**OHIC Measure Alignment Work Group**
**2022 Annual Review of the ACO Measure Set**
**Measure Specifications**

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**Appendix B: Health Equity (Race, Ethnicity, and Language (REL) Measure**

## Background

OHIC has adopted a *Health Equity Measure* that stratifies measure performance by REL for three of its 2022 Aligned Measure Sets. OHIC prioritized stratification of measures that have evidence of disparities in performance by REL in Rhode Island and that are required to be stratified for reporting to the National Committee for Quality Assurance (NCQA). The *Health Equity (REL) Measure* will initially focus on stratifying performance by race, ethnicity, and language to encourage providers to collect REL data and use REL data to stratify measure performance. OHIC aims to include a *Health Equity (REL) Measure* focused on reducing disparities in performance in the future once provider organizations have more robust and more experience with REL data.

These guidelines for *Health Equity (REL) Measure* implementation are a modified version of RI EOHHS' guidelines. RI EOHHS adopted an RELD Measure for its Accountable Entity (AE) program for 2022 (see: https://eohhs.ri.gov/initiatives/accountable-entities/resource-documents).

## Description

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

- ***ACO/Primary Care Health Equity (REL) Measure (Menu):***
  - *Controlling High Blood Pressure*
  - *Developmental Screening in the First Three Years of Life*
  - *Eye Exam for Patients with Diabetes*
  - *Hemoglobin A1c Control for Patients with Diabetes: HbA1c Control (< 8.0%)*
- ***Maternity Care Health Equity (REL) Measure (Menu):***
  - *Behavioral Health Risk Assessment Screenings*
  - *Prenatal and Postpartum Care: Postpartum Care*
  - *Prenatal and Postpartum Care: Timeliness of Prenatal Care*
- ***Acute Care Hospital Health Equity (REL) Measure (On Deck):***
  - *Hospital-wide Readmit*

## General Guidelines

| | |
|---|---|
| **Organizations Responsible and Data Source Used for Reporting Performance** | Providers should use their own EHR-based clinical data, patient age and sex data and REL data to report stratified performance for all measures. |
| **Data Completeness Threshold** | There is no REL data completeness threshold for reporting performance stratified by REL. Organizations should report on all patients for whom they have REL data. |
| **Required REL Reporting Categories** | Providers can use any framework to *collect* REL data but should *report* stratified performance using the following framework.<br><br>***For race***: Providers should use the following race categories proposed by NCQA for reporting stratified performance on select HEDIS measures for 2022:<br>• White<br>• Black |

| | |
|---|---|
| | • American Indian/Alaska Native<br>• Asian<br>• Native Hawaiian and Other Pacific Islander<br>• Some Other Race<br>• Two or More Races<br>• Declined<br>• Unknown<br><br>***For ethnicity***: Providers should use the following ethnicity categories proposed by NCQA for reporting stratified performance on select HEDIS measures for 2022:<br>• Hispanic/Latino<br>• Not Hispanic/Latino<br>• Declined<br>• Unknown<br><br>Please refer to the "Crosswalk of Race/Ethnicity Reporting Categories" section to see how commonly used frameworks for collecting race and ethnicity data map onto the categories providers should use when reporting stratified performance.<br><br>***For language***: Use at least the following language categories (providers can use additional languages if they prefer). Health Level Seven Fast Healthcare Interoperability Resources (HL-7 FHIR) codes used in the US, when available, are included in parentheses.[1] If there is no US-based HL-7 FHIR code available, use the UK-based HL-7 FHIR code denoted with an asterisk (*).[2]<br>• English (en)<br>• Spanish (es)<br>• Portuguese (pt)<br>• Other<br>• Unknown<br><br>***Note****: Each of the categories within each race, ethnicity, and language status stratification are mutually exclusive. Therefore, the sum of all stratifications should equal the total population (e.g., the sum of all nine race stratifications should equal the total population).* |
| **Measure Specifications** | Providers can use the following sources to report performance for the *Health Equity* (*REL) Measure*:<br>• the Agency for Healthcare Research and Quality[3] for:<br>  ○ *Behavioral Health Risk Assessment*<br>• CMS' 2022 Core Set of Children's Health Care Quality Measures for Medicaid and CHIP[4] for:<br>  ○ *Developmental Screening in the First Three Years of Life* |

