth. This adjustment is not allowed for events, numerators and exclusions that do not allow the use of telehealth.

### ADJUSTMENTS ALLOWED WITH LIMITS

- *Ages.* The age determination dates may be changed (e.g., select, “age 12 during the measurement period). The denominator age may be changed if the range is within the specified age range (12 years and older). The denominator age may not be expanded.

### ADJUSTMENTS NOT ALLOWED

- *Initial population:* Event. Value sets and logic may not be changed for denominator 2.
- *Exclusions.* The bipolar disorder and depression exclusions must be applied. Value sets and logic may not be changed.
- *Numerator.* Value sets, direct reference codes and logic may not be changed.

## ***Utilization of the PHQ-9 to Monitor Depression Symptoms for Adolescents and Adults (DMS-E)***

<b>Measure title</b>	Utilization of the PHQ-9 to Monitor Depression Symptoms for Adolescents and Adults*	<b>Measure ID</b>	DMS-E
<b>Description</b>	The percentage of persons 12 years of age and older with a diagnosis of major depression or dysthymia who had an outpatient encounter, with a PHQ-9 score present in their record in the same assessment period as the encounter.		
<b>Measurement period</b>	January 1–December 31.		
<b>Copyright and disclaimer notice</b>	<p><i>*Adapted with financial support from the Agency for Healthcare Research and Quality and the Centers for Medicare &amp; Medicaid Services under the CHIPRA Pediatric Quality Measures Program Centers of Excellence grant number U18HS020503, and with permission from the measure developer, Minnesota Community Measurement.</i></p> <p>Refer to the complete copyright and disclaimer information at the front of this publication.</p> <p>NCQA website: <a href="http://www.ncqa.org">www.ncqa.org</a>.</p> <p>Submit policy clarification support questions via My NCQA (<a href="https://my.ncqa.org">https://my.ncqa.org</a>).</p>		
<b>Clinical recommendation statement/ rationale</b>	<p>Standardized instruments are useful in identifying meaningful change in clinical outcomes over time. Guidelines for adults recommend that providers establish and maintain regular follow-up with patients diagnosed with depression and use a standardized tool to track symptoms (Trangle, 2016). Guidelines for adolescents recommend systematic and regular tracking of treatment goals and outcomes, including assessing depressive symptoms (Cheung, 2018).</p> <p>The PHQ-9 tool assesses the nine DSM, Fourth Edition, Text Revision (DSM-IVTR) criteria symptoms and effects on functioning, and has shown to be highly accurate in discriminating between patients with persistent major depression, partial remission and full remission (Kroenke, 2001).</p>		
<b>Citations</b>	<p>Cheung, A.H., R.A. Zuckerbrot, P.S. Jensen, D. Laraque, R.E.K. Stein, GLADPC Steering Group. 2018. "Guidelines for Adolescent Depression in Primary Care (GLAD-PC): II. Treatment and Ongoing management." <i>Pediatrics</i> 141(3):e20174082.</p> <p>Kroenke, K, R.L. Spitzer, J.B.W. Williams. 2001. "The PHQ-9: Validity of a Brief Depression Severity Measure." <i>Journal of General Internal Medicine</i> 16(9): 606–13.</p> <p>Trangle, M., Gursky, J., Haight, R., Hardwig, J., Hinnenkamp, T., Kessler, D., Mack, N., Myszkowski, M. Institute for Clinical Systems Improvement. <i>Adult Depression in Primary Care</i>. Updated March 2016.</p>		

Characteristics	
<b>Scoring</b>	Proportion.
<b>Type</b>	Process.
<b>Product lines</b>	<ul style="list-style-type: none"> <li>• Commercial.</li> <li>• Medicaid.</li> <li>• Medicare.</li> </ul>
<b>Stratifications</b>	<p>Age as of the start of the measurement period.</p> <ul style="list-style-type: none"> <li>• 12–17 years (commercial and Medicaid only).</li> <li>• 18–44 years.</li> <li>• 45–64 years.</li> <li>• 65 years and older.</li> </ul>
<b>Risk adjustment</b>	None.
<b>Improvement notation</b>	Increased score indicates improvement.
<b>Guidance</b>	<p><b>Data collection methodology:</b> ECDS. Refer to <a href="#">General Guideline: Data Collection Methods</a> for additional information.</p> <p><b>Date specificity:</b> Dates must be specific enough to determine the event occurred in the period being measured.</p> <p><b>Which services count?</b> When using claims, include all paid, suspended, pending and denied claims.</p> <p><b>Other guidance:</b></p> <ul style="list-style-type: none"> <li>• The performance rate is calculated by dividing the sum of the numerators across the three assessment periods by the sum of the denominators across the three assessment periods.</li> <li>• Persons may have an eligible encounter in any or all three assessment periods, and may be included in the measure up to three times during the measurement period.</li> <li>• PHQ-9 assessment may occur during a face-to-face encounter, telephonically or through a web-based portal.</li> </ul>
Definitions	
<b>Assessment period</b>	<p>The measurement period is divided into three assessment periods with specific dates of service:</p> <ul style="list-style-type: none"> <li>• <i>Assessment period 1:</i> January 1–April 30.</li> <li>• <i>Assessment period 2:</i> May 1–August 31.</li> <li>• <i>Assessment period 3:</i> September 1–December 31.</li> </ul>

<b>Interactive outpatient encounter</b>	A bidirectional communication that is face-to-face, phone based, an e-visit or virtual check-in, or via secure electronic messaging. This does not include communications for scheduling appointments.
<b>Initial population</b>	<p><b>Measure item count:</b> Person.</p> <p><b>Attribution basis:</b> Enrollment.</p> <ul style="list-style-type: none"> <li>• <b>Benefits:</b> Medical.</li> <li>• <b>Continuous enrollment:</b> The measurement period.</li> <li>• <b>Allowable gap:</b> No more than one gap of ≤45 days during the measurement period. No gaps on the last day of the measurement period.</li> </ul> <p><b>Ages:</b> 12 years of age and older as of the start of the measurement period.</p> <p><b>Event: Diagnosis of major depression or dysthymia.</b></p> <p>Persons with at least one interactive outpatient encounter (<a href="#">Interactive Outpatient Encounter Value Set</a>) that starts during applicable assessment period with a diagnosis of major depression or dysthymia (<a href="#">Major Depression or Dysthymia Value Set</a>).</p> <ul style="list-style-type: none"> <li>• <i>Initial population 1:</i> Event must start during assessment period 1.</li> <li>• <i>Initial population 2:</i> Event must start during assessment period 2.</li> <li>• <i>Initial population 3:</i> Event must start during assessment period 3.</li> </ul>
<b>Denominator exclusions</b>	<p><b>Persons with a date of death.</b> Death in the measurement period, identified using data sources determined by the organization. Method and data sources are subject to review during the HEDIS audit.</p> <p><b>Persons in hospice or using hospice services.</b> Persons who use hospice services (<a href="#">Hospice Encounter Value Set</a>; <a href="#">Hospice Intervention Value Set</a>) or elect to use a hospice benefit any time during the measurement period. Organizations that use the Monthly Membership Detail Data File to identify these persons must use only the run date of the file.</p> <p><b>Persons with bipolar disorder, personality disorder, psychotic disorder or pervasive developmental disorder.</b> Persons with any of the following any time during the person's history through the last day of the measurement period.</p> <ul style="list-style-type: none"> <li>• Bipolar disorder (<a href="#">Bipolar Disorder Value Set*</a>; <a href="#">Other Bipolar Disorder Value Set*</a>).</li> <li>• Personality disorder (<a href="#">Personality Disorder Value Set*</a>).</li> <li>• Psychotic disorder (<a href="#">Psychotic Disorders Value Set*</a>).</li> <li>• Pervasive developmental disorder (<a href="#">Pervasive Developmental Disorder Value Set*</a>).</li> </ul> <p><b>Coding Guidance</b> *Do not include laboratory claims (claims with POS code 81).</p>

<b>Denominator</b>	<p><b>Denominator 1:</b> The initial population 1 minus exclusions.</p> <p><b>Denominator 2:</b> The initial population 2 minus exclusions.</p> <p><b>Denominator 3:</b> The initial population 3 minus exclusions.</p>																																																												
<b>Numerator</b>	<p><b>For all numerators,</b> a PHQ-9 score (LOINC code 44261-6 for persons 12 years of age and older; LOINC code 89204-2 or 44261-6 for persons 12–17 years of age) in the person's record during the applicable assessment period.</p> <p><b>Numerator 1: Utilization of PHQ-9 period 1.</b> Events with a PHQ-9 score recorded during assessment period 1.</p> <p><b>Numerator 2: Utilization of PHQ-9 period 2.</b> Events with a PHQ-9 score recorded during assessment period 2.</p> <p><b>Numerator 3: Utilization of PHQ-9 period 3.</b> Events with a PHQ-9 score recorded during assessment period 3.</p>																																																												
<b>Summary of changes</b>	<ul style="list-style-type: none"> <li>Removed the definitions of "participation" and "participation period."</li> <li>Removed the SSoR data elements from the data element tables.</li> </ul>																																																												
<b>Data element tables</b>	<p>Organizations that submit HEDIS data to NCQA must provide the following data elements.</p> <p><i>Table DMS-E-1/2: Data Elements for Utilization of the PHQ-9 to Monitor Depression Symptoms for Adolescents and Adults</i></p> <table border="1"> <thead> <tr> <th>Metric</th> <th>Time Period</th> <th>Age</th> <th>Data Element</th> <th>Reporting Instructions</th> </tr> </thead> <tbody> <tr> <td>PHQ9Utilization</td> <td>1</td> <td>12-17</td> <td>InitialPopulation</td> <td>For each Stratification</td> </tr> <tr> <td></td> <td>2</td> <td>18-44</td> <td>Exclusions</td> <td>For each Stratification</td> </tr> <tr> <td></td> <td>3</td> <td>45-64</td> <td>Denominator</td> <td>For each Stratification</td> </tr> <tr> <td></td> <td>Total</td> <td>65+</td> <td>Numerator</td> <td>For each Stratification</td> </tr> <tr> <td></td> <td></td> <td>Total</td> <td>Rate</td> <td>(Percent)</td> </tr> </tbody> </table> <p><i>Table DMS-E-3: Data Elements for Utilization of the PHQ-9 to Monitor Depression Symptoms for Adolescents and Adults</i></p> <table border="1"> <thead> <tr> <th>Metric</th> <th>Time Period</th> <th>Age</th> <th>Data Element</th> <th>Reporting Instructions</th> </tr> </thead> <tbody> <tr> <td>PHQ9Utilization</td> <td>1</td> <td>18-44</td> <td>InitialPopulation</td> <td>For each Stratification</td> </tr> <tr> <td></td> <td>2</td> <td>45-64</td> <td>Exclusions</td> <td>For each Stratification</td> </tr> <tr> <td></td> <td>3</td> <td>65+</td> <td>Denominator</td> <td>For each Stratification</td> </tr> <tr> <td></td> <td>Total</td> <td>Total</td> <td>Numerator</td> <td>For each Stratification</td> </tr> <tr> <td></td> <td></td> <td></td> <td>Rate</td> <td>(Percent)</td> </tr> </tbody> </table>	Metric	Time Period	Age	Data Element	Reporting Instructions	PHQ9Utilization	1	12-17	InitialPopulation	For each Stratification		2	18-44	Exclusions	For each Stratification		3	45-64	Denominator	For each Stratification		Total	65+	Numerator	For each Stratification			Total	Rate	(Percent)	Metric	Time Period	Age	Data Element	Reporting Instructions	PHQ9Utilization	1	18-44	InitialPopulation	For each Stratification		2	45-64	Exclusions	For each Stratification		3	65+	Denominator	For each Stratification		Total	Total	Numerator	For each Stratification				Rate	(Percent)
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<b>Rules for Allowable Adjustments</b>	<p><b>Copyright and use:</b> The “Rules for Allowable Adjustments of HEDIS” (the “Rules”) describe how NCQA’s HEDIS measure specifications can be adjusted for other populations, if applicable. The Rules, reviewed and approved by NCQA measure experts, provide for expanded use of HEDIS measures without changing their clinical intent.</p> <p><b>Adjusted HEDIS measures may not be used for HEDIS health plan reporting.</b></p> <p><b>ADJUSTMENTS ALLOWED</b></p> <ul style="list-style-type: none"> <li>• <i>Product lines.</i> Organizations are not required to use product line criteria; product lines may be combined, and all (or no) product line criteria may be used.</li> <li>• <i>Attribution.</i> Organizations are not required to use enrollment criteria.</li> <li>• <i>Benefits.</i> Organizations are not required to use a benefit.</li> <li>• <i>Other.</i> Organizations may use additional initial population criteria to focus on an area of interest defined by gender, race, ethnicity, socioeconomic or sociodemographic characteristics, geographic region or another characteristic.</li> <li>• <i>Exclusions.</i> Hospice and deceased person exclusions are not required.</li> <li>• <i>Telehealth.</i> Services/events that allow the use of synchronous telehealth visits, telephone visits and asynchronous telehealth (e-visits, virtual check-ins) may be stratified to identify services performed via telehealth. This adjustment is not allowed for events, numerators and exclusions that do not allow the use of telehealth.</li> </ul> <p><b>ADJUSTMENTS ALLOWED WITH LIMITS</b></p> <ul style="list-style-type: none"> <li>• <i>Ages.</i> The age determination dates may be changed (e.g., select, “age as of June 30”). Changing the denominator age range is allowed if the limits are within the specified age range (12 years and older). Expanding the denominator age range to 11 years and older is allowed.</li> </ul> <p><b>ADJUSTMENTS NOT ALLOWED</b></p> <ul style="list-style-type: none"> <li>• <i>Initial population:</i> Event. Only events or diagnoses that contain (or map to) codes in the value sets may be used to identify visits with a diagnosis. Value sets and logic may not be changed.</li> <li>• <i>Exclusions.</i> The bipolar disorder, personality disorder, psychotic disorder and pervasive developmental disorder exclusions must be applied. Value sets and logic may not be changed.</li> <li>• <i>Numerator.</i> Value sets, direct reference codes and logic may not be changed.</li> </ul>
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## Depression Remission or Response for Adolescents and Adults (DRR-E)

<b>Measure title</b>	Depression Remission or Response for Adolescents and Adults*	<b>Measure ID</b>	DRR-E
<b>Description</b>	<p>The percentage of persons 12 years of age and older with a diagnosis of depression and an elevated PHQ-9 score, who had evidence of response or remission within 120–240 days (4–8 months) of the elevated score.</p> <ul style="list-style-type: none"> <li>• <i>Depression Follow-Up PHQ-9.</i> The percentage of persons who have a follow-up PHQ-9 score documented within 120–240 days (4–8 months) after the initial elevated PHQ-9 score.</li> <li>• <i>Depression Remission.</i> The percentage of persons who achieved remission within 120–240 days (4–8 months) after the initial elevated PHQ-9 score.</li> <li>• <i>Depression Response.</i> The percentage of persons who showed response within 120–240 days (4–8 months) after the initial elevated PHQ-9 score.</li> </ul>		
<b>Measurement period</b>	January 1–December 31.		
<b>Copyright and disclaimer notice</b>	<p>*Adapted with financial support from the Agency for Healthcare Research and Quality and the Centers for Medicare &amp; Medicaid Services under the CHIPRA Pediatric Quality Measures Program Centers of Excellence grant number U18HS020503, and with permission from the measure developer, Minnesota Community Measurement.</p> <p>Refer to the complete copyright and disclaimer information at the front of this publication.</p> <p>NCQA website: <a href="http://www.ncqa.org">www.ncqa.org</a>.</p> <p>Submit policy clarification support questions via My NCQA (<a href="https://my.ncqa.org">https://my.ncqa.org</a>).</p>		
<b>Clinical recommendation statement/ rationale</b>	<p>The Institute for Clinical Systems Improvement recommends that clinicians establish and maintain follow-up with adult patients who have depression. Appropriate, reliable follow-up is highly correlated with improved response and remission scores.</p> <p>The American Academy of Pediatrics recommends that adolescents with depression be assessed for treatment response and remission of symptoms using a depression assessment tool such as the PHQ-9 Modified for Teens.</p>		
<b>Citations</b>	<p>Cheung, A.H., R.A. Zuckerbrot, P.S. Jensen, D. Laraque, R.E. Stein, A. Levitt, B. Birmaher, J. Campo, G. Clarke, G. Emslie, and M. Kaufman. 2018. "Guidelines for Adolescent Depression in Primary Care (GLAD-PC): Part II. Treatment and Ongoing Management." <i>Pediatrics</i> 141(3).</p> <p>Trangle, M., J. Gursky, R. Haight, J. Hardwig, T. Hinnenkamp, D. Kessler, N. Mack, M. Myszkowski. Institute for Clinical Systems Improvement. <i>Adult Depression in Primary Care</i>. Updated March 2016.</p>		

Characteristics	
<b>Scoring</b>	Proportion.
<b>Type</b>	Outcome.
<b>Product lines</b>	<ul style="list-style-type: none"> <li>• Commercial.</li> <li>• Medicaid.</li> <li>• Medicare.</li> </ul>
<b>Stratifications</b>	<p>Age as of the start of the intake period.</p> <ul style="list-style-type: none"> <li>• 12–17 years (for commercial and Medicaid only).</li> <li>• 18–44 years.</li> <li>• 45–64 years.</li> <li>• 65 years and older.</li> </ul>
<b>Risk adjustment</b>	None.
<b>Improvement notation</b>	Increased score indicates improvement.
<b>Guidance</b>	<p><b>Data collection methodology:</b> ECDS. Refer to <a href="#">General Guideline: Data Collection Methods</a> for additional information.</p> <p><b>Date specificity:</b> Dates must be specific enough to determine the event occurred in the period being measured.</p> <p><b>What services count?</b> When using claims, include all paid, suspended, pending and denied claims.</p> <p><b>Other guidance:</b> PHQ-9 assessment may occur during a face-to-face encounter, telephonically or through a web-based portal.</p>
Definitions	
<b>Depression follow-up period</b>	The 120–240 day period after the IESD.
<b>IESD</b>	Index episode start date. The earliest date during the intake period when a person has a PHQ-9 total score (LOINC code 44261-6 for persons 12 years of age and older; LOINC code 89204-2 or 44261-6 for persons 12–17 years of age) >9 documented within a 31-day period, including and around (15 days before and 15 days after) an interactive outpatient encounter ( <a href="#">Interactive Outpatient Encounter Value Set</a> ) with a diagnosis of major depression or dysthymia ( <a href="#">Major Depression or Dysthymia Value Set</a> ).
<b>Intake period</b>	May 1 of the year prior to the measurement period through April 30 of the measurement period.
<b>Interactive outpatient encounter</b>	A bidirectional communication that is face-to-face, phone based, an e-visit or virtual check-in, or via secure electronic messaging. This does not include communications for scheduling appointments.

<b>Initial population</b>	<p><b>Measure item count:</b> Person.</p> <p><b>Attribution basis:</b> Enrollment.</p> <ul style="list-style-type: none"> <li>• <b>Benefits:</b> Medical.</li> <li>• <b>Continuous enrollment:</b> May 1 of the year prior to the measurement period through the last day of the measurement period.</li> <li>• <b>Allowable gap:</b> <ul style="list-style-type: none"> <li>– <b>Measurement period:</b> No more than one gap of ≤45 days. No gaps on the last day of the measurement period.</li> <li>– <b>May 1–December 31 of the year prior to the measurement period:</b> None.</li> </ul> </li> </ul> <p><b>Ages:</b> 12 years of age and older as of the beginning of the intake period.</p> <p><b>Event:</b> Persons who meet a depression encounter and PHQ-9 total score &gt;9, as described by IESD.</p>
<b>Denominator exclusions</b>	<p><b>Persons with a date of death.</b> Death in the measurement period, identified using data sources determined by the organization. Method and data sources are subject to review during the HEDIS audit.</p> <p><b>Persons in hospice or using hospice services.</b> Persons who use hospice services (<a href="#">Hospice Encounter Value Set</a>; <a href="#">Hospice Intervention Value Set</a>) or elect to use a hospice benefit any time during the measurement period. Organizations that use the Monthly Membership Detail Data File to identify these persons must use only the run date of the file.</p> <p><b>Persons with bipolar disorder, personality disorder, psychotic disorder or pervasive developmental disorder.</b> Any of the following any time during the person's history through the last day of the measurement period:</p> <ul style="list-style-type: none"> <li>• Bipolar disorder (<a href="#">Bipolar Disorder Value Set*</a>; <a href="#">Other Bipolar Disorder Value Set*</a>).</li> <li>• Personality disorder (<a href="#">Personality Disorder Value Set*</a>).</li> <li>• Psychotic disorder (<a href="#">Psychotic Disorders Value Set*</a>).</li> <li>• Pervasive developmental disorder (<a href="#">Pervasive Developmental Disorder Value Set*</a>).</li> </ul> <p><b>Coding Guidance</b> *Do not include laboratory claims (claims with POS code 81).</p>
<b>Denominator</b>	The initial population minus denominator exclusions.
<b>Numerator</b>	<p><b>Numerator 1: Depression follow-up.</b> A PHQ-9 total score (LOINC code 44261-6 for persons 12 years of age and older; LOINC code 89204-2 or 44261-6 for persons 12–17 years of age) in the person's record during the depression follow-up period.</p>