[1] A full list of HL-7 FHIR common language codes used in the US can be found here: https://www.hl7.org/fhir/valueset-languages.html#definition.
[2] A full list of HL-7 FHIR common language codes used in the UK can be found here: https://simplifier.net/guide/ukcoredevelopment/codesystemukcore-humanlanguage.
[3] See: https://www.ahrq.gov/sites/default/files/wysiwyg/policymakers/chipra/factsheets/0085behavior.pdf.
[4] See: https://www.medicaid.gov/medicaid/quality-of-care/performance-measurement/adult-and-child-health-care-quality-measures/child-core-set-reporting-resources/index.html.

| | |
|---|---|
| | • CMS 2022 eCQM specifications for Eligible Professionals / Eligible Clinicians[5], which are designed for reporting by provider organizations for:<br>  ○ *Controlling High Blood Pressure*<br>  ○ *Eye Exam for Patients with Diabetes*<br>  ○ *Hemoglobin A1c Control for Patients with Diabetes: HbA1c Control (< 8.0%)* (adapted for reporting HbA1c Control (<8.0%) as the specifications are written for HbA1c Poor Control (>9.0%)<br>• CMS' Hospital Inpatient Readmission Measures for 2022[6]<br>  ○ *Hospital-Wide Readmit*<br>• NCQA's HEDIS specifications for MY2022 (adapted for provider reporting using the Allowable Adjustments)[7] for:<br>  ○ *Prenatal and Postpartum Care* |
| **Sample Reporting Template** | REL Measure Reporting Template |

[5] See: https://ecqi.healthit.gov/ep-ec?qt-tabs_ep=1&globalyearfilter=2022.
[6] See: https://qualitynet.cms.gov/inpatient/measures/readmission/methodology.
[7] See: https://www.ncqa.org/hedis/measures/.

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# Crosswalk of Race/Ethnicity Reporting Categories

## Crosswalk of Race/Ethnicity Categories

| National Committee for Quality Assurance (NCQA) Categories[8] | Office of Management and Budget (OMB) Categories[9] | Health Resources & Services Administration (HRSA) Uniform Data System (UDS) Categories[10] |
|---|---|---|
| White | White | White |
| Black | Black or African American | Black/African American |
| American Indian/Alaska Native | American Indian or Alaska Native | American Indian/Alaska Native |
| Asian | Asian | Asian |
| Native Hawaiian and Other Pacific Islander | Native Hawaiian and Other Pacific Islander | Native Hawaiian |
| | | Other Pacific Islander |
| Hispanic/Latino | Hispanic or Latino | Hispanic/Latino |
| Not Hispanic/Latino | Non-Hispanic or Latino | Non-Hispanic/Latino |
| Unknown | Unknown | Unreported/Refused to Report |
| Declined | Asked but No Answer | |
| Some Other Race | N/A | N/A |
| Two or More Races | N/A* | More than One Race |

*OMB allows individuals to select more than one of the five race categories.

[8] Source: NCQA's Proposed Changes to Existing Measures for HEDIS MY 2022: Introduction of Race and Ethnicity Stratification Into Select HEDIS Measures. https://www.ncqa.org/wp-content/uploads/2021/02/02.-Health-Equity.pdf.
[9] Source: CMS' Inventory of Resources for Standardized Demographic and Language Data Collection. https://www.cms.gov/about-cms/agency-information/omh/downloads/data-collection-resources.pdf.
[10] Source: HRSA's Uniform Data System 2021 Health Center Data Reporting Requirements. https://data.hrsa.gov/tools/data-reporting/program-data/state/LA/table?tableName=7.