	<p><b>Numerator 2: Depression remission.</b> Persons who achieve remission of depression symptoms, as demonstrated by the most recent PHQ-9 total score (LOINC code 44261-6 for persons 12 years of age and older; LOINC code 89204-2 or 44261-6 for persons 12–17 years of age) of &lt;5 during the depression follow-up period.</p> <p><b>Numerator 3: Depression response.</b> Persons who indicate a response to treatment for depression, as demonstrated by the most recent PHQ-9 total score (LOINC code 44261-6 for persons 12 years of age and older; LOINC code 89204-2 or 44261-6 for persons 12–17 years of age) of at least 50% lower than the PHQ-9 score associated with the IESD, documented during the depression follow-up period.</p>																																																
<b>Summary of changes</b>	<ul style="list-style-type: none"> <li>Removed the definitions of “participation” and “participation period.”</li> <li>Removed the SSoR data elements from the data element tables.</li> </ul>																																																
<b>Data element tables</b>	<p>Organizations that submit HEDIS data to NCQA must provide the following data elements.</p> <p><i>Table DRR-E-1/2: Data Elements for Depression Remission or Response for Adolescents and Adults</i></p> <table border="1"> <thead> <tr> <th>Metric</th> <th>Age</th> <th>Data Element</th> <th>Reporting Instructions</th> </tr> </thead> <tbody> <tr> <td>FollowUp</td> <td>12-17</td> <td>InitialPopulation</td> <td>For each Stratification, repeat per Metric</td> </tr> <tr> <td>Remission</td> <td>18-44</td> <td>Exclusions</td> <td>For each Stratification, repeat per Metric</td> </tr> <tr> <td>Response</td> <td>45-64</td> <td>Denominator</td> <td>For each Stratification, repeat per Metric</td> </tr> <tr> <td></td> <td>65+</td> <td>Numerator</td> <td>For each Metric and Stratification</td> </tr> <tr> <td></td> <td>Total</td> <td>Rate</td> <td>(Percent)</td> </tr> </tbody> </table> <p><i>Table DRR-E-3: Data Elements for Depression Remission or Response for Adolescents and Adults</i></p> <table border="1"> <thead> <tr> <th>Metric</th> <th>Age</th> <th>Data Element</th> <th>Reporting Instructions</th> </tr> </thead> <tbody> <tr> <td>FollowUp</td> <td>18-44</td> <td>InitialPopulation</td> <td>For each Stratification, repeat per Metric</td> </tr> <tr> <td>Remission</td> <td>45-64</td> <td>Exclusions</td> <td>For each Stratification, repeat per Metric</td> </tr> <tr> <td>Response</td> <td>65+</td> <td>Denominator</td> <td>For each Stratification, repeat per Metric</td> </tr> <tr> <td></td> <td>Total</td> <td>Numerator</td> <td>For each Metric and Stratification</td> </tr> <tr> <td></td> <td></td> <td>Rate</td> <td>(Percent)</td> </tr> </tbody> </table>	Metric	Age	Data Element	Reporting Instructions	FollowUp	12-17	InitialPopulation	For each Stratification, repeat per Metric	Remission	18-44	Exclusions	For each Stratification, repeat per Metric	Response	45-64	Denominator	For each Stratification, repeat per Metric		65+	Numerator	For each Metric and Stratification		Total	Rate	(Percent)	Metric	Age	Data Element	Reporting Instructions	FollowUp	18-44	InitialPopulation	For each Stratification, repeat per Metric	Remission	45-64	Exclusions	For each Stratification, repeat per Metric	Response	65+	Denominator	For each Stratification, repeat per Metric		Total	Numerator	For each Metric and Stratification			Rate	(Percent)
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	<p><b>Adjusted HEDIS measures may not be used for HEDIS health plan reporting.</b></p> <p><b>ADJUSTMENTS ALLOWED</b></p> <ul style="list-style-type: none"><li>• <i>Product lines.</i> Organizations are not required to use product line criteria; product lines may be combined, and all (or no) product line criteria may be used.</li><li>• <i>Attribution.</i> Organizations are not required to use enrollment criteria.</li><li>• <i>Benefits.</i> Organizations are not required to use a benefit.</li><li>• <i>Other.</i> Organizations may use additional initial population criteria to focus on an area of interest defined by gender, race, ethnicity, socioeconomic or sociodemographic characteristics, geographic region or another characteristic.</li><li>• <i>Exclusions.</i> Hospice and deceased persons exclusions are not required.</li><li>• <i>Telehealth:</i> Services/events that allow the use of synchronous telehealth visits, telephone visits and asynchronous telehealth (e-visits, virtual check-ins) may be stratified to identify services performed via telehealth. This adjustment is not allowed for events, numerators and exclusions that do not allow the use of telehealth.</li></ul> <p><b>ADJUSTMENTS ALLOWED WITH LIMITS</b></p> <ul style="list-style-type: none"><li>• <i>Ages.</i> The age determination dates may be changed (e.g., select, "age as of June 30"). Changing the denominator age range is allowed if the limits are within the specified age range (12 years and older). The denominator age may not be expanded.</li></ul> <p><b>ADJUSTMENTS NOT ALLOWED</b></p> <ul style="list-style-type: none"><li>• <i>Initial population:</i> Event. Only events or diagnoses that contain (or map to) codes in the value sets may be used to identify visits with a diagnosis. Value sets and logic may not be changed.</li><li>• <i>Exclusions.</i> The bipolar disorder, personality disorder, psychotic disorder or pervasive developmental disorder exclusions must be applied. Value sets may not be changed.</li><li>• <i>Numerator.</i> Value sets, direct reference codes and logic may not be changed.</li></ul>
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## ***Unhealthy Alcohol Use Screening and Follow-Up (ASF-E)***

<b>Measure title</b>	Unhealthy Alcohol Use Screening and Follow-Up*	<b>Measure ID</b>	ASF-E
<b>Description</b>	<p>The percentage of persons 18 years of age and older who were screened for unhealthy alcohol use using a standardized instrument and, if screened positive, received appropriate follow-up care.</p> <ul style="list-style-type: none"> <li>• <i>Unhealthy Alcohol Use Screening</i>. The percentage of persons who had a systematic screening for unhealthy alcohol use.</li> <li>• <i>Follow-Up Care on Positive Screen</i>. The percentage of persons receiving brief counseling or other follow-up care within 60 days (2 months) of screening positive for unhealthy alcohol use.</li> </ul>		
<b>Measurement period</b>	January 1–December 31.		
<b>Copyright and disclaimer notice</b>	<p><i>*Adapted with financial support from the Substance Abuse and Mental Health Services Administration (SAMHSA) and with permission from the measure developer, the American Medical Association (AMA).</i></p> <p>Refer to the complete copyright and disclaimer information at the front of this publication.</p> <p>NCQA website: <a href="http://www.ncqa.org">www.ncqa.org</a>.</p> <p>Submit policy clarification support questions via My NCQA (<a href="https://my.ncqa.org">https://my.ncqa.org</a>).</p>		
<b>Clinical recommendation statement/ rationale</b>	<p>The U.S. Preventive Services Task Force recommends that clinicians screen adults aged 18 years or older for alcohol misuse and provide brief behavioral counseling interventions to those who misuse alcohol. (B recommendation).</p>		
<b>Citations</b>	<p>U.S. Preventive Services Task Force. 2018. “Unhealthy Alcohol Use in Adolescents and Adults: Screening and Behavioral Counseling Interventions.” <i>JAMA</i> 320(18):1899–909. doi: 10.1001/jama.2018.16789.</p>		
<b>Characteristics</b>			
<b>Scoring</b>	Proportion.		
<b>Type</b>	Process.		
<b>Product lines</b>	<ul style="list-style-type: none"> <li>• Commercial.</li> <li>• Medicaid.</li> <li>• Medicare.</li> </ul>		
<b>Stratifications</b>	<p>Age as of the start of the measurement period.</p> <ul style="list-style-type: none"> <li>• 18–44 years.</li> <li>• 45–64 years.</li> <li>• 65 years and older.</li> </ul>		

<b>Risk adjustment</b>	None.															
<b>Improvement notation</b>	Increased score indicates improvement.															
<b>Guidance</b>	<p><b>Data collection methodology:</b> ECDS. <a href="#">Refer to General Guideline: Data Collection Methods</a> for additional information.</p> <p><b>Date specificity:</b> Dates must be specific enough to determine the event occurred in the period being measured.</p> <p><b>Which services count?</b> When using claims, include all paid, suspended, pending and denied claims.</p>															
<b>Definitions</b>																
<b>Alcohol counseling or other follow-up care</b>	<p>Any of the following on or up to 60 days after the first positive screen:</p> <ul style="list-style-type: none"> <li>• Feedback on alcohol use and harms.</li> <li>• Identification of high-risk situations for drinking and coping strategies.</li> <li>• Increase the motivation to reduce drinking.</li> <li>• Development of a personal plan to reduce drinking.</li> <li>• Documentation of receiving alcohol misuse treatment.</li> </ul>															
<b>Unhealthy alcohol use screening</b>	<p>A standard assessment instrument that has been normalized and validated for the adult patient population. Eligible screening instruments with thresholds for positive findings include:</p> <table border="1"> <thead> <tr> <th>Screening Instrument</th> <th>Total Score LOINC Codes</th> <th>Positive Finding</th> </tr> </thead> <tbody> <tr> <td>Alcohol Use Disorders Identification Test (AUDIT) screening instrument</td> <td>75624-7</td> <td>Total score <math>\geq 8</math></td> </tr> <tr> <td>Alcohol Use Disorders Identification Test Consumption (AUDIT-C) screening instrument</td> <td>75626-2</td> <td>           Total score <math>\geq 4</math> for men            Total score <math>\geq 3</math> for women         </td> </tr> <tr> <td>Single-question screen (for men): "How many times in the past year have you had 5 or more drinks in a day?"</td> <td>88037-7</td> <td>Response <math>\geq 1</math></td> </tr> <tr> <td>Single-question screen (for women and all adults older than 65 years): "How many times in the past year have you had 4 or more drinks in a day?"</td> <td>75889-6</td> <td>Response <math>\geq 1</math></td> </tr> </tbody> </table>	Screening Instrument	Total Score LOINC Codes	Positive Finding	Alcohol Use Disorders Identification Test (AUDIT) screening instrument	75624-7	Total score $\geq 8$	Alcohol Use Disorders Identification Test Consumption (AUDIT-C) screening instrument	75626-2	Total score $\geq 4$ for men Total score $\geq 3$ for women	Single-question screen (for men): "How many times in the past year have you had 5 or more drinks in a day?"	88037-7	Response $\geq 1$	Single-question screen (for women and all adults older than 65 years): "How many times in the past year have you had 4 or more drinks in a day?"	75889-6	Response $\geq 1$
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<b>Initial population</b>	<p><b>Measure item count:</b> Person.</p> <p><b>Attribution basis:</b> Enrollment.</p> <ul style="list-style-type: none"> <li>• <b>Benefits:</b> Medical.</li> <li>• <b>Continuous enrollment:</b> The measurement period.</li> </ul>															

	<ul style="list-style-type: none"> <li>• <b>Allowable gap:</b> No more than one gap of ≤45 days during the measurement period. No gaps on the last day of the measurement period.</li> </ul> <p><b>Ages:</b> 18 years of age and older at the start of the measurement period.  <b>Event:</b> None.</p>
<b>Denominator exclusions</b>	<p><b>Persons with a date of death.</b>  Death in the measurement period, identified using data sources determined by the organization. Method and data sources are subject to review during the HEDIS audit.</p> <p><b>Persons in hospice or using hospice services.</b>  Persons who use hospice services (<u>Hospice Encounter Value Set</u>; <u>Hospice Intervention Value Set</u>) or elect to use a hospice benefit any time during the measurement period. Organizations that use the Monthly Membership Detail Data File to identify these persons must use only the run date of the file.</p> <p><b>Alcohol use disorder.</b>  Persons with a diagnosis for alcohol use disorder (<u>Alcohol Use Disorder Value Set*</u>) that starts during the year prior to the measurement period.</p> <p><b>Dementia.</b>  Persons with a diagnosis of dementia (<u>Dementia Value Set*</u>) any time during the person's history through the last day of the measurement period.</p> <p><b>Coding Guidance</b>  *Do not include laboratory claims (claims with POS code 81).</p>
<b>Denominator</b>	<p><b>Denominator 1:</b> Initial population minus denominator exclusions.</p> <p><b>Denominator 2:</b> Persons from numerator 1 with a positive finding for unhealthy alcohol use screening between January 1 and November 1 of the measurement period.</p>
<b>Numerator</b>	<p><b>Numerator 1: Unhealthy alcohol use screening.</b>  Persons with a documented result for unhealthy alcohol use screening performed between January 1 and November 1 of the measurement period.</p> <p><b>Numerator 2: Follow-up care on positive screen.</b>  Persons receiving alcohol counseling or other follow-up care. Either of the following on or up to 60 days after the date of the first positive screen (61 days total) meets criteria:</p> <ul style="list-style-type: none"> <li>• <u>Alcohol Counseling or Other Follow Up Care Value Set</u>.</li> <li>• A diagnosis of encounter for alcohol counseling and surveillance (ICD-10-CM code Z71.41*).</li> </ul> <p><b>Coding Guidance</b>  *Do not include laboratory claims (claims with POS code 81).</p>
<b>Summary of changes</b>	<ul style="list-style-type: none"> <li>• Removed the definitions of "participation" and "participation period."</li> <li>• Removed the SSoR data elements from the data element tables.</li> </ul>

<b>Data element tables</b>	<p>Organizations that submit HEDIS data to NCQA must provide the following data elements.</p> <p><b>Table ASF-E-1/2/3: Data Elements for Unhealthy Alcohol Use Screening and Follow-Up</b></p> <table border="1"> <thead> <tr> <th>Metric</th><th>Age</th><th>Data Element</th><th>Reporting Instructions</th></tr> </thead> <tbody> <tr> <td>Screening</td><td>18-44</td><td>InitialPopulation</td><td>For each stratification, repeat per metric</td></tr> <tr> <td>FollowUp</td><td>45-64</td><td>Exclusions</td><td>For each stratification, repeat per metric</td></tr> <tr> <td></td><td>65+</td><td>Denominator</td><td>For each Metric and Stratification</td></tr> <tr> <td></td><td>Total</td><td>Numerator</td><td>For each Metric and Stratification</td></tr> <tr> <td></td><td></td><td>Rate</td><td>(Percent)</td></tr> </tbody> </table>	Metric	Age	Data Element	Reporting Instructions	Screening	18-44	InitialPopulation	For each stratification, repeat per metric	FollowUp	45-64	Exclusions	For each stratification, repeat per metric		65+	Denominator	For each Metric and Stratification		Total	Numerator	For each Metric and Stratification			Rate	(Percent)
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<b>Rules for Allowable Adjustments</b>	<p><b>Copyright and use:</b> The “Rules for Allowable Adjustments of HEDIS” (the “Rules”) describe how NCQA’s HEDIS measure specifications can be adjusted for other populations, if applicable. The Rules, reviewed and approved by NCQA measure experts, provide for expanded use of HEDIS measures without changing their clinical intent.</p> <p><b>Adjusted HEDIS measures may not be used for HEDIS health plan reporting.</b></p> <p><b>ADJUSTMENTS ALLOWED</b></p> <ul style="list-style-type: none"> <li>• <b>Product lines.</b> Organizations are not required to use product line criteria; product lines may be combined, and all (or no) product line criteria may be used.</li> <li>• <b>Attribution.</b> Organizations are not required to use enrollment criteria.</li> <li>• <b>Benefits.</b> Organizations are not required to use a benefit.</li> <li>• <b>Other.</b> Organizations may use additional initial population criteria to focus on an area of interest defined by gender, race, ethnicity, socioeconomic or sociodemographic characteristics, geographic region or another characteristic.</li> <li>• <b>Measurement period adjustments.</b> Organizations may adjust the measurement period.</li> <li>• <b>Exclusions:</b> Hospice and deceased person exclusions are not required.</li> <li>• <b>Telehealth.</b> Services/events that allow the use of synchronous telehealth visits, telephone visits and asynchronous telehealth (e-visits, virtual check-ins) may be stratified to identify services performed via telehealth. This adjustment is not allowed for events, numerators and exclusions that do not allow the use of telehealth.</li> </ul> <p><b>ADJUSTMENTS ALLOWED WITH LIMITS</b></p> <ul style="list-style-type: none"> <li>• <b>Ages.</b> The age determination dates may be changed (e.g., select, “age as of June 30”). Changing the denominator age range is allowed if the limits are within the specified age range (18 years and older). Organizations must consult UPSTSF guidelines when considering whether to expand the age range outside current thresholds.</li> </ul>																								

**ADJUSTMENTS NOT ALLOWED**

- *Initial population.* Event. Value sets, medication lists and direct reference codes and logic may not be changed for denominator 2.
- *Exclusions.* The alcohol use disorder and dementia exclusions must be applied. Value sets and logic may not be changed.
- *Numerator.* Value sets, direct reference codes and logic may not be changed.

## ***Tobacco Use Screening and Cessation Intervention (TSC-E)***

<b>Measure title</b>	Tobacco Use Screening and Cessation Intervention	<b>Measure ID</b>	TSC-E
<b>Description</b>	<p>The percentage of persons 12 years of age and older who were screened for commercial tobacco product use at least once during the measurement period, and who received tobacco cessation intervention if identified as a tobacco user. Two rates are reported:</p> <ol style="list-style-type: none"> <li>1. <i>Tobacco Use Screening.</i> The percentage of persons who were screened for tobacco use.</li> <li>2. <i>Cessation Intervention.</i> The percentage of persons who were identified as a tobacco user and who received tobacco cessation intervention.</li> </ol>		
<b>Measurement period</b>	January 1–December 31.		
<b>Copyright and disclaimer notice</b>	<p>Refer to the complete copyright and disclaimer information at the front of this publication.</p> <p>NCQA website: <a href="http://www.ncqa.org">www.ncqa.org</a>.</p> <p>Submit policy clarification support questions via My NCQA (<a href="https://my.ncqa.org">https://my.ncqa.org</a>).</p>		
<b>Clinical recommendation statement</b>	<p>The U.S. Preventive Services Task Force (USPSTF) recommends that clinicians ask all adults about tobacco use, advise them to stop using tobacco and provide behavioral interventions and U.S. Food and Drug Administration (FDA)-approved pharmacotherapy for cessation to nonpregnant adults who use tobacco (Grade A Recommendation) (U.S. Preventive Services Task Force, 2021).</p> <p>The USPSTF recommends that clinicians ask all pregnant persons about tobacco use, advise them to stop using tobacco and provide behavioral interventions for cessation to pregnant persons who use tobacco (Grade A Recommendation) (U.S. Preventive Services Task Force, 2021).</p> <p>The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of pharmacotherapy interventions for tobacco cessation in pregnant women (Grade I Statement) (U.S. Preventive Services Task Force, 2021).</p> <p>The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of electronic cigarettes (e-cigarettes) for tobacco cessation in adults, including pregnant persons. The USPSTF recommends that clinicians direct patients who use tobacco to other tobacco cessation interventions with proven effectiveness and established safety (Grade I Statement) (U.S. Preventive Services Task Force, 2021).</p> <p>The USPSTF recommends that primary care clinicians provide interventions, including education or brief counseling, to prevent initiation of tobacco use among school-aged children and adolescents (Grade B Statement) (U.S. Preventive Services Task Force, 2020).</p>		

	<p>The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of primary care—feasible interventions for the cessation of tobacco use among school-aged children and adolescents (Grade I Statement) (U.S. Preventive Services Task Force, 2020).</p> <p>All patients should be asked if they use tobacco and should have their tobacco use status documented on a regular basis. Evidence has shown that clinic screening systems, such as expanding the vital signs to include tobacco use status or the use of other reminder systems such as chart stickers or computer prompts, significantly increase rates of clinician intervention. (Strength of Evidence = A) (U.S. Department of Health and Human Services. Public Health Service, 2008).</p> <p>All physicians should strongly advise every patient who smokes to quit because evidence shows that physician advice to quit smoking increases abstinence rates. (Strength of Evidence = A) (U.S. Department of Health and Human Services. Public Health Service, 2008).</p> <p>Minimal interventions lasting less than three minutes increase overall tobacco abstinence rates. Every tobacco user should be offered at least a minimal intervention, whether or not he or she is referred to an intensive intervention. (Strength of Evidence = A) (U.S. Department of Health and Human Services. Public Health Service, 2008).</p> <p>The combination of counseling and medication is more effective for smoking cessation than either medication or counseling alone. Therefore, whenever feasible and appropriate, both counseling and medication should be provided to patients trying to quit smoking. (Strength of Evidence = A) (U.S. Department of Health and Human Services. Public Health Service, 2008).</p> <p>For adolescents 11 to 17, the American Academy of Pediatrics recommends the ACT method to assess tobacco product use. Ask: Screen for tobacco use with all youth, during every clinical encounter. Counsel: Advise all youth who use tobacco to quit and have them set a quit date within two weeks. Treat: Link youth to behavioral treatment extenders and prescribe pharmacologic support when indicated. After the visit, follow-up to assess progress and offer support. (American Academy of Pediatrics, 2022).</p>
<b>Citations</b>	<p>US Preventive Services Task Force. 2021. "Interventions for Tobacco Smoking Cessation in Adults, Including Pregnant Persons. US Preventive Services Task Force Recommendation Statement." <i>JAMA</i> 325(3), 265–79. doi:10.1001/jama.2020.25019.</p> <p>US Preventive Services Task Force. 2020. "Primary Care Interventions for Prevention and Cessation of Tobacco Use in Children and Adolescents. US Preventive Services Task Force Recommendation Statement." <i>JAMA</i> 323(16):1590–8. doi:10.1001/jama.2020.4679.</p> <p>Agency for Healthcare Research and Quality. 2008. <i>Treating Tobacco Use and Dependence: 2008 Update</i>. <a href="https://www.ahrq.gov/prevention/guidelines/tobacco/index.html">https://www.ahrq.gov/prevention/guidelines/tobacco/index.html</a></p> <p>American Academy of Pediatrics. 2022. "Youth Tobacco Use: Considerations for Clinicians." <i>JAMA</i>. <a href="https://downloads.aap.org/AAP/PDF/AAP_Youth_Tobacco_Cessation_Con siderations_for_Clinicians.pdf">https://downloads.aap.org/AAP/PDF/AAP_Youth_Tobacco_Cessation_Con siderations_for_Clinicians.pdf</a></p>

Characteristics	
<b>Scoring</b>	Proportion.
<b>Type</b>	Process.
<b>Product lines</b>	<ul style="list-style-type: none"> <li>• Commercial.</li> <li>• Medicaid.</li> <li>• Medicare.</li> </ul>
<b>Stratifications</b>	<p>Age as of the start of the measurement period.</p> <ul style="list-style-type: none"> <li>• 12–17 years (commercial and Medicaid only).</li> <li>• 18–64 years.</li> <li>• 65 and older.</li> </ul>
<b>Risk adjustment</b>	None.
<b>Improvement notation</b>	Increased score indicates improvement.
<b>Guidance</b>	<p><b>Data collection methodology:</b> ECDS. Refer to the <a href="#">General Guideline: Data Collection Methods</a> for additional information.</p> <p><b>Date specificity:</b> Dates must be specific enough to determine that the event occurred in the period being measured.</p> <p><b>Which services count?</b> When using claims, include all paid, suspended, pending and denied claims.</p>
Definitions	
<b>Positive tobacco user</b>	Persons who were screened for tobacco use and had a documented positive result. Any of the following meet criteria: <ul style="list-style-type: none"> <li>• <u>Tobacco Use Screening Value Set with Yes Value Set</u>.</li> <li>• LOINC code 72166-2 <u>with Positive Tobacco Use Status Value Set</u>.</li> </ul>
<b>Negative tobacco user</b>	Persons who were screened for tobacco use and had a documented negative result. Any of the following meet criteria: <ul style="list-style-type: none"> <li>• <u>Tobacco Use Screening Value Set with No Value Set</u>.</li> <li>• LOINC code 72166-2 <u>with Negative Tobacco Use Status Value Set</u>.</li> </ul>
<b>Initial population</b>	<p><b>Measure item count:</b> Person.</p> <p><b>Attribution:</b> Enrollment.</p> <ul style="list-style-type: none"> <li>• <b>Benefits:</b> Medical.</li> <li>• <b>Continuous enrollment:</b> 180 days prior to the measurement period through the last day of the measurement period.</li> <li>• <b>Allowable gap:</b> No more than one gap of ≤45 days during the continuous enrollment period. No gaps on the last day of the measurement period.</li> </ul> <p><b>Ages:</b> 12 years of age and older at the start of the measurement period.</p>

	<i>Event:</i> None.
<b>Denominator exclusions</b>	<p><b>Persons with a date of death.</b> Death in the measurement period, identified using data sources determined by the organization. Method and data sources are subject to review during the HEDIS audit.</p> <p><b>Persons in hospice or using hospice services.</b> Persons who use hospice services (<u>Hospice Encounter Value Set</u>; <u>Hospice Intervention Value Set</u>) or elect to use a hospice benefit any time during the measurement period. Organizations that use the Monthly Membership Detail Data File to identify these persons must use only the run date of the file.</p> <p><b>Persons receiving palliative care.</b> Persons receiving palliative care (<u>Palliative Care Assessment Value Set</u>; <u>Palliative Care Encounter</u>; <u>Palliative Care Intervention Value Set</u>) or who had an encounter for palliative care (ICD-10-CM code Z51.5*) any time during the measurement period.</p> <p><b>Coding Guidance</b> *Do not include laboratory claims (claims with POS code 81).</p>
<b>Denominator</b>	<p><b>Denominator 1:</b> The initial population minus denominator exclusions.</p> <p><b>Denominator 2:</b> Persons from numerator 1 who were identified as a positive tobacco user between January 1 and December 1 of the measurement period.</p>
<b>Numerator</b>	<p><b>Numerator 1—Tobacco use screening.</b> Persons who were screened for tobacco use and identified as either a positive or negative tobacco user (see Definitions above) during the measurement period.</p> <p><b>Numerator 2—Cessation intervention.</b> Persons who received tobacco cessation intervention during the measurement period or 180 days prior to the measurement period. The following meet criteria:</p> <ul style="list-style-type: none"> <li>• Persons 12–17 years of age who received tobacco cessation counseling (<u>Tobacco Use Cessation Counseling Value Set</u>; ICD-10-CM code Z71.6*) during the measurement period or in the 180 days prior to the measurement period.</li> <li>• Persons 18 years of age and older who received tobacco cessation counseling (<u>Tobacco Use Cessation Counseling Value Set</u>; ICD-10-CM code Z71.6*) or dispensed pharmacotherapy intervention (<u>Tobacco Use Cessation Medications List</u>) during the measurement period or 180 days prior to the measurement period.</li> </ul> <p><b>Coding Guidance</b> *Do not include laboratory claims (claims with POS code 81).</p>
<b>Summary of changes</b>	<ul style="list-style-type: none"> <li>• This is a first-year measure.</li> </ul>

<b>Data element tables</b>	<p>Organizations that submit HEDIS data to NCQA must provide the following data elements.</p> <p><b>Table TSC-E-1/2: Data Elements for Tobacco Use Screening and Cessation Intervention</b></p> <table border="1" data-bbox="491 361 1470 684"> <thead> <tr> <th>Metric</th><th>Age</th><th>Data Element</th><th>Reporting Instructions</th></tr> </thead> <tbody> <tr> <td>TobaccoUse</td><td>12-17</td><td>Benefit</td><td>Metadata</td></tr> <tr> <td>Cessation</td><td>18-64</td><td>InitialPopulation</td><td>For each Stratification, repeat per metric</td></tr> <tr> <td></td><td>65+</td><td>Exclusions</td><td>For each Stratification, repeat per metric</td></tr> <tr> <td></td><td>Total</td><td>Denominator</td><td>For each Metric and Stratification</td></tr> <tr> <td></td><td></td><td>Numerator</td><td>For each Metric and Stratification</td></tr> <tr> <td></td><td></td><td>Rate</td><td>(Percent)</td></tr> </tbody> </table>	Metric	Age	Data Element	Reporting Instructions	TobaccoUse	12-17	Benefit	Metadata	Cessation	18-64	InitialPopulation	For each Stratification, repeat per metric		65+	Exclusions	For each Stratification, repeat per metric		Total	Denominator	For each Metric and Stratification			Numerator	For each Metric and Stratification			Rate	(Percent)
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<b>Rules for Allowable Adjustments</b>	<p><b>Copyright and use:</b> The “Rules for Allowable Adjustments of HEDIS” (the “Rules”) describe how NCQA’s HEDIS measure specifications can be adjusted for other populations, if applicable. The Rules, reviewed and approved by NCQA measure experts, provide for expanded use of HEDIS measures without changing their clinical intent.</p> <p><b>Adjusted HEDIS measures may not be used for HEDIS health plan reporting.</b></p> <p><b>ADJUSTMENTS ALLOWED</b></p> <ul style="list-style-type: none"> <li>• <i>Product lines.</i> Organizations are not required to use product line criteria; product lines may be combined, and all (or no) product line criteria may be used.</li> <li>• <i>Attribution.</i> Organizations are not required to use enrollment criteria.</li> <li>• <i>Benefits.</i> Organizations are not required to use a benefit.</li> <li>• <i>Other.</i> Organizations may use additional initial population criteria to focus on an area of interest defined by gender, race, ethnicity, socioeconomic or sociodemographic characteristics, geographic region or another characteristic.</li> <li>• <i>Exclusions.</i> The hospice and deceased persons exclusions are not required.</li> <li>• <i>Measurement period adjustments.</i> Organizations may adjust the measurement period.</li> <li>• <i>Telehealth.</i> Services/events that allow the use of synchronous telehealth visits, telephone visits and asynchronous telehealth (e-visits, virtual check-ins) may be stratified to identify services performed via telehealth.</li> </ul> <p><b>ADJUSTMENTS ALLOWED WITH LIMITS</b></p> <ul style="list-style-type: none"> <li>• <i>Ages.</i> The age determination dates may be changed (e.g., select, “age 60 as of June 30 of the measurement period”). The ages may not be expanded.</li> </ul>																												

	<b>ADJUSTMENTS NOT ALLOWED</b>
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- *Numerators 1 and 2.* Value sets, direct reference codes and logic may not be changed.
- *Denominator 2.* Value sets, direct reference codes and logic may not be changed.

## Adult Immunization Status (AIS-E)

Measure title	Adult Immunization Status*	Measure ID	AIS-E
<b>Description</b>	The percentage of persons 19 years of age and older who are up to date on recommended routine vaccines for influenza, tetanus and diphtheria (Td) or tetanus, diphtheria and acellular pertussis (Tdap), zoster, pneumococcal, hepatitis B and coronavirus disease 2019 (COVID-19).		
<b>Measurement period</b>	January 1–December 31.		
<b>Copyright and disclaimer notice</b>	<p>*Developed with support from the Department of Health and Human Services (DHHS), Office of the Assistant Secretary for Health (OASH), National Vaccine Program Office (NVPO) and The Hepatitis Education Project.</p> <p>Refer to the complete copyright and disclaimer information at the front of this publication.</p> <p>NCQA website: <a href="http://www.ncqa.org">www.ncqa.org</a>.</p> <p>Submit policy clarification support questions via My NCQA (<a href="https://my.ncqa.org">https://my.ncqa.org</a>).</p>		
<b>Clinical recommendation statement/ rationale</b>	The Advisory Committee on Immunization Practices recommends annual influenza vaccination; and tetanus, diphtheria and acellular pertussis (Tdap) and/or tetanus and diphtheria (Td) vaccine; herpes zoster, pneumococcal, hepatitis B and COVID-19 vaccination for adults at various ages.		
<b>Citations</b>	Wodi, A.P., A.N. Issa, C.A. Moser, S. Cineas. 2025. “Advisory Committee on Immunization Practices Recommended Immunization Schedule for Adults Aged 19 Years or Older—United States, 2025.” <i>MMWR Morb Mortal Wkly Rep</i> 74:30–33. doi: <a href="http://dx.doi.org/10.15585/mmwr.mm7402a3">http://dx.doi.org/10.15585/mmwr.mm7402a3</a>		
<b>Characteristics</b>			
<b>Scoring</b>	Proportion.		
<b>Type</b>	Process.		
<b>Product lines</b>	<ul style="list-style-type: none"> <li>• Commercial.</li> <li>• Medicaid.</li> <li>• Medicare.</li> </ul>		
<b>Stratifications</b>	<p>Influenza and Td/Tdap: Age as of the start of the measurement period.</p> <ul style="list-style-type: none"> <li>• 19–64 years.</li> <li>• 65 years and older.</li> </ul> <p>Zoster: Age as of the start of the measurement period.</p> <ul style="list-style-type: none"> <li>• 50–64 years.</li> <li>• 65 years and older.</li> </ul>		

	<p>Pneumococcal and COVID-19: Age as of the start of the measurement period.</p> <ul style="list-style-type: none"> <li>• 65 years and older.</li> </ul> <p>Hepatitis B: Age as of the start of the measurement period.</p> <ul style="list-style-type: none"> <li>• 19–30 years.</li> <li>• 31–59 years.</li> </ul> <p>Race. (Refer to <a href="#">General Guideline: Race and Ethnicity Stratification</a>.)</p> <ul style="list-style-type: none"> <li>• American Indian or Alaska Native.</li> <li>• Asian.</li> <li>• Black or African American.</li> <li>• Middle Eastern or North African.</li> <li>• Native Hawaiian or Pacific Islander.</li> <li>• White.</li> <li>• Some Other Race.</li> <li>• Two or More Races.</li> <li>• Asked But No Answer.</li> <li>• Unknown.</li> </ul> <p>Ethnicity. (Refer to <a href="#">General Guideline: Race and Ethnicity Stratification</a>.)</p> <ul style="list-style-type: none"> <li>• Hispanic or Latino.</li> <li>• Not Hispanic or Latino.</li> <li>• Asked But No Answer.</li> <li>• Unknown.</li> </ul>
<b>Risk adjustment</b>	None.
<b>Improvement notation</b>	Increased score indicates improvement.
<b>Guidance</b>	<p><b>Data collection methodology:</b> ECDS. Refer to <a href="#">General Guideline: Data Collection Methods</a> for additional information.</p> <p><b>Date specificity:</b> Dates must be specific enough to determine the event occurred in the period being measured.</p> <p><b>Which services count?</b> When using claims, include all paid, suspended, pending and denied claims.</p> <p><b>Other guidance:</b> Measure rates are specific to clinical guideline recommendations for the age group included in the rates.</p>
<b>Initial population</b>	<p><i>Measure item count:</i> Person.</p> <p><i>Attribution basis:</i> Enrollment.</p> <ul style="list-style-type: none"> <li>• <i>Benefits:</i> Medical.</li> <li>• <i>Continuous enrollment:</i> The measurement period.</li> </ul>

	<ul style="list-style-type: none"> <li>• <b>Allowable gap:</b> No more than one gap of ≤45 days during the measurement period. No gaps on the last day of the measurement period.</li> </ul> <p><b>Ages:</b></p> <ul style="list-style-type: none"> <li>• <i>Initial populations 1 and 2:</i> 19 years of age and older at the start of the measurement period.</li> <li>• <i>Initial population 3:</i> 50 years of age and older at the start of the measurement period.</li> <li>• <i>Initial populations 4 and 6:</i> 65 years of age and older at the start of the measurement period.</li> <li>• <i>Initial population 5:</i> 19–59 years of age at the start of the measurement period.</li> </ul> <p><b>Event:</b> None.</p>
<b>Denominator exclusions</b>	<p><b>Persons with a date of death.</b> Death in the measurement period, identified using data sources determined by the organization. Method and data sources are subject to review during the HEDIS audit.</p> <p><b>Persons in hospice or using hospice services.</b> Persons who use hospice services (<u>Hospice Encounter Value Set</u>; <u>Hospice Intervention Value Set</u>) or elect to use a hospice benefit any time during the measurement period. Organizations that use the Monthly Membership Detail Data File to identify these persons must use only the run date of the file.</p>
<b>Denominator</b>	<p><b>Denominator 1 and Denominator 2: Immunization status—Influenza and Td/Tdap.</b> The initial populations 1 and 2 minus denominator exclusions.</p> <p><b>Denominator 3: Immunization status—Zoster.</b> The initial population 3 minus denominator exclusions.</p> <p><b>Denominator 4 and Denominator 6: Immunization status—Pneumococcal and COVID-19.</b> The initial populations 4 and 6 minus denominator exclusions.</p> <p><b>Denominator 5: Immunization status—Hepatitis B.</b> The initial population 5 minus denominator exclusions.</p>
<b>Numerator</b>	<p><b>Numerator 1: Immunization status—Influenza.</b> Persons who meet either of the following criteria:</p> <ul style="list-style-type: none"> <li>• Received the influenza vaccine (<u>Adult Influenza Immunization Value Set</u>; <u>Adult Influenza Vaccine Procedure Value Set</u>; <u>Influenza Virus LAIV Immunization Value Set</u>; <u>Influenza Virus LAIV Vaccine Procedure Value Set</u>) on or between July 1 of the year prior to the measurement period and June 30 of the measurement period.</li> <li>• Had anaphylaxis due to the influenza vaccine (SNOMED CT code 471361000124100) any time before or during the measurement period.</li> </ul>

**Numerator 2: Immunization status—Td/Tdap.**

Persons who meet any of the following criteria:

- Received at least one Td or Tdap vaccine ([Td Immunization Value Set](#); CPT code 90714, CVX code 115; CPT code 90715) between 9 years prior to the start of the measurement period and the last day of the measurement period.
- Had anaphylaxis due to the diphtheria, tetanus or pertussis vaccine ([Anaphylaxis Due to Diphtheria, Tetanus or Pertussis Vaccine Value Set](#)) any time before or during the measurement period.
- Had encephalitis due to the diphtheria, tetanus or pertussis vaccine ([Encephalitis Due to Diphtheria, Tetanus or Pertussis Vaccine Value Set](#)) any time before or during the measurement period.

**Numerator 3: Immunization status—Zoster.**

Persons who meet either of the following criteria:

- Received two doses of the herpes zoster recombinant vaccine (CVX code 187; CPT code 90750) at least 28 days apart, on October 20, 2017, through the last day of the measurement period.
- Had anaphylaxis due to the herpes zoster vaccine ([Anaphylaxis Due to Herpes Zoster Vaccine Value Set](#)) any time before or during the measurement period.

**Numerator 4: Immunization status—Pneumococcal.**

Persons who meet either of the following criteria:

- Received at least one dose of adult pneumococcal vaccine ([Adult Pneumococcal Immunization Value Set](#); [Adult Pneumococcal Vaccine Procedure Value Set](#)) on or after their 19th birthday, any time before or during the measurement period.
- Had anaphylaxis due to the pneumococcal vaccine (SNOMED CT code 471141000124102) any time before or during the measurement period.

**Numerator 5: Immunization status—Hepatitis B.**

Persons who meet any of the following criteria:

- Received at least three doses of the childhood Hepatitis B vaccine ([Hepatitis B Immunization Value Set](#); [Hepatitis B Vaccine Procedure Value Set](#)) with different dates of service on or before their 19th birthday.
  - One of the three vaccinations can be a newborn hepatitis B vaccination (ICD-10-PCS code 3E0234Z) during the 8-day period that begins on the date of birth and ends 7 days after the date of birth.
- Received Hepatitis B vaccine series on or after their 19th birthday, before or during the measurement period, including either of the following:
  - At least two doses of the recommended two-dose adult Hepatitis B vaccine (CVX code 189; [Adult Hepatitis B Vaccine Procedure \(2 dose\) Value Set](#)) administered at least 28 days apart; **or**

	<ul style="list-style-type: none"> <li>– At least three doses of any other recommended adult Hepatitis B vaccine (<a href="#">Adult Hepatitis B Immunization (3 dose) Value Set</a>; <a href="#">Adult Hepatitis B Vaccine Procedure (3 dose) Value Set</a>) administered on different days of service.</li> <li>• Had a hepatitis B surface antigen, hepatitis B surface antibody or total antibody to hepatitis B core antigen test with a finding of immunity any time before or during the measurement period, including either of the following: <ul style="list-style-type: none"> <li>– A test (<a href="#">Hepatitis B Tests With Threshold of 10 Value Set</a>) with a result greater than 10 mIU/mL.</li> <li>– A test (<a href="#">Hepatitis B Prevaccination Tests Value Set</a>) with a finding of immunity (<a href="#">Hepatitis B Immunity Finding Value Set</a>).</li> </ul> </li> <li>• History of hepatitis B illness (<a href="#">Hepatitis B and History of Hepatitis B Value Set*</a>) any time before or during the measurement period.</li> <li>• Had anaphylaxis due to the hepatitis B vaccine (SNOMED CT code 428321000124101) any time before or during the measurement period.</li> </ul>
	<p><b>Numerator 6: Immunization status—COVID-19.</b>  Persons who meet either of the following criteria:</p> <ul style="list-style-type: none"> <li>• Received at least one dose of a COVID-19 vaccine (<a href="#">Adult COVID19 Immunization Value Set</a>; <a href="#">Adult COVID19 Vaccine Procedure Value Set</a>) that occurred <b>both</b> on or between July 1 of the year prior to the measurement period through June 30 of the measurement period <b>and</b> on or after their 65th birthday.</li> <li>• Had anaphylaxis due to the COVID-19 vaccine (SNOMED CT code 914587451000119107) any time before or during the measurement period.</li> </ul> <p><b>Coding Guidance</b>  *Do not include laboratory claims (claims with POS code 81).</p>
<b>Summary of changes</b>	<ul style="list-style-type: none"> <li>• Removed the definitions of “participation” and “participation period.”</li> <li>• Added the COVID-19 indicator for adults 65 and older. This indicator is in first-year status for measurement year 2026.</li> <li>• Updated the citation for clinical recommendation statement and rationale.</li> <li>• Updated the race and ethnicity stratification categories to align with OMB SPD 15 2024.</li> <li>• Removed the SSoR data elements from the data element tables.</li> <li>• Added instructions on allowable adjustments to the race and ethnicity stratifications.</li> </ul>

<b>Data element tables</b>	<p>Organizations that submit HEDIS data to NCQA must provide the following data elements.</p> <p><b>Table AIS-E-A:-1/2/3 Data Elements for Adult Immunization Status</b></p> <table border="1"> <thead> <tr> <th>Metric</th><th>Age</th><th>Data Element</th><th>Reporting Instructions</th></tr> </thead> <tbody> <tr> <td>Influenza</td><td>19-64</td><td>InitialPopulation</td><td>For each Metric and Stratification</td></tr> <tr> <td>TdTdap</td><td>65+</td><td>Exclusions</td><td>For each Metric and Stratification</td></tr> <tr> <td></td><td>Total</td><td>Denominator</td><td>For each Metric and Stratification</td></tr> <tr> <td></td><td></td><td>Numerator</td><td>For each Metric and Stratification</td></tr> <tr> <td>Zoster</td><td>50-64</td><td>Rate</td><td>(Percent)</td></tr> <tr> <td></td><td>65+</td><td></td><td></td></tr> <tr> <td></td><td>Total</td><td></td><td></td></tr> <tr> <td>Pneumococcal</td><td>65+</td><td></td><td></td></tr> <tr> <td>COVID-19</td><td></td><td></td><td></td></tr> <tr> <td>HepatitisB</td><td>19-30</td><td></td><td></td></tr> <tr> <td></td><td>31-59</td><td></td><td></td></tr> <tr> <td></td><td>Total</td><td></td><td></td></tr> </tbody> </table> <p><b>Table AIS-E-B-1/2/3: Data Elements for Adult Immunization Status: Stratifications by Race</b></p> <table border="1"> <thead> <tr> <th>Metric</th><th>Race</th><th>Data Element</th><th>Reporting Instructions</th></tr> </thead> <tbody> <tr> <td>Influenza</td><td>AmericanIndianOrAlaskaNative</td><td>InitialPopulation</td><td>For each Metric and Stratification</td></tr> <tr> <td>TdTdap</td><td>Asian</td><td>Exclusions</td><td>For each Metric and Stratification</td></tr> <tr> <td>Zoster</td><td>BlackOrAfricanAmerican</td><td>Denominator</td><td>For each Metric and Stratification</td></tr> <tr> <td>Pneumococcal</td><td>MiddleEasternOrNorthAfrican</td><td>Numerator</td><td>For each Metric and Stratification</td></tr> <tr> <td>HepatitisB</td><td>NativeHawaiianOrPacificIslander</td><td>Rate</td><td>(Percent)</td></tr> <tr> <td>COVID-19</td><td>White</td><td></td><td></td></tr> <tr> <td></td><td>SomeOtherRace</td><td></td><td></td></tr> <tr> <td></td><td>TwoOrMoreRaces</td><td></td><td></td></tr> <tr> <td></td><td>AskedButNoAnswer</td><td></td><td></td></tr> <tr> <td></td><td>Unknown</td><td></td><td></td></tr> </tbody> </table>	Metric	Age	Data Element	Reporting Instructions	Influenza	19-64	InitialPopulation	For each Metric and Stratification	TdTdap	65+	Exclusions	For each Metric and Stratification		Total	Denominator	For each Metric and Stratification			Numerator	For each Metric and Stratification	Zoster	50-64	Rate	(Percent)		65+				Total			Pneumococcal	65+			COVID-19				HepatitisB	19-30				31-59				Total			Metric	Race	Data Element	Reporting Instructions	Influenza	AmericanIndianOrAlaskaNative	InitialPopulation	For each Metric and Stratification	TdTdap	Asian	Exclusions	For each Metric and Stratification	Zoster	BlackOrAfricanAmerican	Denominator	For each Metric and Stratification	Pneumococcal	MiddleEasternOrNorthAfrican	Numerator	For each Metric and Stratification	HepatitisB	NativeHawaiianOrPacificIslander	Rate	(Percent)	COVID-19	White				SomeOtherRace				TwoOrMoreRaces				AskedButNoAnswer				Unknown		
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Metric	Ethnicity	Data Element	Reporting Instructions
Influenza	HispanicOrLatino	InitialPopulation	For each Metric and Stratification
TdTdap	NotHispanicOrLatino	Exclusions	For each Metric and Stratification
Zoster	AskedButNoAnswer	Denominator	For each Metric and Stratification
Pneumococcal	Unknown	Numerator	For each Metric and Stratification
HepatitisB		Rate	(Percent)
COVID-19			

<b>Rules for Allowable Adjustments</b>	<p><b>Copyright and use:</b> The “Rules for Allowable Adjustments of HEDIS” (the “Rules”) describe how NCQA’s HEDIS measure specifications can be adjusted for other populations, if applicable. The Rules, reviewed and approved by NCQA measure experts, provide for expanded use of HEDIS measures without changing their clinical intent.</p> <p><b>Adjusted HEDIS measures may not be used for HEDIS health plan reporting.</b></p> <p><b>ADJUSTMENTS ALLOWED</b></p> <ul style="list-style-type: none"> <li>• <b>Product lines.</b> Organizations are not required to use product line criteria; product lines may be combined, and all (or no) product line criteria may be used.</li> <li>• <b>Attribution.</b> Organizations are not required to use enrollment criteria.</li> <li>• <b>Benefits.</b> Organizations are not required to use a benefit.</li> <li>• <b>Other.</b> Organizations may use additional initial population criteria to focus on a population of interest such as gender, race and ethnicity, socioeconomic or sociodemographic characteristics, geographic region or another characteristic.</li> <li>• <b>Measurement period adjustments.</b> Organizations may adjust the measurement period.</li> <li>• <b>Stratifications:</b> Race and ethnicity stratification. The race and ethnicity stratification is not required. Organizations may adjust this stratification as needed.</li> <li>• <b>Exclusions.</b> Hospice and deceased persons exclusions are not required.</li> <li>• <b>Telehealth.</b> Services/events that allow the use of synchronous telehealth visits, telephone visits and asynchronous telehealth (e-visits, virtual check-ins) may be stratified to identify services performed via telehealth. This adjustment is not allowed for events, numerators and exclusions that do not allow the use of telehealth.</li> </ul>
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**ADJUSTMENTS ALLOWED WITH LIMITS**

- **Ages.** The age determination dates may be changed (e.g., select, “age as of June 30”). Changing the denominator age range is allowed; however, organizations must consult ACIP guidelines when considering whether to expand the age range outside current thresholds.