# Breast Cancer Screening (BCS-E)

## SUMMARY OF CHANGES TO HEDIS MY 2023

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

| | |
|---|---|
| **Description** | The percentage of women 50–74 years of age who had a mammogram to screen for breast cancer. |
| **Measurement period** | January 1–December 31. |
| **Clinical recommendation statement** | The U.S. Preventive Services Task Force recommends screening women 50–74 years of age for breast cancer every 2 years. (B recommendation) |
| **Citations** | U.S. Preventive Services Task Force. 2016. "Screening for Breast Cancer: U.S. Preventive Services Task Force Recommendation Statement. *Ann Intern Med* 164(4):279–96. |
| **Characteristics** | |
| **Scoring** | Proportion. |
| **Type** | Process. |
| **Stratification** | • Breast Cancer Screening.<br>– Product line:<br>▪ Commercial.<br>▪ Medicaid.<br>▪ Medicare.<br>– SES (for Medicare only):<br>▪ SES—Non-LIS/DE, Nondisability.<br>▪ SES—LIS/DE.<br>▪ SES—Disability.<br>▪ SES—LIS/DE and Disability.<br>▪ SES—Other.<br>▪ SES—Unknown.<br>– Race (for each product line):<br>▪ Race—White.<br>▪ Race—Black or African American.<br>▪ Race—American Indian or Alaska Native.<br>▪ Race—Asian. |

| | |
|---|---|
| | ▪ Race—Native Hawaiian or Other Pacific Islander.<br>▪ Race—Some Other Race.<br>▪ Race—Two or More Races.<br>▪ Race—Asked but No Answer.<br>▪ Race—Unknown.<br>– Ethnicity (for each product line):<br>▪ Ethnicity—Hispanic or Latino.<br>▪ Ethnicity—Not Hispanic or Latino.<br>▪ Ethnicity—Asked but No Answer.<br>▪ Ethnicity—Unknown. |
| **Risk adjustment** | None. |
| **Improvement notation** | A higher rate indicates better performance. |
| **Guidance** | • For Medicare plans, I-SNP and LTI exclusions are not included in the measure calculation logic and need to be programmed manually. Administrative data must be used for these exclusions.<br>• Non-administrative data may be used for the frailty and advanced illness exclusion.<br><br>**Allocation:**<br>The member was enrolled with a medical benefit throughout the participation period.<br><br>No more than one gap in enrollment of up to 45 days for each full calendar year of the participation period (i.e., the measurement period and the year prior to the measurement period).<br><br>No gaps in enrollment are allowed from October 1 two years prior to the measurement period through December 31 two years prior to the measurement period.<br><br>When identifying members in hospice, the requirements described in *General Guideline 15* for identification of hospice members using the monthly membership detail data files are not included in the measure calculation logic and need to be programmed manually.<br><br>**Reporting:**<br>For Medicare plans, the SES stratifications are mutually exclusive. NCQA calculates a total rate for Medicare plans by adding all six Medicare stratifications.<br><br>For all plans, the race and ethnicity stratifications are mutually exclusive and the sum of all categories in each stratification is the total population.<br><br>SES and product line stratifications are not included in the measure calculation logic and need to be programmed manually.<br><br>The race and ethnicity stratifications are reported by data source—direct or indirect. |

| Definitions | |
|---|---|
| **Participation** | The identifiers and descriptors for each organization's coverage used to define members' eligibility for measure reporting. Allocation for reporting is based on eligibility during the participation period. |
| **Participation period** | October 1 two years prior to the measurement period through the end of the measurement period. |
| **Initial population** | Women 52–74 years of age by the end of the measurement period who also meet the criteria for participation. |
| **Exclusions** | • Members in hospice or using hospice services any time during the measurement period.<br>• Members who had a bilateral mastectomy or both right and left unilateral mastectomies any time during the member's history through the end of the measurement period. Any of the following meet the criteria for bilateral mastectomy:<br>– Bilateral mastectomy (Bilateral Mastectomy Value Set).<br>– Unilateral mastectomy (Unilateral Mastectomy Value Set) with a bilateral modifier (Bilateral Modifier Value Set) (same procedure).<br>– Unilateral mastectomy found in clinical data (Clinical Unilateral Mastectomy Value Set) with a bilateral modifier (Clinical Bilateral Modifier Value Set) (same procedure).<br>***Note:*** *The "clinical" mastectomy value sets identify mastectomy; the word "clinical" refers to the data source, not to the type of mastectomy.*<br>– History of bilateral mastectomy (History of Bilateral Mastectomy Value Set).<br>• Any combination of codes from the table below that indicate a mastectomy on ***both*** the left ***and*** right side on the same or different dates of service. |