**ADJUSTMENTS NOT ALLOWED**

- **Numerator.** Value sets, direct reference codes and logic may not be changed.

## Prenatal Immunization Status (PRS-E)

<b>Measure title</b>	Prenatal Immunization Status*	<b>Measure ID</b>	PRS-E
<b>Description</b>	The percentage of deliveries in the measurement period in which persons received influenza and tetanus, diphtheria toxoids and acellular pertussis (Tdap) vaccinations.		
<b>Measurement period</b>	January 1–December 31.		
<b>Copyright and disclaimer notice</b>	<p><i>*Developed with support from the Department of Health and Human Services (DHHS), Office of the Assistant Secretary for Health (OASH), National Vaccine Program Office (NVPO).</i></p> <p>Refer to the complete copyright and disclaimer information at the front of this publication.</p> <p>NCQA website: <a href="http://www.ncqa.org">www.ncqa.org</a>.</p> <p>Submit policy clarification support questions via My NCQA (<a href="https://my.ncqa.org">https://my.ncqa.org</a>).</p>		
<b>Clinical recommendation statement and rationale</b>	Advisory Committee on Immunization Practices (ACIP) clinical guidelines recommend that all women who are pregnant or who might be pregnant in the upcoming influenza season receive inactivated influenza vaccines. ACIP also recommends that pregnant women receive one dose of Tdap during each pregnancy, preferably during the early part of gestational weeks 27–36, regardless of prior history of receiving Tdap.		
<b>Citations</b>	Wodi, A.P., A.N. Issa, C.A. Moser, S. Cineas. 2025. “Advisory Committee on Immunization Practices Recommended Immunization Schedule for Adults Aged 19 Years or Older—United States, 2025.” <i>MMWR Morb Mortal Wkly Rep</i> 74:30–33. doi: <a href="http://dx.doi.org/10.15585/mmwr.mm7402a3">http://dx.doi.org/10.15585/mmwr.mm7402a3</a>		
<b>Characteristics</b>			
<b>Scoring</b>	Proportion.		
<b>Type</b>	Process.		
<b>Product lines</b>	<ul style="list-style-type: none"> <li>• Commercial.</li> <li>• Medicaid.</li> </ul>		
<b>Stratifications</b>	<p>Race. (Refer to <a href="#">General Guideline: Race and Ethnicity Stratification</a>.)</p> <ul style="list-style-type: none"> <li>• American Indian or Alaska Native.</li> <li>• Asian.</li> <li>• Black or African American.</li> <li>• Middle Eastern or North African.</li> <li>• Native Hawaiian or Pacific Islander.</li> <li>• White.</li> </ul>		

	<ul style="list-style-type: none"> <li>• Some Other Race.</li> <li>• Two or More Races.</li> <li>• Asked But No Answer.</li> <li>• Unknown.</li> </ul> <p>Ethnicity. (Refer to <a href="#">General Guideline: Race and Ethnicity Stratification</a>.)</p> <ul style="list-style-type: none"> <li>• Hispanic or Latino.</li> <li>• Not Hispanic or Latino.</li> <li>• Asked But No Answer.</li> <li>• Unknown.</li> </ul>
<b>Risk adjustment</b>	None.
<b>Improvement notation</b>	Increased score indicates improvement.
<b>Guidance</b>	<p><b>Data collection methodology:</b> ECDS. Refer to <a href="#">General Guideline: Data Collection Methods</a> for additional information.</p> <p><b>Date specificity:</b> Dates must be specific enough to determine that the event occurred in the period being measured.</p> <p><b>Which services count?</b> When using claims, include all paid, suspended, pending and denied claims.</p> <p><b>Other guidance:</b> The measure is based on deliveries; therefore, it is possible for denominator to include multiple deliveries for the same person.</p>
<b>Definitions</b>	
<b>Pregnancy episode</b>	Calculate pregnancy start date by subtracting the gestational age (in weeks) at the time of delivery from the delivery date. Use the last gestational age assessment or diagnosis within 1 day of the delivery date.
<b>Initial population</b>	<p><b>Measure item count:</b> Episode.</p> <p><b>Attribution basis:</b> Enrollment.</p> <ul style="list-style-type: none"> <li>• <b>Benefits:</b> Medical.</li> <li>• <b>Continuous enrollment:</b> From 28 days prior to the delivery date through the delivery date.</li> <li>• <b>Allowable gap:</b> None.</li> </ul> <p><b>Ages:</b> None.</p> <p><b>Event: Deliveries.</b></p> <p>Deliveries (<a href="#">Deliveries Value Set</a>), in any setting, during the measurement period that have a gestational age assessment (<a href="#">Weeks of Gestation Value Set</a>; value is not null) or gestational age diagnosis within 1 day of the start or end of the delivery.</p> <p>Determine the delivery date using the date as of the end of the delivery procedure.</p>

	<p>A code from any of the following value sets meets criteria for gestational age diagnosis:</p> <ul style="list-style-type: none"> <li>• <a href="#">Weeks of Gestation Less Than 37 Value Set</a>.</li> <li>• <a href="#">37 Weeks Gestation Value Set</a>.</li> <li>• <a href="#">38 Weeks Gestation Value Set</a>.</li> <li>• <a href="#">39 Weeks Gestation Value Set</a>.</li> <li>• <a href="#">40 Weeks Gestation Value Set</a>.</li> <li>• <a href="#">41 Weeks Gestation Value Set</a>.</li> <li>• <a href="#">42 Weeks Gestation Value Set</a>.</li> <li>• 43 weeks gestation (ICD-10-CM code Z3A.49).</li> </ul> <p>If a person has more than one delivery in a 180-day period, include only the first eligible delivery. Then, if applicable include the next delivery that occurs after the 180-day period. Identify deliveries chronologically, including only one per 180-day period.</p> <p><b>Note:</b> Removal of multiple deliveries in a 180-day period is based on eligible deliveries. Assess each delivery for exclusions and attribution before removing multiple deliveries in a 180-day period.</p>
<b>Denominator exclusions</b>	<p><b>Persons with a date of death.</b> Death in the measurement period, identified using data sources determined by the organization. Method and data sources are subject to review during the HEDIS audit.</p> <p><b>Persons in hospice or using hospice services.</b> Persons who use hospice services (<a href="#">Hospice Encounter Value Set</a>; <a href="#">Hospice Intervention Value Set</a>) or elect to use a hospice benefit any time during the measurement period. Organizations that use the Monthly Membership Detail Data File to identify these persons must use only the run date of the file.</p> <p><b>Deliveries that occur at less than 37 weeks of gestation.</b> Length of gestation in weeks is identified by one of two methods:</p> <ul style="list-style-type: none"> <li>• Gestational age assessment (<a href="#">Weeks of Gestation Value Set</a>; value &lt;37 weeks), <b>or</b></li> <li>• Gestational age diagnosis (<a href="#">Weeks of Gestation Less Than 37 Value Set</a>).</li> </ul>
<b>Denominator</b>	The initial population minus denominator exclusions.
<b>Numerator</b>	<p><b>Numerator 1: Immunization status—Influenza.</b></p> <ul style="list-style-type: none"> <li>• Deliveries where persons received an adult influenza vaccine (<a href="#">Adult Influenza Immunization Value Set</a>; <a href="#">Adult Influenza Vaccine Procedure Value Set</a>) on or between July 1 of the year prior to the measurement period and the delivery date, <b>or</b></li> <li>• Deliveries where persons had anaphylaxis due to the influenza vaccine (SNOMED CT code 471361000124100) on or before the delivery date.</li> </ul>

	<p><b>Numerator 2: Immunization status—Tdap.</b></p> <ul style="list-style-type: none"> <li>• Deliveries where persons received at least one Tdap vaccine (CVX code 115; CPT code 90715) during the pregnancy (including on the delivery date), <b>or</b></li> <li>• Deliveries where persons had either of the following: <ul style="list-style-type: none"> <li>– Anaphylaxis due to the diphtheria, tetanus or pertussis vaccine (<a href="#">Anaphylaxis Due to Diphtheria, Tetanus or Pertussis Vaccine Value Set</a>) on or before the delivery date.</li> <li>– Encephalitis due to the diphtheria, tetanus or pertussis vaccine (<a href="#">Encephalitis Due to Diphtheria, Tetanus or Pertussis Vaccine Value Set</a>) on or before the delivery date.</li> </ul> </li> </ul> <p><b>Numerator 3: Immunization status—Combination.</b></p> <p>Deliveries that met criteria for numerator 1 and numerator 2.</p>																																						
<b>Summary of changes</b>	<ul style="list-style-type: none"> <li>• Updated the citation for the clinical recommendation statement and rationale.</li> <li>• Updated the race and ethnicity stratification categories to align with OMB SPD 15 2024.</li> <li>• Removed the definitions of “participation” and “participation period.”</li> <li>• Removed the SSoR data elements from the data element tables.</li> <li>• Added instructions on allowable adjustments to the race and ethnicity stratifications.</li> </ul>																																						
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Metric	Race	Data Element	Reporting Instructions
	NativeHawaiianOrPacificIslander	Rate	(Percent)
	White		
	SomeOtherRace		
	TwoOrMoreRaces		
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	Unknown		
<b>Table PRS-E-C-1/2: Data Elements for Prenatal Immunization Status: Stratifications by Ethnicity</b>			
Metric	Ethnicity	Data Element	Reporting Instructions
Influenza	HispanicOrLatino	InitialPopulation	For each Stratification, repeat per Metric
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	Unknown	Numerator	For each Metric and Stratification
		Rate	(Percent)
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- *Stratifications:* Race and ethnicity stratification. The race and ethnicity stratification is not required. Organizations may adjust this stratification as needed.
- *Exclusions:* Hospice and deceased persons exclusions are not required.
- *Telehealth:* Services/events that allow the use of synchronous telehealth visits, telephone visits and asynchronous telehealth (e-visits, virtual check-ins) may be stratified to identify services performed via telehealth. This adjustment is not allowed for events, numerators and exclusions that do not allow the use of telehealth.

**ADJUSTMENTS ALLOWED WITH LIMITS**

- *Exclusions:* Organizations may choose to not exclude deliveries that occurred at less than 37 weeks gestation. Apply exclusions according to specified value sets.

**ADJUSTMENTS NOT ALLOWED**

- *Initial population:* Event. Only events or diagnoses that contain (or map to) codes in the value sets may be used to identify visits with a diagnosis. The value sets and logic may not be changed.
- *Numerator:* Value sets, direct reference codes and logic may not be changed.

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

Measure title	Prenatal Depression Screening and Follow-Up*	Measure ID	PND-E
<b>Description</b>	<p>The percentage of deliveries in which persons were screened for clinical depression while pregnant and, if screened positive, received follow-up care.</p> <ul style="list-style-type: none"> <li>• <i>Depression Screening.</i> The percentage of deliveries in which persons were screened for clinical depression during pregnancy using a standardized instrument.</li> <li>• <i>Follow-Up on Positive Screen.</i> The percentage of deliveries in which persons received follow-up care within 30 days of a positive depression screen finding.</li> </ul>		
<b>Measurement period</b>	January 1–December 31.		
<b>Copyright and disclaimer notice</b>	<p>*Developed with support from the California HealthCare Foundation (CHCF). CHCF works to ensure that people have access to the care they need, when they need it, at a price they can afford. Visit <a href="https://www.chcf.org/">https://www.chcf.org/</a> to learn more. Also supported by the Zoma Foundation.</p> <p>Refer to the complete copyright and disclaimer information at the front of this publication.</p> <p>NCQA website: <a href="http://www.ncqa.org">www.ncqa.org</a>.</p> <p>Submit policy clarification support questions via My NCQA (<a href="https://my.ncqa.org">https://my.ncqa.org</a>).</p>		
<b>Clinical recommendation statement/ rationale</b>	<p>The U.S. Preventive Services Task Force (USPSTF) recommends screening for depression among adolescents and adults, including pregnant and postpartum women. (B recommendation)</p> <p>The American College of Obstetricians and Gynecologists (ACOG) recommends that clinicians screen patients at the initial prenatal visit, later in pregnancy, and at postpartum visits using a standardized, validated tool.</p> <p>The USPSTF and ACOG also recommend that screening be implemented with adequate systems in place to ensure accurate diagnosis, effective treatment and appropriate follow-up. (B recommendation)</p>		
<b>Citations</b>	<p>American College of Obstetricians and Gynecologists. 2023. “Screening and Diagnosis of Mental Health Conditions During Pregnancy and Postpartum: ACOG Clinical Practice Guideline No. 4.” <i>Obstet Gynecol</i> 141.6: 1232–61.</p> <p>U.S. Preventive Services Task Force et al. 2023. “Screening for Depression and Suicide Risk in Adults: U.S. Preventive Task Force Recommendation Statement.” <i>JAMA</i> vol. 329,23: 2057–67.</p> <p>U.S. Preventive Services Task Force et al. 2022. “Screening for Depression and Suicide Risk in Children and Adolescents: U.S. Preventive Task Force Recommendation Statement.” <i>JAMA</i> vol. 328,15: 1534–42.</p>		

Characteristics	
<b>Scoring</b>	Proportion.
<b>Type</b>	Process.
<b>Product lines</b>	<ul style="list-style-type: none"> <li>Commercial.</li> <li>Medicaid.</li> </ul>
<b>Stratifications</b>	<p>Race. (Refer to <a href="#">General Guideline: Race and Ethnicity Stratification</a>.)</p> <ul style="list-style-type: none"> <li>American Indian or Alaska Native.</li> <li>Asian.</li> <li>Black or African American.</li> <li>Middle Eastern or North African.</li> <li>Native Hawaiian or Pacific Islander.</li> <li>White.</li> <li>Some Other Race.</li> <li>Two or More Races.</li> <li>Asked But No Answer.</li> <li>Unknown.</li> </ul> <p>Ethnicity. (Refer to <a href="#">General Guideline: Race and Ethnicity Stratification</a>.)</p> <ul style="list-style-type: none"> <li>Hispanic or Latino.</li> <li>Not Hispanic or Latino.</li> <li>Asked But No Answer.</li> <li>Unknown.</li> </ul>
<b>Risk adjustment</b>	None.
<b>Improvement notation</b>	Increased score indicates improvement.
<b>Guidance</b>	<p><b>Data collection methodology:</b> ECDS. Refer to <a href="#">General Guideline: Data Collection Methods</a> for additional information.</p> <p><b>Date specificity:</b> Dates must be specific enough to determine that the event occurred in the period being measured.</p> <p><b>Which services count?</b> When using claims, include all paid, suspended, pending and denied claims.</p> <p><b>Other guidance:</b> The measure is based on deliveries; therefore, it is possible for denominator to include multiple deliveries for the same person.</p>
Definitions	
<b>Pregnancy start date</b>	Pregnancy start date is calculated by subtracting the gestational age (in weeks) at the time of delivery from the delivery date. Use the last gestational age assessment or diagnosis within 1 day of the delivery date.

<b>Depression screening instrument</b>	A standard assessment instrument normalized and validated for the appropriate patient population. Eligible screening instruments with thresholds for positive findings include:				
<b>Instruments for Adolescents (≤17 Years)</b>		<b>Total Score LOINC Codes</b>	<b>Positive Finding</b>		
Patient Health Questionnaire (PHQ-9) <sup>®</sup>	44261-6	Total score ≥10			
Patient Health Questionnaire Modified for Teens (PHQ- 9M) <sup>®</sup>	89204-2	Total score ≥10			
Patient Health Questionnaire-2 (PHQ-2) <sup>®1</sup>	55758-7	Total score ≥3			
Beck Depression Inventory—Fast Screen (BDI-FS) <sup>®1,2</sup>	89208-3	Total score ≥8			
Center for Epidemiologic Studies Depression Scale—Revised (CESD-R)	89205-9	Total score ≥17			
Edinburgh Postnatal Depression Scale (EPDS)	99046-5	Total score ≥10			
PROMIS Depression	71965-8	Total score (T Score) ≥60			
<sup>1</sup> Brief screening instrument. All other instruments are full-length.					
<sup>2</sup> Proprietary; there may be a cost or licensing requirement associated with use.					
<b>Instruments for Adults (18+ Years)</b>		<b>Total Score LOINC Codes</b>	<b>Positive Finding</b>		
Patient Health Questionnaire (PHQ-9) <sup>®</sup>	44261-6	Total score ≥10			
Patient Health Questionnaire-2 (PHQ-2) <sup>®1</sup>	55758-7	Total score ≥3			
Beck Depression Inventory—Fast Screen (BDI-FS) <sup>®1,2</sup>	89208-3	Total score ≥8			
Beck Depression Inventory (BDI-II)	89209-1	Total score ≥20			
Center for Epidemiologic Studies Depression Scale—Revised (CESD-R)	89205-9	Total score ≥17			
Duke Anxiety-Depression Scale (DUKE-AD) <sup>®2</sup>	90853-3	Total score ≥30			
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PROMIS Emotional Distress—Depression—Short Form	77861-3	Total score (T Score) ≥60			
Clinically Useful Depression Outcome Scale (CUDOS)	90221-3	Total score ≥31			
<sup>1</sup> Brief screening instrument. All other instruments are full-length.					
<sup>2</sup> Proprietary; there may be a cost or licensing requirement associated with use.					

<b>Initial population</b>	<p><b>Measure item count:</b> Episode.</p> <p><b>Attribution basis:</b> Enrollment.</p> <ul style="list-style-type: none"> <li>• <b>Benefits:</b> Medical.</li> <li>• <b>Continuous enrollment:</b> 28 days prior to the delivery date through the delivery date.</li> <li>• <b>Allowable gap:</b> None.</li> </ul> <p><b>Ages:</b> None.</p> <p><b>Event: Deliveries.</b></p> <p>Deliveries (<a href="#">Deliveries Value Set</a>), in any setting, during the measurement period that have a gestational age assessment (<a href="#">Weeks of Gestation Value Set</a>; value is not null) or gestational age diagnosis within 1 day of the start or end of the delivery.</p> <p>Determine the delivery date using the date as of the end of the delivery procedure.</p> <p>A code from any of the following value sets meets criteria for gestational age diagnosis:</p> <ul style="list-style-type: none"> <li>• <a href="#">Weeks of Gestation Less Than 37 Value Set</a>.</li> <li>• <a href="#">37 Weeks Gestation Value Set</a>.</li> <li>• <a href="#">38 Weeks Gestation Value Set</a>.</li> <li>• <a href="#">39 Weeks Gestation Value Set</a>.</li> <li>• <a href="#">40 Weeks Gestation Value Set</a>.</li> <li>• <a href="#">41 Weeks Gestation Value Set</a>.</li> <li>• <a href="#">42 Weeks Gestation Value Set</a>.</li> <li>• 43 weeks gestation (ICD-10-CM code Z3A.49).</li> </ul> <p>If a person has more than one delivery in a 180-day period, include only the first eligible delivery. Then, if applicable include the next delivery that occurs after the 180-day period. Identify deliveries chronologically, including only one per 180-day period.</p> <p><b>Note:</b> Removal of multiple deliveries in a 180-day period is based on eligible deliveries. Assess each delivery for exclusions and attribution before removing multiple deliveries in a 180-day period.</p>
<b>Denominator exclusions</b>	<p><b>Persons with a date of death.</b> Death in the measurement period, identified using data sources determined by the organization. Method and data sources are subject to review during the HEDIS audit.</p> <p><b>Persons in hospice or using hospice services.</b> Persons who use hospice services (<a href="#">Hospice Encounter Value Set</a>; <a href="#">Hospice Intervention Value Set</a>) or elect to use a hospice benefit any time during the measurement period. Organizations that use the Monthly Membership Detail Data File to identify these persons must use only the run date of the file.</p>

	<p><b>Deliveries that occurred at less than 37 weeks gestation.</b>  Length of gestation in weeks is identified by one of two methods:</p> <ul style="list-style-type: none"> <li>• Gestational age assessment (<a href="#">Weeks of Gestation Value Set</a>; value &lt;37 weeks), <b>or</b></li> <li>• Gestational age diagnosis (<a href="#">Weeks of Gestation Less Than 37 Value Set</a>).</li> </ul>
<b>Denominator</b>	<p><b>Denominator 1:</b> The initial population minus denominator exclusions.</p> <p><b>Denominator 2:</b> Deliveries from numerator 1 with a positive finding for depression.</p>
<b>Numerator</b>	<p><b>Numerator 1: Depression screening.</b>  Deliveries in which persons had a documented result for depression screening, using an age-appropriate standardized screening instrument performed during pregnancy (on or between pregnancy start date and the delivery date).</p> <ul style="list-style-type: none"> <li>• <i>Deliveries between January 1 and December 1 of the measurement period:</i> Screening should be performed between the pregnancy start date and the delivery date (including on the delivery date).</li> <li>• <i>Deliveries between December 2 and December 31 of the measurement period:</i> Screening should be performed between the pregnancy start date and December 1 of the measurement period.</li> </ul> <p><b>Numerator 2: Follow-up on positive screen.</b>  Deliveries in which persons received follow-up care on or up to 30 days after the date of the first positive screen (31 total days).</p> <p>Any of the following on or up to 30 days after the first positive screen:</p> <ul style="list-style-type: none"> <li>• An outpatient, telephone, e-visit or virtual check-in follow-up visit (<a href="#">Follow Up Visit Value Set</a>) with a diagnosis of depression or other behavioral health condition (<a href="#">Depression or Other Behavioral Health Condition Value Set</a>).</li> <li>• A depression case management encounter (<a href="#">Depression Case Management Encounter Value Set</a>) that documents assessment for symptoms of depression (<a href="#">Symptoms of Depression Value Set</a>) or a diagnosis of depression or other behavioral health condition (<a href="#">Depression or Other Behavioral Health Condition Value Set</a>).</li> <li>• A behavioral health encounter, including assessment, therapy, collaborative care or medication management (<a href="#">Behavioral Health Encounter Value Set</a>).</li> <li>• A diagnosis of encounter for exercise counseling (ICD-10-CM code Z71.82*).</li> <li>• A dispensed antidepressant medication (<a href="#">Antidepressant Medications List</a>).</li> </ul> <p><b>OR</b></p>

	<ul style="list-style-type: none"> <li>Documentation of additional depression screening on a full-length instrument indicating either no depression or no symptoms that require follow-up (i.e., a negative screen) on the same day as a positive screen on a brief screening instrument.</li> </ul> <p><i>For example</i>, if there is a positive screen resulting from a PHQ-2 score, documentation of a negative finding from a PHQ-9 performed on the same day qualifies as evidence of follow-up.</p> <p><b>Coding Guidance</b> *Do not include laboratory claims (claims with POS code 81).</p>																																						
<b>Summary of changes</b>	<ul style="list-style-type: none"> <li>Updated clinical recommendation language to be consistent with 2023 ACOG clinical practice guidelines.</li> <li>Updated the race and ethnicity stratification categories to align with OMB SPD 15 2024.</li> <li>Removed the definitions of “participation” and “participation period.”</li> <li>Added the PROMIS Emotional Distress instrument to the depression screening instruments for adults.</li> <li>Removed the SSoR data elements from the data element tables.</li> <li>Added instructions on allowable adjustments to the race and ethnicity stratifications.</li> </ul>																																						
<b>Data element tables</b>	<p>Organizations that submit HEDIS data to NCQA must provide the following data elements.</p> <p><b>Table PND-E-A-1/2: Data Elements for Prenatal Depression Screening and Follow-Up</b></p> <table border="1"> <thead> <tr> <th>Metric</th> <th>Data Element</th> <th>Reporting Instructions</th> </tr> </thead> <tbody> <tr> <td>Screening</td> <td>InitialPopulation</td> <td>Repeat per Metric</td> </tr> <tr> <td>FollowUp</td> <td>Exclusions</td> <td>Repeat per Metric</td> </tr> <tr> <td></td> <td>Denominator</td> <td>For each Metric</td> </tr> <tr> <td></td> <td>Numerator</td> <td>For each Metric</td> </tr> <tr> <td></td> <td>Rate</td> <td>(Percent)</td> </tr> </tbody> </table> <p><b>Table PND-E-B-1/2: Data Elements for Prenatal Depression Screening and Follow-Up: Stratifications by Race</b></p> <table border="1"> <thead> <tr> <th>Metric</th> <th>Race</th> <th>Data Element</th> <th>Reporting Instructions</th> </tr> </thead> <tbody> <tr> <td>Screening</td> <td>AmericanIndianOrAlaskaNative</td> <td>InitialPopulation</td> <td>For each Stratification, repeat per Metric</td> </tr> <tr> <td>FollowUp</td> <td>Asian</td> <td>Exclusions</td> <td>For each Stratification, repeat per Metric</td> </tr> <tr> <td></td> <td>BlackOrAfricanAmerican</td> <td>Denominator</td> <td>For each Stratification, repeat per Metric</td> </tr> <tr> <td></td> <td>MiddleEasternOrNorthAfrican</td> <td>Numerator</td> <td>For each Metric and Stratification</td> </tr> </tbody> </table>	Metric	Data Element	Reporting Instructions	Screening	InitialPopulation	Repeat per Metric	FollowUp	Exclusions	Repeat per Metric		Denominator	For each Metric		Numerator	For each Metric		Rate	(Percent)	Metric	Race	Data Element	Reporting Instructions	Screening	AmericanIndianOrAlaskaNative	InitialPopulation	For each Stratification, repeat per Metric	FollowUp	Asian	Exclusions	For each Stratification, repeat per Metric		BlackOrAfricanAmerican	Denominator	For each Stratification, repeat per Metric		MiddleEasternOrNorthAfrican	Numerator	For each Metric and Stratification
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Metric	Race	Data Element	Reporting Instructions
	NativeHawaiianOrPacificIslander	Rate	(Percent)
	White		
	SomeOtherRace		
	TwoOrMoreRaces		
	AskedButNoAnswer		
	Unknown		
<b>Table PND-E-C-1/2: Data Elements for Prenatal Depression Screening and Follow-Up: Stratifications by Ethnicity</b>			
Metric	Ethnicity	Data Element	Reporting Instructions
Screening	HispanicOrLatino	InitialPopulation	For each Stratification, repeat per Metric
FollowUp	NotHispanicOrLatino	Exclusions	For each Stratification, repeat per Metric
	AskedButNoAnswer	Denominator	For each Stratification, repeat per Metric
	Unknown	Numerator	For each Metric and Stratification
		Rate	(Percent)
<b>Rules for Allowable Adjustments</b>	<p><b>Copyright and use:</b> The “Rules for Allowable Adjustments of HEDIS” (the “Rules”) describe how NCQA’s HEDIS measure specifications can be adjusted for other populations, if applicable. The Rules, reviewed and approved by NCQA measure experts, provide for expanded use of HEDIS measures without changing their clinical intent.</p> <p><b>Adjusted HEDIS measures may not be used for HEDIS health plan reporting.</b></p> <p><b>ADJUSTMENTS ALLOWED</b></p> <ul style="list-style-type: none"> <li>• <b>Product lines.</b> Organizations are not required to use product line criteria; product lines may be combined, and all (or no) product line criteria may be used.</li> <li>• <b>Attribution.</b> Organizations are not required to use enrollment criteria.</li> <li>• <b>Benefits.</b> Organizations are not required to use a benefit.</li> <li>• <b>Other.</b> Organizations may use additional initial population criteria to focus on an area of interest defined by gender, race, ethnicity, socioeconomic or sociodemographic characteristics, geographic region or another characteristic.</li> <li>• <b>Measurement period adjustments.</b> Organizations may adjust the measurement period.</li> <li>• <b>Stratifications:</b> Race and ethnicity stratification. The race and ethnicity stratification is not required. Organizations may adjust this stratification as needed.</li> </ul>		

- *Exclusions.* Hospice and deceased persons exclusions are not required.
- *Telehealth.* Services/events that allow the use of synchronous telehealth visits, telephone visits and asynchronous telehealth (e-visits, virtual check-ins) may be stratified to identify services performed via telehealth. This adjustment is not allowed for events, numerators and exclusions that do not allow the use of telehealth.

**ADJUSTMENTS ALLOWED WITH LIMITS**

- *Exclusions.* Organizations may choose to not exclude deliveries that occurred at less than 37 weeks gestation. Apply exclusions according to specified value sets.

**ADJUSTMENTS NOT ALLOWED**

- *Initial population:* Event. Value sets, medication lists, direct reference codes and logic may not be changed.
- *Numerator.* Value sets, direct reference codes and logic may not be changed.

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

Measure title	Postpartum Depression Screening and Follow-Up*	Measure ID	PDS-E
<b>Description</b>	<p>The percentage of deliveries in which persons were screened for clinical depression during the postpartum period, and if screened positive, received follow-up care.</p> <ul style="list-style-type: none"> <li>• <i>Depression Screening.</i> The percentage of deliveries in which persons were screened for clinical depression using a standardized instrument during the postpartum period.</li> <li>• <i>Follow-Up on Positive Screen.</i> The percentage of deliveries in which persons received follow-up care within 30 days of a positive depression screen finding.</li> </ul>		
<b>Measurement period</b>	January 1–December 31.		
<b>Copyright and disclaimer notice</b>	<p><i>*Developed with support from the California HealthCare Foundation (CHCF). CHCF works to ensure that people have access to the care they need, when they need it, at a price they can afford. Visit <a href="https://www.chcf.org/">https://www.chcf.org/</a> to learn more. Also supported by the Zoma Foundation.</i></p> <p>Refer to the complete copyright and disclaimer information at the front of this publication.</p> <p>NCQA website: <a href="http://www.ncqa.org">www.ncqa.org</a>.</p> <p>Submit policy clarification support questions via My NCQA (<a href="https://my.ncqa.org">https://my.ncqa.org</a>).</p>		
<b>Clinical recommendation statement/ rationale</b>	<p>The U.S. Preventive Services Task Force (USPSTF) recommends screening for depression among adolescents and adults, including pregnant and postpartum women. (B recommendation)</p> <p>The American College of Obstetricians and Gynecologists (ACOG) recommends that screening for perinatal depression and anxiety occur at the initial prenatal visit, later in pregnancy, and at postpartum visits with a standardized, validated instrument.</p> <p>The American Academy of Pediatrics recommends that pediatricians screen mothers for postpartum depression at the infant's 1-, 2-, 4- and 6-month visits.</p> <p>The USPSTF and ACOG also recommend that screening be implemented with adequate systems in place to ensure accurate diagnosis, effective treatment and appropriate follow-up. (B recommendation)</p>		
<b>Citations</b>	<p>American College of Obstetricians and Gynecologists. 2023. "Screening and Diagnosis of Mental Health Conditions During Pregnancy and Postpartum: ACOG Clinical Practice Guideline No. 4." <i>Obstet Gynecol</i> 141.6: 1232–61.</p> <p>Stone, J., &amp; L. Allen. 2021. "Increasing Postpartum Depression Screening in the Pediatric Setting." <i>Carolina Journal of Interdisciplinary Medicine</i> 1(1), 43–52. <a href="https://doi.org/10.47265/cjim.v1i1.539">https://doi.org/10.47265/cjim.v1i1.539</a></p>		

	<p>U.S. Preventive Services Task Force et al. 2023. "Screening for Depression and Suicide Risk in Adults: U.S. Preventive Task Force Recommendation Statement." <i>JAMA</i> vol. 329,23: 2057–67.</p> <p>U.S. Preventive Services Task Force et al. 2022. "Screening for Depression and Suicide Risk in Children and Adolescents: U.S. Preventive Task Force Recommendation Statement." <i>JAMA</i> vol. 328,15: 1534–42.</p>
<b>Characteristics</b>	
<b>Scoring</b>	Proportion.
<b>Type</b>	Process.
<b>Product lines</b>	<ul style="list-style-type: none"> <li>• Commercial.</li> <li>• Medicaid.</li> </ul>
<b>Stratifications</b>	<p>Race. (Refer to <a href="#">General Guideline: Race and Ethnicity Stratification</a>.)</p> <ul style="list-style-type: none"> <li>• American Indian or Alaska Native.</li> <li>• Asian.</li> <li>• Black or African American.</li> <li>• Middle Eastern or North African.</li> <li>• Native Hawaiian or Pacific Islander.</li> <li>• White.</li> <li>• Some Other Race.</li> <li>• Two or More Races.</li> <li>• Asked But No Answer.</li> <li>• Unknown.</li> </ul> <p>Ethnicity. (Refer to <a href="#">General Guideline: Race and Ethnicity Stratification</a>.)</p> <ul style="list-style-type: none"> <li>• Hispanic or Latino.</li> <li>• Not Hispanic or Latino.</li> <li>• Asked But No Answer.</li> <li>• Unknown.</li> </ul>
<b>Risk adjustment</b>	None.
<b>Improvement notation</b>	Increased score indicates improvement.
<b>Guidance</b>	<p><b>Data collection methodology:</b> ECDS. Refer to <a href="#">General Guideline: Data Collection Methods</a> for additional information.</p> <p><b>Date specificity:</b> Dates must be specific enough to determine that the event occurred in the period being measured.</p> <p><b>Which services count?</b> When using claims, include all paid, suspended, pending and denied claims.</p>

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<sup>1</sup> Brief screening instrument. All other instruments are full-length.			
<sup>2</sup> Proprietary; may have cost or licensing requirement associated with use.			
<b>Initial population</b>	<p><i>Measure item count:</i> Episode.</p> <p><i>Attribution basis:</i> Enrollment.</p> <ul style="list-style-type: none"> <li>• <i>Benefits:</i> Medical.</li> <li>• <i>Continuous enrollment:</i> The delivery date through 60 days following the delivery date.</li> <li>• <i>Allowable gap:</i> None.</li> </ul> <p><i>Ages:</i> None.</p> <p><b>Event: Deliveries.</b></p> <p>Deliveries (<a href="#">Deliveries Value Set</a>), in any setting, during September 8 of the year prior to the measurement period through September 7 of the measurement period. Determine the delivery date using the date as of the end of the delivery.</p> <p>If a person has more than one delivery in a 180-day period, include only the first eligible delivery. Then, if applicable include the next delivery that occurs after the 180-day period. Identify deliveries chronologically, including only one per 180-day period.</p> <p><b>Note:</b> Removal of multiple deliveries in a 180-day period is based on eligible deliveries. Assess each delivery for exclusions and attribution before removing multiple deliveries in a 180-day period.</p>		
<b>Denominator exclusions</b>	<p><b>Persons with a date of death.</b></p> <p>Death in the measurement period, identified using data sources determined by the organization. Method and data sources are subject to review during the HEDIS audit.</p> <p><b>Persons in hospice or using hospice services.</b></p> <p>Persons who use hospice services (<a href="#">Hospice Encounter Value Set</a>; <a href="#">Hospice Intervention Value Set</a>) or elect to use a hospice benefit any time during the measurement period. Organizations that use the Monthly Membership Detail Data File to identify these persons must use only the run date of the file.</p>		
<b>Denominator</b>	<p><b>Denominator 1:</b> The initial population minus denominator exclusions.</p> <p><b>Denominator 2:</b> All deliveries from numerator 1 with a positive finding for depression during the 7–84 days following the date of delivery.</p>		
<b>Numerator</b>	<p><b>Numerator 1: Depression screening.</b></p> <p>Deliveries in which persons had a documented result for depression screening, using an age-appropriate standardized instrument, performed during the 7–84 days following the delivery date.</p>		

	<p>Depression screening captured in health risk assessments or other types of health assessments are allowed if the questions align with a specific instrument that is validated for depression screening. For example, if a health risk assessment includes questions from the PHQ-2, it counts as screening if the person answered the questions and a total score is calculated.</p> <p><b>Numerator 2: Follow-up on positive screen.</b></p> <p>Deliveries in which persons received follow-up care on or up to 30 days after the date of the first positive screen (31 total days).</p> <p>Any of the following on or up to 30 days after the first positive screen:</p> <ul style="list-style-type: none"> <li>• An outpatient, telephone, e-visit or virtual check-in follow-up visit (<a href="#">Follow Up Visit Value Set</a>) with a diagnosis of depression or other behavioral health condition (<a href="#">Depression or Other Behavioral Health Condition Value Set</a>).</li> <li>• A depression case management encounter (<a href="#">Depression Case Management Encounter Value Set</a>) that documents assessment for symptoms of depression (<a href="#">Symptoms of Depression Value Set</a>) or a diagnosis of depression or other behavioral health condition (<a href="#">Depression or Other Behavioral Health Condition Value Set</a>).</li> <li>• A behavioral health encounter, including assessment, therapy, collaborative care or medication management (<a href="#">Behavioral Health Encounter Value Set</a>).</li> <li>• A diagnosis of encounter for exercise counseling (ICD-10-CM code Z71.82*).</li> <li>• A dispensed antidepressant medication (<a href="#">Antidepressant Medications List</a>).</li> </ul> <p><b>OR</b></p> <ul style="list-style-type: none"> <li>• Documentation of additional depression screening on a full-length instrument indicating either no depression or no symptoms that require follow-up (i.e., a negative screen) on the same day as a positive screen on a brief screening instrument. <ul style="list-style-type: none"> <li>– <i>For example</i>, if there is a positive screen resulting from a PHQ-2 score, documentation of a negative finding from a PHQ-9 performed on the same day qualifies as evidence of follow-up.</li> </ul> </li> </ul> <p><b>Coding Guidance</b></p> <p>*Do not include laboratory claims (claims with POS code 81).</p>
<b>Summary of changes</b>	<ul style="list-style-type: none"> <li>• Updated clinical recommendation language to be consistent with 2023 ACOG clinical practice guidelines.</li> <li>• Updated the race and ethnicity stratification categories to align with OMB SPD 15 2024.</li> <li>• Removed the definitions of “participation” and “participation period.”</li> <li>• Added the PROMIS Emotional Distress instrument to the depression screening instrument for adults.</li> <li>• Removed the SSoR data elements from the data element tables.</li> <li>• Added instructions on allowable adjustments to the race and ethnicity stratifications.</li> </ul>

**Data element tables**

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

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

Metric	Data Element	Reporting Instructions
Screening	InitialPopulation	Repeat per Metric
FollowUp	Exclusions	Repeat per Metric
	Denominator	For each Metric
	Numerator	For each Metric
	Rate	(Percent)

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

Metric	Race	Data Element	Reporting Instructions
Screening	AmericanIndianOrAlaskaNative	InitialPopulation	For each Stratification, repeat per Metric
FollowUp	Asian	Exclusions	For each Stratification, repeat per Metric
	BlackOrAfricanAmerican	Denominator	For each Stratification, repeat per Metric
	MiddleEasternOrNorthAfrican	Numerator	For each Metric and Stratification
	NativeHawaiianOrPacificIslander	Rate	(Percent)
	White		
	SomeOtherRace		
	TwoOrMoreRaces		
	AskedButNoAnswer		
	Unknown		

**Table PDS-E-C-1/2: Data Elements for Postpartum Depression Screening and Follow-Up: Stratifications by Ethnicity**

Metric	Ethnicity	Data Element	Reporting Instructions
Screening	HispanicOrLatino	InitialPopulation	For each Stratification, repeat per Metric
FollowUp	NotHispanicOrLatino	Exclusions	For each Stratification, repeat per Metric
	AskedButNoAnswer	Denominator	For each Stratification, repeat per Metric
	Unknown	Numerator	For each Metric and Stratification
		Rate	(Percent)

**Rules for Allowable Adjustments**

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

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

**ADJUSTMENTS ALLOWED**

- *Product lines.* Organizations are not required to use product line criteria; product lines may be combined, and all (or no) product line criteria may be used.
- *Attribution.* Organizations are not required to use enrollment criteria.
- *Benefits.* Organizations are not required to use a benefit.
- *Other.* Organizations may use additional initial population criteria to focus on an area of interest defined by gender, race, ethnicity, socioeconomic or sociodemographic characteristics, geographic region or another characteristic.
- *Measurement period adjustments.* Organizations may adjust the measurement period.
- *Stratifications:* Race and ethnicity stratification. The race and ethnicity stratification is not required. Organizations may adjust this stratification as needed.
- *Exclusions.* Hospice and deceased persons exclusions are not required.
- *Telehealth.* Services/events that allow the use of synchronous telehealth visits, telephone visits and asynchronous telehealth (e-visits, virtual check-ins) may be stratified to identify services performed via telehealth. This adjustment is not allowed for events, numerators and exclusions that do not allow the use of telehealth.

**ADJUSTMENTS NOT ALLOWED**

- *Initial population:* Event. Only events or diagnoses that contain (or map to) codes in the value sets may be used to identify visits with a diagnosis. The value sets, medication lists and logic may not be changed.
- *Numerator.* Value sets, direct reference codes and logic may not be changed.