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

| | |
|---|---|
| | • Medicare members 66 years of age and older by the end of the measurement period who meet either of the following:<br>– Enrolled in an Institutional SNP (I-SNP) any time during the measurement period.<br>– 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.<br>• Members 66 years of age and older by the end of the measurement period, with frailty and advanced illness. Members must meet BOTH of the following frailty and advanced illness criteria to be excluded:<br>– 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.<br>– Any of the following during the measurement period or the year prior to the measurement period (count services that occur over both years):<br>▪ At least two outpatient visits (Outpatient Value Set), observation visits (Observation Value Set), ED visits (ED Value Set), telephone visits (Telephone Visits Value Set), e-visits or virtual check-ins (Online Assessments Value Set), nonacute inpatient encounters (Nonacute Inpatient Value Set) or nonacute inpatient discharges (instructions below; the diagnosis must be on the discharge claim) on different dates of service, with an advanced illness diagnosis (Advanced Illness Value Set). Visit type need not be the same for the two visits. To identify a nonacute inpatient discharge:<br>1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).<br>2. Confirm the stay was for nonacute care based on the presence of a nonacute code (Nonacute Inpatient Stay Value Set) on the claim.<br>3. Identify the discharge date for the stay.<br>▪ At least one acute inpatient encounter (Acute Inpatient Value Set) with an advanced illness diagnosis (Advanced Illness Value Set).<br>▪ At least one acute inpatient discharge with an advanced illness diagnosis (Advanced Illness Value Set) on the discharge claim. To identify an acute inpatient discharge:<br>1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).<br>2. Exclude nonacute inpatient stays (Nonacute Inpatient Stay Value Set).<br>3. Identify the discharge date for the stay.<br>▪ A dispensed dementia medication (Dementia Medications List).<br>• Members receiving palliative care (Palliative Care Assessment Value Set; Palliative Care Encounter Value Set; Palliative Care Intervention Value Set; ICD-10-CM code Z51.5) any time during the measurement period. |
| **Denominator** | The initial population, minus exclusions. |

| Numerator | One or more mammograms (Mammography Value Set) any time on or between October 1 two years prior to the measurement period and the end of the measurement period. |
|---|---|

**Data criteria (element level)**

***Value Sets:***

- **BCSE_HEDIS_MY2023-2.0.0**
  - Absence of Left Breast (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1329)
  - Absence of Right Breast (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1330)
  - Bilateral Mastectomy (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1042)
  - Bilateral Modifier (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1043)
  - Clinical Bilateral Modifier (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1951)
  - Clinical Left Modifier (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1949)
  - Clinical Right Modifier (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1950)
  - Clinical Unilateral Mastectomy (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1948)
  - History of Bilateral Mastectomy (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1331)
  - Left Modifier (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1148)
  - Mammography (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1168)
  - Right Modifier (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1230)
  - Unilateral Mastectomy (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1256)
  - Unilateral Mastectomy Left (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1334)
  - Unilateral Mastectomy Right (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1335)
- **NCQA_AdvancedIllnessandFrailty-2.0.0**
  - Acute Inpatient (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1810)
  - Advanced Illness (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1465)
  - Dementia Medications (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1729)
  - ED (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1086)
  - Frailty Device (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1530)
  - Frailty Diagnosis (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1531)
  - Frailty Encounter (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1532)
  - Frailty Symptom (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1533)
  - Nonacute Inpatient (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1189)
  - Observation (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1191)
  - Online Assessments (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1446)
  - Outpatient (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1202)
  - Telephone Visits (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1246)