## Social Need Screening and Intervention (SNS-E)

Measure title	Social Need Screening and Intervention	Measure ID	SNS-E
<b>Description</b>	The percentage of persons who were screened using prespecified instruments, or assessed by a provider, for unmet food, housing and transportation needs at least once during the measurement period, and the percentage of persons with a positive screen or identified need for food, housing or transportation who received an intervention corresponding to the positive screen or identified need within 30 days.		
<b>Measurement period</b>	January 1–December 31.		
<b>Copyright and disclaimer notice</b>	Refer to the complete copyright and disclaimer information at the front of this publication. NCQA website: <a href="http://www.ncqa.org">www.ncqa.org</a> . Submit policy clarification support questions via My NCQA ( <a href="https://my.ncqa.org">https://my.ncqa.org</a> ).		
<b>Clinical recommendation statement/rationale</b>	<p>The American Academy of Family Physicians urges health insurers and payers to provide appropriate payment to support health care practices to identify, monitor, assess and address social determinants of health.</p> <p>The American Academy of Pediatrics recommends surveillance for risk factors related to social determinants of health during all patient encounters.</p> <p>The American Diabetes Association recommends assessing food insecurity, housing insecurity/homelessness, financial barriers and social capital/social community support to inform treatment decisions, with referral to appropriate local community resources.</p> <p>The United States Preventive Services Task Force (USPSTF) found insufficient evidence to determine the impact of screening for food insecurity in primary care settings. The Task Force did not review evidence for other social needs.</p>		
<b>Citations</b>	<p>American Academy of Family Physicians. 2019. “Advancing Health Equity by Addressing the Social Determinants of Health in Family Medicine (Position Paper).” <a href="https://www.aafp.org/about/policies/all/social-determinants-health-family-medicine-position-paper.html">https://www.aafp.org/about/policies/all/social-determinants-health-family-medicine-position-paper.html</a></p> <p>American Academy of Pediatrics. 2016. “Poverty and Child Health in the United States.” <a href="https://pediatrics.aappublications.org/content/137/4/e20160339#sec-12">https://pediatrics.aappublications.org/content/137/4/e20160339#sec-12</a></p> <p>American Diabetes Association. 2022. “Standards of Medical Care in Diabetes-2022.” <i>Diabetes Care</i> 45(Suppl 1) S4–7. doi:10.2337/dc22-Srev</p> <p>US Preventive Services Task Force. 2025. “Screening for Food Insecurity: US Preventive Services Task Force Recommendation Statement.” <i>JAMA</i>. doi:10.1001/jama.2025.0879</p> <p>The Gravity Project. “Terminology Workstream Dashboard.” The Gravity Project Confluence, n.d. <a href="https://confluence.hl7.org/display/GRAV/Terminology+Workstream+Dashboard">https://confluence.hl7.org/display/GRAV/Terminology+Workstream+Dashboard</a></p>		

Characteristics	
<b>Scoring</b>	Proportion.
<b>Type</b>	Process.
<b>Product lines</b>	<ul style="list-style-type: none"> <li>• Commercial.</li> <li>• Medicaid.</li> <li>• Medicare.</li> </ul>
<b>Stratifications</b>	<p>Age as of the start of the measurement period.</p> <ul style="list-style-type: none"> <li>• ≤17 years.</li> <li>• 18–64 years.</li> <li>• 65 years and older.</li> </ul>
<b>Risk adjustment</b>	None.
<b>Improvement notation</b>	Increased score indicates improvement.
<b>Guidance</b>	<p><b>Data collection methodology:</b> ECDS. Refer to <a href="#">General Guideline: Data Collection Methods</a> for additional information.</p> <p><b>Date specificity:</b> Dates must be specific enough to determine the event occurred in the period being measured.</p> <p><b>What services count?</b> When using claims, include all paid, suspended, pending and denied claims.</p>
Definitions	
<b>Food insecurity</b>	Uncertain, limited or unstable access to food that is adequate in quantity and in nutritional quality, culturally acceptable, safe and acquired in socially acceptable ways.
<b>Housing instability</b>	Currently consistently housed, however may have experienced any of the following circumstances in the past 365 days: being behind on rent or mortgage, multiple moves, cost burden or risk of eviction.
<b>Homelessness</b>	Currently living in an environment that is not meant for permanent human habitation (e.g., car, park, sidewalk, abandoned building, on the street), not having a consistent place to sleep at night, or because of economic difficulties, currently living in a shelter, motel, temporary or transitional living situation.
<b>Housing inadequacy</b>	Housing does not meet habitability standards.
<b>Transportation insecurity</b>	Uncertain, limited or no access to safe, reliable, accessible, affordable and socially acceptable transportation infrastructure and modalities necessary for maintaining one's health, well-being or livelihood.

<b>Food insecurity screening instruments</b>	Eligible screening instruments with thresholds for positive findings include:		
Food Insecurity Instruments	Screening Item LOINC Codes	Positive Finding LOINC Codes	
Accountable Health Communities (AHC) Health-Related Social Needs (HRSN) Screening Tool	88122-7	LA28397-0 LA6729-3	
	88123-5	LA28397-0 LA6729-3	
American Academy of Family Physicians (AAFP) Social Needs Screening Tool	88122-7	LA28397-0 LA6729-3	
	88123-5	LA28397-0 LA6729-3	
American Academy of Family Physicians (AAFP) Social Needs Screening Tool—short form	88122-7	LA28397-0 LA6729-3	
	88123-5	LA28397-0 LA6729-3	
Health Leads Screening Panel® <sup>1</sup>	95251-5	LA33-6	
Hunger Vital Sign™ <sup>1</sup> (HVS)	88124-3	LA19952-3	
Protocol for Responding to and Assessing Patients' Assets, Risks and Experiences [PRAPARE]® <sup>1</sup>	93031-3	LA30125-1	
Safe Environment for Every Kid (SEEK)® <sup>1</sup>	95400-8	LA33-6	
	95399-2	LA33-6	
U.S. Household Food Security Survey [U.S. FSS]	95264-8	LA30985-8 LA30986-6	
U.S. Adult Food Security Survey [U.S. FSS]	95264-8	LA30985-8 LA30986-6	
U.S. Child Food Security Survey [U.S. FSS]	95264-8	LA30985-8 LA30986-6	
U.S. Household Food Security Survey—Six-Item Short Form [U.S. FSS]	95264-8	LA30985-8 LA30986-6	
We Care Survey	96434-6	LA32-8	
WellRx Questionnaire	93668-2	LA33-6	

<sup>1</sup>Proprietary; may be cost or licensing requirement associated with use.

<b>Housing instability, homelessness and housing inadequacy screening instruments</b>	Eligible screening instruments with thresholds for positive findings include:			
<b>Housing Instability and Homelessness Instruments</b>	<b>Screening Item LOINC Codes</b>	<b>Positive Finding LOINC Codes</b>		
	Accountable Health Communities (AHC) Health-Related Social Needs (HRSN) Screening Tool	71802-3	LA31994-9 LA31995-6	
	American Academy of Family Physicians (AAFP) Social Needs Screening Tool	99550-6	LA33-6	
	American Academy of Family Physicians (AAFP) Social Needs Screening Tool—short form	71802-3	LA31994-9 LA31995-6	
	Children's Health Watch Housing Stability Vital Signs™ <sup>1</sup>	98976-4	LA33-6	
		98977-2	≥2	
		98978-0	LA33-6	
	Health Leads Screening Panel® <sup>1</sup>	99550-6	LA33-6	
	Protocol for Responding to and Assessing Patients' Assets, Risks and Experiences [PRAPARE]® <sup>1</sup>	93033-9	LA33-6	
		71802-3	LA30190-5	
We Care Survey				
WellRx Questionnaire				

<sup>1</sup>Proprietary; may be cost or licensing requirement associated with use.

<b>Housing Inadequacy Instruments</b>	<b>Screening Item LOINC Codes</b>	<b>Positive Finding LOINC Codes</b>
Accountable Health Communities (AHC) Health-Related Social Needs (HRSN) Screening Tool	96778-6	LA31996-4 LA28580-1 LA31997-2 LA31998-0 LA31999-8 LA32000-4 LA32001-2
American Academy of Family Physicians (AAFP) Social Needs Screening Tool	96778-6	LA32691-0 LA28580-1 LA32693-6 LA32694-4 LA32695-1 LA32696-9 LA32001-2
American Academy of Family Physicians (AAFP) Social Needs Screening Tool—short form	96778-6	LA31996-4 LA28580-1 LA31997-2 LA31998-0 LA31999-8 LA32000-4 LA32001-2

	Housing Inadequacy Instruments	Screening Item LOINC Codes	Positive Finding LOINC Codes
Norwalk Community Health Center Screening Tool [NCHC]	99134-9	LA33-6	
	99135-6	LA31996-4 LA28580-1 LA31997-2 LA31998-0 LA31999-8 LA32000-4 LA32001-2	
<sup>1</sup> Proprietary; may be cost or licensing requirement associated with use.			
Transportation insecurity screening instruments			
Eligible screening instruments with thresholds for positive findings include:			
	Transportation Insecurity Instruments	Screening Item LOINC Codes	Positive Finding LOINC Codes
Accountable Health Communities (AHC) Health-Related Social Needs (HRSN) Screening Tool	93030-5	LA33-6	
	99594-4	LA33-6	
American Academy of Family Physicians (AAFP) Social Needs Screening Tool—short form	99594-4	LA33093-8 LA30134-3	
	89569-8	LA29232-8 LA29233-6 LA29234-4	
Comprehensive Universal Behavior Screen (CUBS)	99553-0	LA33-6	
	101351-5	LA30133-5 LA30134-3	
Health Leads Screening Panel <sup>®1</sup>	101351-5	LA30133-5 LA30134-3	
	101351-5	LA30133-5 LA30134-3	
Inpatient Rehabilitation Facility—Patient Assessment Instrument (IRF-PAI)—version 4.0 [CMS Assessment]	101351-5	LA30133-5 LA30134-3	
	101351-5	LA30133-5 LA30134-3	
Outcome and assessment information set (OASIS) form—version E—Discharge from Agency [CMS Assessment]	101351-5	LA30133-5 LA30134-3	
	101351-5	LA30133-5 LA30134-3	
Outcome and assessment information set (OASIS) form—version E—Resumption of Care [CMS Assessment]	101351-5	LA30133-5 LA30134-3	
	101351-5	LA30133-5 LA30134-3	
Protocol for Responding to and Assessing Patients' Assets, Risks and Experiences [PRAPARE] <sup>®1</sup>	93030-5	LA30133-5 LA30134-3	
	92358-1	LA30024-6 LA30026-1 LA30027-9	
PROMIS <sup>®1</sup>	93671-6	LA33-6	
	101351-5	LA30133-5 LA30134-3	
<sup>1</sup> Proprietary; may be cost or licensing requirement associated with use.			

	<p>NCQA recognizes that organizations might need to adapt or modify instruments to meet the needs of their membership. To clarify:</p> <ul style="list-style-type: none"> <li>• The SNS-E measure specification does not prohibit cultural adaptations or linguistic translations from being counted toward the measure's screening numerators.</li> <li>• The Regenstrief Institute, which maintains the LOINC database, has indicated that LOINC codes are not developed at the level of granularity that distinguishes between original and adapted or translated instruments.</li> </ul> <p>Tool developers have varying policies with regard to cultural adaptation and translations; some state that users may adapt screening instruments, others state that organizations must obtain permission first. NCQA urges organizations to refer to the tool developer for information about adaptations or translations that are available or allowed.</p> <p><b>Interventions</b></p> <p>An intervention corresponding to the type of need identified on or up to 30 days after the date of the first positive screening during the measurement period.</p> <ul style="list-style-type: none"> <li>• An identified food need or positive food insecurity screen finding must be met by a food insecurity intervention.</li> <li>• An identified housing instability or homelessness need, or positive housing instability or homelessness screen finding, must be met by a housing instability or homelessness intervention.</li> <li>• An identified housing inadequacy need or positive housing inadequacy screen finding must be met by a housing inadequacy intervention.</li> <li>• An identified transportation need or positive transportation insecurity screen finding must be met by a transportation insecurity intervention.</li> </ul> <p>Interventions may include assistance, counseling, coordination, education, evaluation of eligibility, provision or referral.</p>
<b>Initial population</b>	<p><i>Measure item count:</i> Person.</p> <p><i>Attribution basis:</i> Enrollment.</p> <ul style="list-style-type: none"> <li>• <i>Benefits:</i> Medical.</li> <li>• <i>Continuous enrollment:</i> The measurement period.</li> <li>• <i>Allowable gap:</i> No more than one gap of ≤45 days during the measurement period. No gaps on the last day of the measurement period.</li> </ul> <p><i>Ages:</i> 0+ years of age as of the start of the measurement period.</p> <p><i>Event:</i> None.</p>
<b>Denominator exclusions</b>	<p><b>Persons with a date of death.</b></p> <p>Death in the measurement period, identified using data sources determined by the organization. Method and data sources are subject to review during the HEDIS audit.</p>

	<p><b>Persons in hospice or using hospice services.</b> Persons who use hospice services (<a href="#">Hospice Encounter Value Set</a>; <a href="#">Hospice Intervention Value Set</a>) or elect to use a hospice benefit any time during the measurement period. Organizations that use the Monthly Membership Detail Data File to identify these persons must use only the run date of the file.</p> <p><b>Medicare enrollees in an institutional SNP (I-SNP) or living long-term in an institution (LTI).</b></p> <ul style="list-style-type: none"> <li>• Enrolled in an Institutional SNP (I-SNP) any time during the measurement period.</li> <li>• Living long-term in an institution any time during the measurement period as identified by the LTI flag in the Monthly Membership Detail Data File. Use the run date of the file to determine if a member had an LTI flag during the measurement period.</li> </ul>
<b>Denominator</b>	<p><b>Denominators 1, 3, 5:</b> The initial population minus denominator exclusions.</p> <p><b>Denominator 2:</b> All persons in numerator 1 with an identified food need (<a href="#">Food Insecurity Value Set</a>), or a positive food insecurity screen finding, between January 1 and December 1 of the measurement period.</p> <p><b>Denominator 4:</b> All persons in numerator 3 with an identified housing need (<a href="#">Housing Instability Value Set</a>; <a href="#">Homelessness Value Set</a>; <a href="#">Housing Inadequacy Value Set</a>) or a positive housing instability, homelessness or housing inadequacy screen finding, between January 1 and December 1 of the measurement period.</p> <p><b>Denominator 6:</b> All persons in numerator 5 with an identified transportation need (ICD10CM code Z59.82), or a positive transportation insecurity screen finding, between January 1 and December 1 of the measurement period.</p>
<b>Numerator</b>	<p><b>Numerator 1: Food screening.</b> Persons in denominator 1 with a documented result for food insecurity screening, or assessment by a provider (HCPCS code G0136), performed between January 1 and December 1 of the measurement period.</p> <p><b>Numerator 2: Food intervention.</b> Persons in denominator 2 who received a food insecurity intervention (<a href="#">Food Insecurity Procedures Value Set</a>) on or up to 30 days after the date of the first food need identified or positive food insecurity screen (31 days total).</p> <p><b>Numerator 3: Housing screening.</b> Persons in denominator 3 with a documented result for housing instability, homelessness or housing inadequacy screening, or assessment by a provider (HCPCS code G0136), performed between January 1 and December 1 of the measurement period.</p> <p><b>Numerator 4: Housing intervention.</b> Persons in denominator 4 who received an intervention corresponding to the type of housing need identified on or up to 30 days after the date of the first housing need identified or positive housing screen (31 days total).</p> <ul style="list-style-type: none"> <li>• Housing Instability Intervention (<a href="#">Housing Instability Procedures Value Set</a>).</li> </ul>

	<ul style="list-style-type: none"> <li>• Homelessness Intervention (<a href="#">Homelessness Procedures Value Set</a>).</li> <li>• Housing Inadequacy Intervention (<a href="#">Housing Inadequacy Procedures Value Set</a>).</li> </ul> <p><b>Numerator 5: Transportation screening.</b> Persons in denominator 5 with a documented result for transportation insecurity screening, or assessment by a provider (HCPCS code G0136), performed between January 1 and December 1 of the measurement period.</p> <p><b>Numerator 6: Transportation intervention.</b> Persons in denominator 6 who received a transportation insecurity intervention (<a href="#">Transportation Insecurity Procedures Value Set</a>) on or up to 30 days after the date of the first transportation need identified or positive transportation screen (31 days total).</p>																												
<b>Summary of changes</b>	<ul style="list-style-type: none"> <li>• Removed the definitions of “participation” and “participation period.”</li> <li>• Added provider assessments to the screening numerators 1, 3 and 5.</li> <li>• Added an additional method for identifying positive needs in denominators 2, 4 and 6.</li> <li>• Removed health risk and behavior assessments from interventions in numerators 2, 4 and 6.</li> <li>• Added community health integration service and principal navigator service codes to the intervention numerators.</li> <li>• Removed the age requirement for exclusion of Medicare enrollees in an institutional SNP (I-SNP) or living long-term in an institution (LTI).</li> <li>• Removed the SSoR exclusions data elements from the data element tables.</li> </ul>																												
<b>Data element tables</b>	<p>Organizations that submit HEDIS data to NCQA must provide the following data elements.</p> <p><i>Table SNS-E-1/2/3: Metadata Elements for Social Need Screening and Intervention</i></p> <table border="1"> <thead> <tr> <th>Metric</th> <th>Age</th> <th>Data Element</th> <th>Reporting Instructions</th> </tr> </thead> <tbody> <tr> <td>FoodScreening*</td> <td>0-17</td> <td>InitialPopulation</td> <td>For each Metric and Stratification</td> </tr> <tr> <td>FoodIntervention</td> <td>18-64</td> <td>Exclusions</td> <td>For each Metric and Stratification</td> </tr> <tr> <td>HousingScreening*</td> <td>65+</td> <td>Denominator</td> <td>For each Metric and Stratification</td> </tr> <tr> <td>HousingIntervention</td> <td>Total</td> <td>Numerator</td> <td>For each Metric and Stratification</td> </tr> <tr> <td>TransportationScreening*</td> <td></td> <td>Rate</td> <td>(Percent)</td> </tr> <tr> <td>TransportationIntervention</td> <td></td> <td></td> <td></td> </tr> </tbody> </table> <p>*These metrics share an initial population. Repeat the initial population, denominator and exclusions data elements for all three screening metrics.</p>	Metric	Age	Data Element	Reporting Instructions	FoodScreening*	0-17	InitialPopulation	For each Metric and Stratification	FoodIntervention	18-64	Exclusions	For each Metric and Stratification	HousingScreening*	65+	Denominator	For each Metric and Stratification	HousingIntervention	Total	Numerator	For each Metric and Stratification	TransportationScreening*		Rate	(Percent)	TransportationIntervention			
Metric	Age	Data Element	Reporting Instructions																										
FoodScreening*	0-17	InitialPopulation	For each Metric and Stratification																										
FoodIntervention	18-64	Exclusions	For each Metric and Stratification																										
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HousingIntervention	Total	Numerator	For each Metric and Stratification																										
TransportationScreening*		Rate	(Percent)																										
TransportationIntervention																													
<b>Rules for Allowable Adjustments</b>	<p><b>Copyright and use:</b> The “Rules for Allowable Adjustments of HEDIS” (the “Rules”) describe how NCQA’s HEDIS measure specifications can be adjusted for other populations, if applicable. The Rules, reviewed and approved by NCQA measure experts, provide for expanded use of HEDIS measures without changing their clinical intent.</p>																												

	<p><b>Adjusted HEDIS measures may not be used for HEDIS health plan reporting.</b></p> <p><b>ADJUSTMENTS ALLOWED</b></p> <ul style="list-style-type: none"><li>• <i>Product lines.</i> Organizations are not required to use product line criteria; product lines may be combined, and all (or no) product line criteria may be used.</li><li>• <i>Ages.</i> The age determination dates may be changed (e.g., select, “age 60 as of June 30 of the measurement period”).</li><li>• <i>Attribution.</i> Organizations are not required to use enrollment criteria.</li><li>• <i>Benefits.</i> Organizations are not required to use a benefit.</li><li>• <i>Other.</i> Organizations may use additional initial population criteria to focus on an area of interest defined by gender, race, ethnicity, socioeconomic or sociodemographic characteristics, geographic region or another characteristic.</li><li>• <i>Exclusion.</i> Hospice, deceased persons, I-SNP and LTI exclusions are not required.</li><li>• <i>Measurement period adjustments.</i> Organizations may adjust the measurement period.</li><li>• <i>Telehealth.</i> Services/events that allow the use of synchronous telehealth visits, telephone visits and asynchronous telehealth (e-visits, virtual check-ins) may be stratified to identify services performed via telehealth. This adjustment is not allowed for events, numerators and exclusions that do not allow the use of telehealth.</li></ul> <p><b>ADJUSTMENTS NOT ALLOWED</b></p> <ul style="list-style-type: none"><li>• <i>Initial population:</i> Event. Value sets, direct reference codes and logic may not be changed.</li><li>• <i>Numerator.</i> Value sets, direct reference codes and logic may not be changed.</li></ul>
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# **Health Plan Descriptive Information Measures**

## ***Enrollment by Product Line (ENP)***

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### **SUMMARY OF CHANGES TO HEDIS MY 2026**

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- No changes to this measure.

#### **Description**

The total number of members enrolled in the product line, stratified by age.

#### **Calculations**

**Product lines** Report the following tables for each applicable product line, stratified by age:

- Table ENP-1 Medicaid.
- Table ENP-2 Commercial.
- Table ENP-3 Medicare.

**Member months** For each product line, report all member months for the measurement year. IDSS will convert these to member years. Member months are a member's "contribution" to the total yearly membership.

**Step 1** Determine member months using a specified day of each month (e.g., the 15th or the last day of the month), to be determined according to the organization's administrative processes. The day selected must be consistent from member to member, month to month and from year to year. For example, if the organization tallies membership on the 15th of the month, a member who is enrolled in the organization on January 15 contributes 1 member month in January.

*Retroactive enrollment.* The organization may include any months in which members were enrolled retrospectively and for which the organization received a retroactive capitation payment.

**Step 2** Use the member's age on the specified day of each month to determine the age group to which member months will be contributed. For example, if an organization tallies membership on the 15th of each month, a member who turns 25 on April 3 and is enrolled for the entire year contributes 3 member months (January, February, March) to the 20–24 age category and 9 member months to the 25–29 age category.

**Medicaid—Table ENP-1** Include all Medicaid members enrolled in the organization who receive Medicaid benefits, including those who receive a restricted benefits package smaller in scope than the other Medicaid members enrolled in the same organization. A **restricted benefits package** meets one of the following criteria:

- Pregnant members whose Medicaid eligibility is based on poverty-related coverage and whose Medicaid benefits are restricted to services related to pregnancy and other conditions that may complicate pregnancy.
- Other members whose benefits are limited (e.g., emergency services).

Include members in either of these two groups in this category.

**Table ENP-1/2/3: Data Elements for Enrollment by Product Line**

Metric	Age	Data Element	Reporting Instructions
Enrollment	LessThan1	MemberMonths	For each Stratification
	1-4	Rate	(Member Years)
	5-9		
	10-14		
	15-17		
	18-19		
	20-24		
	25-29		
	30-34		
	35-39		
	40-44		
	45-49		
	50-54		
	55-59		
	60-64		
	65-69		
	70-74		
	75-79		
	80-84		
	85-89		
	90+		
	Unknown		
	Total		

## Language Description of Membership (LDM)

### SUMMARY OF CHANGES TO HEDIS MY 2026

- Updated the measure title.

### Description

An unduplicated count and percentage of members enrolled at any time during the measurement year by spoken language preferred for health care and preferred language for written materials.

### Calculations

<b>Product lines</b>	Commercial, Medicaid, Medicare (report each product line separately).
<b>Table instructions</b>	Report the number of members for whom the organization has information about spoken language preferred for health care and for written materials for each population. If any of these data are unknown or unavailable, report as "Unknown."
<b>Data source</b>	Report the number of members for whom data have been collected from each data source for each of the three indicators: spoken language preferred for health care, preferred language for written materials, and other language needs. Data sources include data the organization has collected directly from its members (e.g., enrollment forms, surveys, health risk assessments, disease management registries) or from enrollment information furnished by state Medicaid agencies or other third-party sources.
<b>Spoken language preferred for health care</b>	<p>Enter the number of members with data from each data source in Table LDM-A-1/2/3. Identify the category (English/non-English) for preferred language for health care, unknown and declined in Table LDM-B-1/2/3.</p> <p><b>Data collection guidance.</b> This information can be gathered through questions such as:</p> <p><i>What language do you feel most comfortable speaking with your clinician or health care provider?</i></p> <p><i>What language do you feel most comfortable speaking with your doctor or nurse?</i></p> <p><i>In what language do you prefer to receive your medical care?</i></p> <p><i>In what language do you want us to speak to you?</i></p> <p><i>What language do you prefer to speak when you come to the medical center?</i></p> <p><i>What language do you feel most comfortable speaking?</i></p>
<b>Preferred language for written materials</b>	Enter the number of members with data from each data source in Table LDM-A-1/2/3. Identify the category (English/non-English) for preferred language for written materials, unknown and declined in Table LDM-B-1/2/3.

**Data collection guidance.** This information can be gathered through questions such as:

*In which language would you feel most comfortable reading health care information?*

*In which language would you feel most comfortable reading medical or health care instructions?*

*What language should we write [to] you in?*

*What is your preferred written language?*

*In what language do you prefer to read health-related materials?*

*What language do you prefer for written materials?*

**Other language needs** Enter the number of members with data from each data source in Table LDM-A-1/2/3. Identify the category (English/non-English) for any “Other Language Needs,” “Unknown” and “Declined” in Table LDM-B-1/2/3.

**Data collection guidance.** This category captures data collected from questions that cannot be mapped to any of the categories above, such as:

*What is the primary language spoken at home?*

### Note

- It is considered “best practice” to collect data directly from members because this method reflects members’ self-identification. If data collected directly are not available, third-party data collected directly by another entity (e.g., the state or CMS) are desired.
- Indirect data may not be used when reporting this measure. Table LDM-B-1/2/3 is reported using the total unduplicated count of members; report any data not collected using a direct method in the “Unknown” category.
- When multiple sources of data are used, there may be disagreements in the data collected. In such a case, use a logical process that considers the relative accuracy of each data source to resolve the difference. For example, one way to use a stepwise logic for any data disagreement is to:
  - Select specific categories over nonspecific categories.
  - Select the most frequently or consistently reported category over less frequently reported categories.
  - Data sources might also be prioritized after an analysis of the reliability of the different data sources.

**Table LDM-A-1/2/3: Percentage of Members With Language Value From Each Data Source**

Metric	Source	Data Element	Reporting Instructions
SpokenSource	CmsStateDatabases	MemberCount	For each Metric and Source
WrittenSource	HealthPlanDirect	Rate	(Percent)
OtherSource	Other3rdParty		

**Note:** Include members who decline to provide language information. The “Declined” category is included because it indicates that the organization asked about the member’s language needs.

**Table LDM-B-1/2/3: Preferred Language Data**

Metric	Language	Data Element	Reporting Instructions
SpokenPreferred	English	MemberCount	For each Metric and Language
WrittenPreferred	NonEnglish	Rate	(Percent)
OtherPreferred	Unknown		
	Declined		
	TotalKnown		

**Notes:**

- The sum of the member counts (English + Non-English + Unknown + Declined) for each metric must be the same for all three metrics in Table LDM-B-1/2/3.
- The Total Known count is the sum of English, non-English and Declined language for each metric and represents the count of members for whom preferred language data is available for each metric.

## Race/Ethnicity Description of Membership (RDM)

### SUMMARY OF CHANGES TO HEDIS MY 2026

- Updated the measure title.
- Updated the race and ethnicity stratification categories to align with OMB SPD 15 2024.

### Description

An unduplicated count and percentage of members enrolled any time during the measurement year, by race and ethnicity.

### Calculations

<b>Product lines</b>	Commercial, Medicaid, Medicare (report each product line separately).
<b>Table instructions</b>	Report the number of members by race/ethnicity for the population in each reporting category.
<b>Data source</b>	Report the number of members for whom data have been collected from each data source for race and ethnicity. Data sources must fall into one of four types (direct, imputed, unknown, no data), and include data collected directly from members (such as self-reported data collected by the health plan), data collected via state enrollment files or CMS databases and data collected from other sources (e.g., HIEs and clinical feeds).

Imputed data include information generated through imputation methods such as surname analysis or geocoding. Unknown data include data for which there is a recorded race or ethnicity value but no recorded source. “No data” reflects instances in which both the race or ethnicity value *and* the source are missing.

Table RDM-B-1/2/3 reports the percentage of each race (e.g., White, Black or African American) within each ethnicity (e.g., Hispanic or Latino, Not Hispanic or Latino) category.

### Reporting Category Definitions

Refer to [General Guideline: Race and Ethnicity Stratification](#) for instructions on determining race reporting category and determining ethnicity reporting category. When using the combined race/ethnicity data format for collection or if using CMS as the data source, refer to [General Guideline: Race and Ethnicity Stratification](#), Table RES-A-1/2/3 and Table RES-B-1/2/3 for a crosswalk of reporting categories. Refer to Tables RES-C-1/2/3 and RES-D-1/2/3 for the value sets and direct reference codes that must be used to report the measure. Organizations that do not use these codes must map race and ethnicity data to them.

<b>Reporting categories for race</b>	<ul style="list-style-type: none"> <li>• American Indian or Alaska Native.</li> <li>• Asian.</li> <li>• Black or African American.</li> <li>• Middle Eastern or North African.</li> </ul>
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- Native Hawaiian or Pacific Islander.
  - White.
  - Some Other Race.
  - Two or More Races.
  - Asked But No Answer
  - Unknown.
- Reporting categories for ethnicity**
- Hispanic or Latino.
  - Not Hispanic or Latino.
  - Asked But No Answer.
  - Unknown.

#### Note

- It is considered best practice to collect data directly from members because this method reflects members' self-identification. If data collected directly by the health plan are not available, third-party data collected directly by another entity (e.g., the state, CMS, HIE or clinical feeds) are desired. When multiple sources of data are used for race and ethnicity, disagreements in the data collected may exist. When disagreements exist, data sources should be prioritized based on an evaluation of anticipated accuracy. This includes use of specific categories over nonspecific categories, most frequent or consistently reported category, and selection of data with clear provenance (source, method of collection) over data without clear provenance.
- If detailed ethnicity information is collected, these data must be aggregated and reported in the OMB categories provided. If a combined race/ethnicity category question is used to collect data, data must be disaggregated and race and ethnicity categories must be reported separately.
- NCQA recommends the mapping strategy in Tables RES-A-1/2/3 and RES-B-1/2/3 based on research on the sensitivity and specificity of CMS data, expert input and lessons from data collection learning initiatives. This crosswalk is a guide only. If organizations have more accurate race or ethnicity information, they may overwrite these data and code race or ethnicity to the more accurate categories. However, data must be reported using the defined HEDIS categories.
- Data on race and data on ethnicity may come from different categories of data source (direct, imputed, unknown and no data). In such cases, report using the data category that applies to that data element (race, ethnicity). If the same category of information is received from two different data sources, prioritize data sources based on the first bullet above.

**Table RDM-A-1/2/3: Percentage of Members for Whom the Organization Has Race/Ethnicity Information by Data Source**

Metric	Source	Data Element	Reporting Instructions
RaceSource	HealthPlanCollected	MemberCount	For each Metric and Source
EthnicitySource	EnrollmentFiles	Rate	(Percent)
	Other		
	DirectTotal		
	Imputed		
	Unknown		
	NoData		

**Note**

- Percentages include the sum of all race and ethnicity response options, which does not include “Unknown.” The “Asked But No Answer” response option is included in the Direct Data Collection Method percentages because it indicates that the organization asked about the member’s race/ethnicity. The “Asked But No Answer” category is only reported using direct data. “Unknown” includes members for whom the organization did not obtain race/ethnicity information and for whom the organization did not receive a declined response (i.e., “Asked But No Answer”). The “Unknown” category is only reported using the no data category for data source, as “unknown” values cannot be attributed to a particular data source.
- The DirectTotal count is the sum of HealthPlanCollected, EnrollmentFiles and Other.
- The total member counts (DirectTotal + Imputed + Unknown + No Data) for the Source of Race Information table must be identical to the total member count for the Source of Ethnicity Information table and the total member count for Table RDM-B-1/2/3.
- The HealthPlanCollected data source category within DirectTotal includes gold-standard, member self-reported data that are collected in house by the health plan, which in this case has full control over the method by which the data are obtained (i.e., the member self-reported data sources do not capture data obtained through an intermediary or third party organization).
- “Unknown” data source category includes data for which the plan has a recorded race or ethnicity value but no recorded source (i.e., cases where an organization has a race or ethnicity value on file from a legacy system, but does not know the source).
- Any data reported via the no data category reflects instances where the organization did not obtain race or ethnicity information and did not obtain source information.
- Prioritize data sources as specified in the measure.

**Table RDM-B-1/2/3: Race/Ethnicity Categories Reported**

Metric	Race	Ethnicity	Data Element	Reporting Instructions
RaceEthnicity	AmericanIndianOrAlaskaNative	HispanicOrLatino	MemberCount	For each Stratification
	Asian	NotHispanicOrLatino	Rate	(Percent)
	BlackOrAfricanAmerican	AskedButNoAnswer		
	MiddleEasternOrNorthAfrican	Unknown		
	NativeHawaiianOrPacificIslander	Total		
	White			
	SomeOtherRace			
	TwoOrMoreRaces			
	AskedButNoAnswer			
	Unknown			
	Total			

## ***Disability Description of Membership (DDM)***

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### **SUMMARY OF CHANGES TO HEDIS MY 2026**

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- This is a first-year measure.

#### **Description**

An unduplicated count and percentage of members enrolled at any time during the measurement year, by disability status and disability status source.

#### **Calculations**

<b>Product lines</b>	Commercial, Medicaid, Medicare (report each product line separately).
<b>Table instructions</b>	<p><b>Table DDM-1/2/3</b></p> <p>Report the number of members by disability status and the source from which those data were obtained (i.e., the disability status source), including reporting disability status information sourced from:</p> <ul style="list-style-type: none"> <li>• Self-reported questionnaires.</li> <li>• Self-reported accommodations.</li> <li>• Obtained enrollment status/eligibility criteria.</li> </ul> <p>For members whose disability status is not collected or not documented, report in “Missing” under <i>Disability Status</i> and “No Data” under <i>Disability Status Source</i>.</p> <p>For members whose disability status is known, but the disability status source is not traceable, include under the appropriate <i>Disability Status</i> and “Unknown” under <i>Disability Status Source</i>.</p> <p>Report non-disabled members under “Not Disabled” <i>Disability Status</i> category.</p>
<b>Disability status source</b>	<p>Report the number of members for whom data has been collected from each source for disability status. Disability status sources must fall into one of the following types: self-reported questionnaire, self-reported accommodations, enrollment status, unknown, no data.</p> <ul style="list-style-type: none"> <li>• <i>Self-Reported Questionnaire</i>. Includes data that the organization has collected directly from members; for example, through surveys, health risk assessments or case management systems. Questionnaires may include, but are not limited to, the American Community Survey Six-item (ACS-6) Disability Questions and the Washington Group Short Set (WG-SS) on Disability. LOINC codes may be used to report this source category and disability type.</li> <li>• <i>Self-Reported Accommodations</i>. Organizations may collect information on accommodations requested by members. These may include, but are not limited to: wheelchair access, braille materials, text magnifiers, materials in large print, audio recordings of materials, sign language interpreters, audio described content, communication cards/boards, alternative communication devices, text-to-speech or speech-to-text applications,</li> </ul>

voice amplifiers, Communication Access Real Time Translation (CART), low stimulation environments, sensory fidgets, appointment time accommodations.

- *Enrollment Status:* Enrollment information furnished by state Medicaid agencies, patient enrollment information in claims.
- *Unknown:* When the reported disability status value is known, but the source is unknown (i.e., there is a disability status value on file from a legacy system, but the organization does not know the source).

## Notes

- *It is considered “best practice” to collect data directly from members, because this method reflects members’ self-identification. If self-reported data from a questionnaire are not available, disability status may be identified by the proxy of accommodation requests. If self-reported accommodations are not available, third-party data collected directly by another entity, such as the state or CMS, are desired. If multiple disability statuses are identified for a single member, report disability status source according to the following hierarchy: self-reported questionnaire, self-reported accommodations, enrollment status.*
- *When multiple sources of data are used, there may be disagreements in the data collected. To resolve a disagreement, the organization should use a logical process that considers the relative accuracy of each status source but does not undercount the disability population.*
  - *If a member’s disability status is “disabled” according to any source, this member counts as disabled regardless of if another status source suggests “not disabled”.*

**Table DDM-1/2/3: Data Elements for Disability Description of Membership**

Metric	DisabilityStatus	DisabilityStatusSource	Data Element	Reporting Instructions
DisabilityAndSource	Disabled	SelfReportedQuestionnaire	MemberCount***	For each Stratification
	Not Disabled	SelfReportedAccommodations	Rate	(Percent)
	Missing	EnrollmentStatus		
	Total	Unknown*		
		NoData**		
		Total		

\*Source = “Unknown” is only reported for members who have DisabilityStatus = “Disabled” or DisabilityStatus = “NotDisabled,” but the Disability Status Source is unknown.

\*\* DisabilityStatus = “Missing” is only reported for members with DisabilityStatusSource = “NoData” and DisabilityStatusSource = “NoData” is only reported for DisabilityStatus = “Missing”

\*\*\*MemberCount numbers in Table DDM-A-1/2/3 are mutually exclusive and will add up to 100% of the health plan population.

# **Appendix 1**

## **Glossary**

## APPENDIX 1

### GLOSSARY

<b>access</b>	A patient's ability to obtain medical care. Ease of access is determined by components such as availability of medical services and their acceptability to the patient, location of health care facilities, transportation, hours of operation and affordability of care.
<b>accreditation</b>	An official authorization or designation to an organization determined by compliance with a set of industry-derived standards.
<b>accuracy</b>	The extent to which recorded data (on medical records, forms and computer databases) are error-free and reflect defining events.
<b>acute care</b>	Treatment of a short-term or episodic illness; treatment of an exacerbated chronic condition.
<b>administrative database</b>	Automated data, including claims and encounter systems used by an organization to manage delivery of health services to members.
<b>Administrative Method</b>	An organization must identify a measure's denominator and numerator, using transaction data or other administrative databases. The denominator comprises all eligible members. See initial population. The organization reports a rate based on all members who meet the denominator criteria and who are found through administrative data to have received a particular service.
<b>algorithm</b>	A method used to create a calculated result. For example, algorithms are used to combine medical record results with administrative results to produce a measure's rate.
<b>ambulatory care</b>	Outpatient health care services that do not require hospitalization, such as those delivered at a physician's office, clinic, medical or surgical center or outpatient facility.
<b>attestation</b>	A statement ensuring the validity of a report or document (e.g., practitioner attestation).
<b>attribution basis</b>	Health plan enrollment requirements for members to be included in a measure's initial population. Includes continuous enrollment and allowable gaps criteria.
<b>audit</b>	A systemic investigation of procedures and operations that determine conformity with prescribed criteria.
<b>audit results</b>	Designations that are assigned by the HEDIS Compliance Auditor indicating the report status of each measure.
<b>benchmark</b>	National, state and regional averages among organizations submitting data to NCQA. Benchmark data come from accredited and nonaccredited organizations and consist of reporting measures publicly and privately.

<b>bias (degree of bias)</b>	Degree of error. HEDIS rate measures are reported using a 95% confidence interval. A greater than 5% error in the reported rate is considered materially biased and receives a Biased Rate (BR) designation. For non-rate based measures, the error is greater than 10% for material bias and BR designation.
<b>bundling</b>	The organization accepts a single code as representative of several services or encounters. For example, prenatal care visits are bundled with delivery, or all hospital services may be under the revenue code for room and board.
<b>CAHPS</b>	Consumer Assessment of Healthcare Providers and Systems. The CAHPS Program is overseen by the Agency for Healthcare Research and Quality (AHRQ) and includes a number of survey products designed to capture consumer experience across different levels of the health care system. NCQA uses adult and child versions of the CAHPS Health Plan Survey for HEDIS and refers to them as the <i>CAHPS Health Plan Survey, Adult Version</i> and <i>CAHPS Health Plan Survey, Child Version</i> .
<b>capitation</b>	A set amount of money received or paid and based on membership rather than services delivered. Generally refers to a negotiated, per capita rate to be paid periodically (usually monthly) by an organization to a provider.
<b>carve out</b>	An organization sponsor (e.g., employer or purchaser) contracts for a service or function (e.g., mental health or laboratory) to be performed by an entity other than the organization.
<b>chronic care</b>	A general description of a medical condition from which a person may suffer periodically or continuously, as opposed to a condition that can be healed with treatment.
<b>claim audit/ error rate</b>	A rate that indicates the reliability of a claims processing system. Most organizations review a sample of processed claims to compute an error rate, usually expressed as financial and nonfinancial.
<b>claim-dependent denominator</b>	To determine the denominator through claims data (e.g., diabetic members are identified by claims showing diagnoses for diabetes or dispensing insulin).
<b>concurrent audit</b>	Evaluation of methods and data during the data collection period. HEDIS Compliance Audits take place during data collection, allowing organizations to correct errors before data are reported.
<b>confidence level</b>	The degree of confidence, expressed as a percentage, that a reported number's true value is between the lower and upper range specified.
<b>continuous enrollment</b>	The minimum amount of time, including allowed gaps, that a member must be enrolled in an organization to be eligible for a measure.
<b>copayment</b>	A fixed payment paid by a patient at each visit to an organization clinician or when receiving covered services in a health plan.
<b>corrective action</b>	An activity an organization completes between the onsite visit and data submission to correct problems that may result in a Biased Rate (BR) designation.

<b>CPM</b>	Committee on Performance Measurement. This committee decides the measures included in HEDIS and content or changes to these measures.
<b>CQL</b>	<a href="#">Clinical Quality Language</a> . A Health Level Seven International® (HL7®) domain-specific language focused on clinical quality and targeted at measure authors. The CQL specification describes a machine-readable canonical representation, <a href="#">ELM</a> , that is designed to enable sharing of clinical knowledge.
<b>database</b>	Data collected and organized in a computer file for ease of expansion, updating and retrieval.
<b>data collection method</b>	Data collection methods used in HEDIS are the Administrative Method (A), which includes claims and encounter data; the Hybrid Method (H), which combines claims/encounter data and chart (medical record) review data; Electronic Clinical Data Systems (ECDS), which includes data from electronic databases; and survey data collected through the CAHPS survey.
<b>data completeness</b>	Determination or evaluation of missing data. Data-completeness issues must be quantified and Biased Rate (BR) designations must be supported by determination of material bias.
<b>data completeness assessment</b>	An assessment of the effect of claim lag and encounter data submission rates on organization data completeness.
<b>data consolidation</b>	A combination of data from multiple sources, such as multiple electronic sources or electronic and medical record sources.
<b>data extraction</b>	Collecting data from medical records or from electronic and automated systems.
<b>data integration</b>	Combining data from multiple sources, with additional steps to ensure that duplicate data are removed and the remaining data are refined.
<b>data integrity</b>	Data that have not been altered or destroyed.
<b>data reliability</b>	A measure of data consistency based on reproducibility and an estimation of measurement error.
<b>deductible</b>	A fixed amount a patient must pay each year before an insurer will begin covering any part of the cost of care.
<b>delegation</b>	An organization gives another entity the authority to perform certain functions on its behalf, such as providing mental health care and laboratory and vision services. Delegation may also include service functions such as claims processing and call center functions. Although the organization may delegate the authority to perform a function, it may not delegate the responsibility for ensuring that the function is performed appropriately.  Delegates of NCQA-Accredited health plans may also perform credentialing, utilization management and quality improvement activities.
<b>direct pay</b>	Premium payments made by members directly to the organization rather than through an intermediary such as an employer or state or federal program.

<b>direct reference code</b>	A single code that meets criteria for a service or condition. Listed in the measure specification; also included in the Direct Reference Codes spreadsheet of the VSD (as are direct reference codes used for measures reported using ECDS).  <i>Note: Value sets that contain only one code will be phased out (and turned into direct reference codes) as measures are digitalized.</i>
<b>discharges</b>	The number of people released from a hospital.
<b>disenrollment</b>	Termination of participation in an organization.
<b>ECDS</b>	Electronic clinical data systems. A HEDIS reporting standard for health plans that collect and submit quality measures to NCQA. This reporting standard defines the data sources and types of electronic data acceptable for use in a HEDIS measure report. Data systems that may be eligible for ECDS reporting include, but are not limited to, administrative claims, clinical registries, health information exchanges, immunization information systems, disease/case management systems and electronic health records.
<b>eligible population</b>	All members who satisfy a measure's specified criteria, including age, continuous enrollment, benefit, event and anchor date enrollment.  <i>Note: This term is only used in the FRM, MUI and PAO measures.</i>
<b>ELM</b>	<a href="#">Expression Logical Model</a> . A Unified Modeling Language™ specification for representing measure logic independent of syntax and special-purpose constructs introduced at the syntactic level. It is intended to enable distribution and sharing of computable quality logic.
<b>EPO</b>	Exclusive provider organization. A type of health insurance product that usually limits coverage to care from providers, or groups of providers, who have contracts with the health insurance issuer to be part of a network of participating providers. EPO members are generally not reimbursed, nor do they receive benefits for out-of-network services; however, some EPOs provide partial reimbursement for emergency situations.
<b>external data</b>	Automated data supplied by contracted practitioners, vendors or public agencies (e.g., pharmacies, labs, hospitals, schools, state public health agencies).  External data can also come from electronic medical records (EMR). An EMR system is typically developed and maintained at a hospital or a physician's office, and may be integrated (or linked) to the organization's system. External data files may be standard or nonstandard.
<b>FAQ</b>	Frequently asked questions posted to the NCQA website on the 15th of each month.
<b>fee-for-service</b>	A method of charging for medical services. A physician charges a fee for each service provided and the insurer or patient pays all or part of the fee.

<b>FHIR®</b>	Fast Healthcare Interoperability Resources. A specification standard for exchanging health care information electronically that supports exchange of structured and standardized data. Resources are defined and represented in common ways, and are built from data types that define common, reusable patterns of elements and share a common set of metadata.
<b>HEDIS repository</b>	A database or file system that stores HEDIS information, including practitioners, claims and membership, and which may be updated during the data collection period.
<b>HIPAA</b>	Health Insurance Portability and Accountability Act. Federal government standards regarding privacy regulation that set specific and explicit rights individuals have to access, make changes to and restrict the use of their protected health information. See <a href="#">PHI</a> .
<b>HMO</b>	Health maintenance organization. An organized health care system that is accountable for both the financing and delivery of a broad range of comprehensive health services to an enrolled population, and for assessing access and ensuring quality and appropriate care. In this type of organization, members must obtain all services from practitioners affiliated with the HMO, and must usually comply with a predefined authorization system in order to receive reimbursement.
<b>hybrid measure</b>	A measure that requires identification of a numerator using administrative and medical record data. The denominator is a systematic sample of members drawn from the administrative denominator.
<b>I-SNP</b>	Institutional-Special Needs Plan. I-SNPs are their own benefit category for CMS Special Needs Plans. I-SNPs are for Medicare Advantage members who have had, or are expected to need, care in an institutional setting for 90 days or longer. See <a href="#">SNP</a> .
<b>in-network</b>	A predesignated set of providers in an organization is referred to as a <i>network of providers</i> . Members usually receive a higher rate of coverage when they see an in-network provider for care.
<b>inclusiveness</b>	The extent to which an entire population or defined group is intentionally included in a database.
<b>indicator</b>	HEDIS measures consist of one-to-many indicators, each corresponding to a specific rate. For measures with multiple metrics and/or stratifications, each indicator corresponds to a unique combination of metric and stratifications. For example, the Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents measure has three metrics, each with two age stratifications and a Total, resulting in nine indicators.
<b>initial population</b>	The initial population includes all persons who satisfy attribution criteria, including age, continuous enrollment, allowable gap, benefit, and event criteria.
<b>inpatient</b>	Procedures performed or services rendered to patients during a hospital stay.

<b>internal data</b>	Any automated data file created by the organization, which supplements the claim/encounter data in the HEDIS repository. The data can come from internal systems such as DM programs. Internal files are nonstandard.
<b>interrater reliability</b>	A methodology for quality control and evaluation of the medical record review process. Organizations use this method to compare a record reviewer's results to those of another reviewer.
<b>LOS</b>	Length of stay. Number of hospital days from admission to discharge.
<b>LTI flag</b>	Long Term Institutional flag. Identifies members who are long-term residents in an institution. This flag is populated in CMS's Monthly Membership Detail Data File.
<b>measurement period</b>	The period of time during which a measure is calculated.
<b>measurement year</b>	The year that an organization evaluates HEDIS measures.
<b>medication list</b>	Some measures require the use of clinical pharmacy data or pharmacy claims data to identify dispensed medications. The specifications reference medication lists that must be used for HEDIS reporting for each pharmacy-dependent measure. In the specifications, medication list references are underlined (e.g., <u>Diabetes Medications List</u> ). Medication lists used for HEDIS reporting are included in the Medication List Directory. A medication list includes the National Drug Codes (NDC) and RxNorm codes that may be used for reporting along with the generic name, the brand name (if applicable), the strength/ dose and the route for each code.
<b>member</b>	An individual (and the individual's eligible dependents) who pays premiums to the organization as a member of the organization's enrollment population. Members usually receive specified health care services from a defined network for a specified time.
<b>metric</b>	Metrics are used in HEDIS submission and result XML files to group data elements and optional stratification values within a measure.  For single-metric measures, the metric describes the subject of the measure. For multi-metric measures, the metrics describe the various concepts evaluated in the measure (e.g., BMIPercentile, PhysicalActivityCounseling and NutritionCounseling for the Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents measure).
<b>network</b>	Doctors, clinics, health centers, medical group practices, hospitals and other providers that an organization selects and contracts with to care for its members.
<b>outpatient visits</b>	Visits to providers that do not require hospital admission.
<b>PHI</b>	Protected health information. Information that can identify a specific person. Person-identified information is associated with names, social security numbers, alphanumeric codes or other unique individual information.

<b>POS</b>	Point of service. An HMO with an opt-out option. In this type of organization, members may choose to receive services either within the organization's health care system (e.g., an in-network practitioner) or outside the organization's health care delivery system (e.g., an out-of-network practitioner).
	The level of benefits or reimbursement is generally determined by whether the member uses in-network or out-of-network services. Common uses of "POS" include references to products that enroll each member in both an HMO (or HMO-like) system and in an indemnity product. A POS product is also referred to as an "HMO swing-out organization," an "out-of-organization benefits rider to an HMO" or an "open-ended HMO."
<b>positive numerator event</b>	Evidence of a measure-required service/events/diagnoses in either the administrative data or the medical record.
<b>positive numerator hit</b>	A person who satisfies the numerator requirements of a measure and who may be counted in the numerator. Some measures have multiple numerator requirements; for example, in the Childhood Immunization Status measure, the DTaP numerator requires four separate immunizations for a member to be a positive numerator hit.
<b>PPO</b>	Preferred provider organization. PPOs are responsible for providing health benefits-related services to covered individuals and for managing a practitioner network. They may administer health benefits programs for employers by assuming insurance risk or by providing only administrative services.
<b>product</b>	An organized health care system that is accountable for financing and delivering a broad range of comprehensive health services to an enrolled population (HMO, POS, PPO, EPO).
<b>product line</b>	Commercial, Medicaid, Medicare, Exchange.
<b>provider</b>	An institution or organization that provides services for the organization's members. Examples of providers include hospitals and home health agencies.  NCQA uses the term <i>practitioner</i> to refer to professionals who provide health care services; however, it recognizes that a <i>provider directory</i> generally includes both providers and practitioners, and that the inclusive definition is the more common usage.
<b>quality assurance</b>	Activities that safeguard or improve quality of medical care.
<b>rater-to-standard</b>	A methodology for evaluating the medical record review process. Organizations using this method compare their medical record reviewers' results to a supervisor or lead reviewer's results and strive for consistency of reviewer results.
<b>required benefit</b>	HEDIS measures evaluate performance and hold organizations accountable for services provided in their members' benefits package. Measure specifications include benefits (i.e., medical, pharmacy, mental health, chemical dependency) required during the continuous enrollment period.

<b>RES</b>	Race and Ethnicity Stratification. NCQA requires reporting race and ethnicity as defined by the Office of Management and Budget (OMB) Standards for Maintaining, Collecting, and Presenting Federal Data on Race and Ethnicity.
<b>retrospective audit</b>	Evaluation of methods and data after the data collection period has ended. With this type of audit, organizations are not given a chance to correct errors before data are reported. HEDIS Compliance Audits are conducted using a <i>concurrent audit</i> .
<b>risk adjustment</b>	A statistical adjustment that controls for factors beyond the control of an organization so that results can be validly compared with those of other organizations.
<b>Rules for Allowable Adjustments</b>	The “Rules” specify how HEDIS measures may be adapted for use outside the traditional health plan setting for different purposes and levels of analysis (e.g., population health management, quality improvement).
<b>sample frame</b>	The file that contains the eligible population for survey measures. The sample frame must be approved by the auditor before it is sent to the NCQA-Certified Survey Vendor.
<b><u>scoring</u></b>	Indicates how the calculation is performed for the measure, including proportion, ratio, continuous-variable, and cohort. The value set is extensible, allowing additional measure scoring types to be represented.
<b>SNP</b>	<p>Special Needs Plan. SNPs were created by Congress as part of the Medicare Modernization Act (MMA) of 2003 as a new type of Medicare managed care plan focused on certain vulnerable groups of Medicare beneficiaries: the institutionalized, dual eligibles and beneficiaries with severe or disabling chronic conditions.</p> <p>An SNP benefit package, referred to by CMS as the “plan,” may be a stand-alone Medicare Advantage contract or a benefit package within a larger Medicare Advantage contract. SNPs submit structure and process measures and HEDIS measures at the benefit package level.</p>
<b>supplemental data</b>	Data other than claims and encounters used by the organization to collect information about its members and about delivery of health services to its members.
<b>systematic sample</b>	The methodology that NCQA requires the organization to use to create a subset of members from the administrative denominator. This subset or sample is used for reporting hybrid measures.
<b>telehealth</b>	<p>Synchronous telehealth requires real-time interactive audio and video telecommunications.</p> <p>Asynchronous telehealth, sometimes referred to as an “e-visit” or “virtual check-in,” is not in real-time, but still requires two-way interaction between the member and provider. For example, asynchronous telehealth can occur through a patient portal, secure text messaging or email.</p>

<b>type</b>	Indicates whether the measure is used to examine a process, an outcome over time, a patient-reported outcome, or a structure measure such as utilization.
<b>validity</b>	The extent to which data correspond to an actual event or documentation that supports a measure.
<b>value sets</b>	A value set contains two or more codes that meet criteria for a service or condition that is being measured. In the specifications, value set references are capitalized and underlined (e.g., <u>Essential Hypertension Value Set</u> ). Organizations refer to the Value Set Directory (VSD) for codes in the value sets.

## Practitioner Types

<b>clinical pharmacist</b>	<p>A pharmacist with extensive education in the biomedical, pharmaceutical, sociobehavioral and clinical sciences. Clinical pharmacists are experts in the therapeutic use of medications and are a primary source of scientifically valid information and advice regarding the safe, appropriate and cost-effective use of medications.</p> <p>Most clinical pharmacists have a Doctor of Pharmacy (PharmD) degree, and many have completed one or more years of post-graduate training (e.g., a general and/or specialty pharmacy residency). In some states, clinical pharmacists have prescriptive authority.</p>
<b>mental health provider</b>	<p>A provider who delivers mental health services and meets any of the following criteria:</p> <ul style="list-style-type: none"> <li>• An MD or doctor of osteopathy (DO) who is certified as a psychiatrist or child psychiatrist by the American Medical Specialties Board of Psychiatry and Neurology or by the American Osteopathic Board of Neurology and Psychiatry; or, if not certified, who successfully completed an accredited program of graduate medical or osteopathic education in psychiatry or child psychiatry and is licensed to practice patient care psychiatry or child psychiatry, if required by the state of practice.</li> <li>• An individual who is licensed as a psychologist in their state of practice, if required by the state of practice.</li> <li>• An individual who is certified in clinical social work by the American Board of Examiners; who is listed on the National Association of Social Worker's Clinical Register; or who has a master's degree in social work and is licensed or certified to practice as a social worker, if required by the state of practice.</li> <li>• A registered nurse (RN) who is certified by the American Nurses Credentialing Center (a subsidiary of the American Nurses Association) as a psychiatric nurse or mental health clinical nurse specialist, or who has a master's degree in nursing with a specialization in psychiatric/mental health and 2 years of supervised clinical experience, and is licensed to practice as a psychiatric or mental health nurse if required by the state of practice.</li> </ul>

- An individual (normally with a master’s or a doctoral degree in marital and family therapy and at least 2 years of supervised clinical experience) who practices as a marital and family therapist, and is licensed as a certified counselor by the state of practice, or, if licensure or certification is not required by the state of practice, who is eligible for clinical membership in the American Association for Marriage and Family Therapy.
- An individual (normally with a master’s or doctoral degree in counseling and at least 2 years of supervised clinical experience) who practices as a professional counselor, and is licensed or certified to do so by the state of practice, or, if licensure or certification is not required by the state of practice, is a National Certified Counselor with a Specialty Certification in Clinical Mental Health Counseling from the National Board for Certified Counselors.
- A physician assistant who is certified to practice psychiatry by the National Commission on Certification of Physician Assistants.
- A certified community mental health center (CMHC), or the comparable term (e.g., behavioral health organization, mental health agency, behavioral health agency) used in the state of location, or a Certified Community Behavioral Health Clinic (CCBHC).

Only authorized CMHCs are considered mental health providers. To be authorized as a CMHC, an entity must meet one of the following criteria:

- The entity has been certified by CMS to meet the conditions of participation (CoPs) that community mental health centers (CMHCs) must meet in order to participate in the Medicare program, as defined in the Code of Federal Regulations Title 42. CMS defines a CMHC as an entity that meets applicable licensing or certification requirements for CMHCs in the State in which it is located and provides the set of services specified in section 1913(c)(1) of the Public Health Service Act (PHS Act).
- The entity has been licensed, operated, authorized, or otherwise recognized as a CMHC by a state or county in which it is located.

Only authorized CCBHCs are considered mental health providers. To be authorized as a CCBHC, an entity must meet one of the following criteria:

- Has been certified by a State Medicaid agency as meeting criteria established by the Secretary for participation in the Medicaid CCBHC demonstration program pursuant to Protecting Access to Medicare Act.
- § 223(a) (42 U.S.C. § 1396a note); or as meeting criteria within the State’s Medicaid Plan to be considered a CCBHC.
- Has been recognized by the Substance Abuse and Mental Health Services Administration, through the award of grant funds or otherwise, as a CCBHC that meets certification criteria of a CCBHC.

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<b>OB/GYN and other prenatal care practitioner</b>	<p>Includes:</p> <ul style="list-style-type: none"> <li>• Physicians certified as obstetricians or gynecologists by the American Medical Specialties Board of Obstetrics or Gynecology or the American Osteopathic Association; or, if not certified, who successfully completed an accredited program of graduate medical or osteopathic education in obstetrics and gynecology.</li> <li>• Certified nurse midwives, nurse practitioners or physician assistants who deliver prenatal care services in a specialty setting (under the direction of an OB/GYN certified or accredited provider).</li> <li>• Direct entry midwives who deliver prenatal and postpartum services, in a specialty setting (under the direction of an OB/GYN certified or accredited provider) and are licensed in their state of practice.</li> </ul>
<b>ongoing care provider</b>	A practitioner who assumes responsibility for the member's care.
<b>PCP</b>	<p>Primary care practitioner. A physician or nonphysician (e.g., nurse practitioner, physician assistant, certified nurse midwife) who offers primary care medical services.</p> <p>Licensed practical nurses and registered nurses are not considered PCPs.</p> <p>Only certified Federally Qualified Health Centers (FQHC) are considered PCPs. This must be reviewed and approved by an auditor. To be certified as an FQHC, an entity must meet any one of the following criteria:</p> <ul style="list-style-type: none"> <li>• Is receiving a grant under Section 330 of the Public Health Service (PHS) Act (42 United States Code Section 254a) or is receiving funding from such a grant and meets other requirements.</li> <li>• Is not receiving a grant under Section 330 of the PHS Act but is determined by the Secretary of the Department of Health &amp; Human Services (HHS) to meet the requirements for receiving such a grant (qualifies as a “FQHC look-alike”) based on the recommendation of the Health Resources and Services Administration.</li> <li>• Was treated by the Secretary of HHS for purposes of Medicare Part B as a comprehensive federally funded health center as of January 1, 1990.</li> <li>• Is operating as an outpatient health program or facility of a tribe or tribal organization under the Indian Self Determination Act or as an urban Indian organization receiving funds under Title V of the Indian Health Care Improvement Act as of October 1991.</li> <li>• For certification as an FQHC, the entity must meet all of the following criteria (in addition to one of the criteria above): <ul style="list-style-type: none"> <li>– Provide comprehensive services and have an ongoing quality assurance program.</li> <li>– Meet other health and safety requirements.</li> <li>– Not be concurrently approved as a Rural Health Clinic (RHC). <ul style="list-style-type: none"> <li>▪ Only certified RHCs are considered PCPs. This must be reviewed and approved by an auditor.</li> </ul> </li> </ul> </li> </ul>

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	To be certified as an RHC, the entity must meet <a href="#">CMS requirements</a> to qualify for payment via an all-inclusive rate (AIR) for medically-necessary primary health services and qualified preventive health services furnished by an RHC practitioner.
<b>practitioner</b>	A professional who provides health care services. Practitioners must usually be licensed as defined by law.
<b>prescribing practitioner</b>	A practitioner with prescribing privileges, including nurse practitioners, physician assistants and other non-MDs who have the authority to prescribe medications.
<b>provider</b>	An institution or organization that provides services for the organization's members. Examples of providers include hospitals and home health agencies. NCQA uses the term <i>practitioner</i> to refer to professionals who provide health care services, recognizing that a provider directory generally includes both providers and practitioners, and that the inclusive definition is the more common usage.

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## **Appendix 2**

### **Data Element Definitions**

## APPENDIX 2

### DATA ELEMENT DEFINITIONS

Organizations that submit audited HEDIS data to NCQA must report the data elements identified in each measure specification. Data elements are standard for hybrid, administrative, digital and ECDS reported measures.

**Table 1: Data Element Definitions for Reporting**

Data Element	Description	Admin	Hybrid	ECDS	Meaning
CollectionMethod	Data collection methodology	✓	✓	✓	Method used to collect HEDIS data. The Administrative Method is from transactional data for the denominator and the Hybrid Method is from medical record or electronic medical record and transactional data for the sample. Only reported for measures allowing both the Administrative and the Hybrid Method. ECDS uses electronic method for data collection.
Benefit	Benefit	✓	✓	✓	For measures requiring a benefit other than Medical, the Benefit flag is reported in the Metadata section of the submission XML.
InitialPopulation	Initial population	✓	✓	✓	Number of members in the initial population.
Exclusions	Number of required exclusions	✓	✓	✓	Number of members excluded from the initial population based on transaction data because they did not meet the required exclusion criteria.
NumeratorByAdminDenom	Number of numerator events by administrative data in the administrative denominator		✓		The number of members in the administrative denominator who met the numerator criteria. <i>This may or may not include supplemental data, it depends on when an organization loads its supplemental data for reporting.</i>
CYAR	Current year's administrative rate		✓		This is a calculated field in IDSS. NumeratorByAdminDenom / (InitialPopulation – Exclusions) <i>This rate may or may not include numerator events by supplemental data.</i>
MinReqSampleSize	Minimum required sample size (MRSS)		✓		When selecting the sample, this is the required number of members in the sample. Organizations can reduce their samples using Tables 2 in the sampling guidelines.
OversampleRate	Oversampling rate		✓		The percentage of additional records used only to replace exclusions and valid data errors in the denominator reported as a proportion. Organizations that need more than a 20% oversample must contact NCQA. The oversample rate should reflect the true percentage that an organization needs to maintain the MRSS and should not result in an amount larger than the eligible population.

Data Element	Description	Admin	Hybrid	ECDS	Meaning
OversampleRecordsNumber	Number of oversample records		✓		This is a calculated field in IDSS. MinReqSampleSize * OversampleRate (rounded up to next whole number) <i>Oversample records should be used only to replace cases taken out of the sample because of valid data errors, false positives, etc., otherwise, not all records will be reported in the final denominator.</i>
ExclusionValidDataErrors	Number of original sample records excluded because of valid data errors		✓		If medical record review shows that the member does not meet the criteria outlined in the administrative denominator, that member is considered a valid data error. If an administrative exclusion is found during data refresh, the member is also considered a valid data error.
ExclusionEmployeeOrDep	Number of employee/dependent medical records excluded		✓		Number of records in the sample excluded because the member was an organization employee or a dependent of an organization employee. <i>Employees/dependents are only excluded from the sample, they are not removed from the initial population.</i>
OversampleRecsAdded	Records added from the oversample list		✓		Replacement records for members in the sample who had an exclusion or valid data error. <i>This number should not exceed the number of oversample records and should be accounted for in the exclusion categories above.</i>
Denominator	Denominator	✓	✓	✓	For the Administrative Method and ECDS, the initial population minus exclusions. For the Hybrid Method the final sample size: MRSS – exclusions + members added from the oversample list.
NumeratorByAdmin	Numerator events by administrative data	✓	✓		The number of members in the denominator who met numerator criteria using transactional data.
NumeratorBySupplemental	Numerator events by supplemental data	✓	✓		The number of members in the denominator who met numerator criteria using supplemental data (includes standard and nonstandard data). This data element is collected for only EOC and EOC-like measures.
NumeratorByMedicalRecords	Numerator events by medical records		✓		The number of members in the denominator who met numerator criteria using medical record data.
Numerator	Numerator	✓	✓	✓	The number of members in the denominator who met numerator criteria as an aggregate across all data sources. This is reported in the ECDS and Race Ethnicity Stratification Tables.
Rate	Reported rate	✓	✓	✓	This is a calculated field in IDSS. <i>Administrative Method:</i> NumeratorByAdmin ÷ Denominator. <i>Hybrid Method:</i> (NumeratorByAdmin + NumeratorByMedicalRecords) ÷ Denominator.

Data Element	Description	Admin	Hybrid	ECDS	Meaning
					<p><i>ECDS Method:</i> Numerator ÷ Denominator</p> <p><u>Measures that collect numerator events by supplemental data:</u></p> <p><i>Administrative:</i> (NumeratorByAdmin + NumeratorBySupplemental) ÷ Denominator.</p> <p><i>Hybrid:</i> (NumeratorByAdmin + NumeratorBySupplemental + NumeratorByMedicalRecords) ÷ Denominator.</p>

#### Reporting Instruction Explanations

Reporting Instructions	Explanation
Metadata	For Measures requiring a benefit other than Medical, the Benefit flag is reported in the Metadata section of the submission XML.
For each Metric	Report independent values for each metric.
For each Stratification*	Report independent values for each stratification.
For each Metric and Stratification*	Report independent values for each metric and stratification.
Report once	For single Indicator measures.
Repeat per Metric	The same value is repeated across all Metrics. Used e.g., when the same Denominator is used for the calculation of multiple rates within a measure (e.g., CIS, IMA).
Repeat per Stratification*	The same value is repeated across all Stratifications. This is common for measures using the Hybrid collection method where a single sample is drawn for all stratifications. The sample corresponds to the Total stratification but plans only report the individual stratifications. Therefore, plans must repeat the sample data elements for all stratifications.
Repeat per Metric and Stratification*	The same value is repeated across all Metrics and Stratifications. For example, the Hybrid sample data elements for WCC and TRC when reporting using the Hybrid collection method.
For each Stratification, repeat per Metric*	Report independent values for each stratification but repeat these for the same stratifications over multiple metrics.
For each Metric, repeat per Stratification*	Report independent values for each Metric but repeat these for all stratifications within each Metric (e.g., CollectionMethod).
Only for Total	Only used for CYAR in stratified measures. Plans report NumeratorByAdminDenom (Number of numerator events by administrative data in the administrative denominator) for each stratification, but IDSS calculates the CYAR (Current year's administrative rate), only at the total stratification. Only this total CYAR can be used to reduce the minimum required sample size for measures where this is allowed. Refer to the <a href="#">Guidelines for Calculations and Sampling</a> for more information.

\*For measures with multiple stratifications, the reporting instructions apply to all stratification combinations.

# **Appendix 3**

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## APPENDIX 3

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