- **NCQA_Claims-2.0.0**
  - Inpatient Stay (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1395)
  - Nonacute Inpatient Stay (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1398)
- **NCQA_Hospice-2.0.0**
  - Hospice Encounter (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1761)
  - Hospice Intervention (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1762)
- **NCQA_PalliativeCare-2.0.0**
  - Palliative Care Assessment (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.2225)
  - Palliative Care Encounter (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1450)
  - Palliative Care Intervention (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.2224)
- **NCQA_Stratification-1.0.0**
  - American Indian or Alaska Native Detailed Race (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.2365)
  - Asian Detailed Race (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.2366)
  - Black or African American Detailed Race (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.2367)
  - Hispanic or Latino Detailed Ethnicity (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.2368)
  - Native Hawaiian or Other Pacific Islander Detailed Race (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.2369)
  - White Detailed Race (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.2370)

***Direct reference codes and codesystems:***

- **NCQA_PalliativeCare-2.0.0**
  - codesystem "ICD-10-CM": 'http://hl7.org/fhir/sid/icd-10-cm'
  - code "Encounter for palliative care": 'Z51.5' from "ICD-10-CM" display 'Encounter for palliative care'
- **NCQA_Terminology-2.0.0**
  - codesystem "ActCode": 'http://terminology.hl7.org/CodeSystem/v3-ActCode'
  - codesystem "ClaimTypeCodes": 'http://terminology.hl7.org/CodeSystem/claim-type'
  - codesystem "ConditionClinicalStatusCodes": 'http://terminology.hl7.org/CodeSystem/condition-clinical'
  - codesystem "NullFlavor": 'http://terminology.hl7.org/CodeSystem/v3-NullFlavor'
  - codesystem "RaceAndEthnicityCDC": 'https://www.hl7.org/fhir/us/core/CodeSystem-cdcrec'
  - code "active": 'active' from "ConditionClinicalStatusCodes"
  - code "American Indian or Alaska Native": '1002-5' from "RaceAndEthnicityCDC" display 'American Indian or Alaska Native'
  - code "Asian": '2028-9' from "RaceAndEthnicityCDC" display 'Asian'
  - code "Asked but no answer": 'ASKU' from "NullFlavor" display 'Asked but no answer'
  - code "Black or African American": '2054-5' from "RaceAndEthnicityCDC" display 'Black or African American'
  - code "Hispanic or Latino": '2135-2' from "RaceAndEthnicityCDC" display 'Hispanic or Latino'

- code "Institutional": 'institutional' from "ClaimTypeCodes"
- code "managed care policy": 'MCPOL' from "ActCode"
- code "Native Hawaiian or Other Pacific Islander": '2076-8' from "RaceAndEthnicityCDC" display 'Native Hawaiian or Other Pacific Islander'
- code "Non Hispanic or Latino": '2186-5' from "RaceAndEthnicityCDC" display 'Non Hispanic or Latino'
- code "Other": 'OTH' from "NullFlavor" display 'Other'
- code "Pharmacy": 'pharmacy' from "ClaimTypeCodes"
- code "Professional": 'professional' from "ClaimTypeCodes"
- code "retiree health program": 'RETIRE' from "ActCode"
- code "subsidized health program": 'SUBSIDIZ' from "ActCode"
- code "Unknown": 'UNK' from "NullFlavor" display 'Unknown'
- code "White": '2106-3' from "RaceAndEthnicityCDC" display 'White'

## Data Elements for Reporting

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

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

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

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

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

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

| Metric |
|---|
| BreastCancerScreening |

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

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

| Metric |
|---|
| BreastCancerScreening |

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

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

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

## Rules for Allowable Adjustments of HEDIS

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

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

***Rules for Allowable Adjustments of Breast Cancer Screening—ECDS***

| NONCLINICAL COMPONENTS | | |
|---|---|---|
| **Eligible Population** | **Adjustments Allowed (Yes/No)** | **Notes** |
| Product lines | Yes | Organizations are not required to use product line criteria; product lines may be combined and all (or no) product line criteria may be used. |
| Ages | Yes, with limits | Age determination dates may be changed (e.g., select, "age as of June 30").<br>The denominator age range may be expanded to 40–74 years. |
| Allocation | Yes | Organizations are not required to use enrollment criteria; adjustments are allowed. |
| Benefit | Yes | Organizations are not required to use a benefit; adjustments are allowed. |
| Other | Yes | Organizations may use additional eligible population criteria to focus on a population of interest such as gender, race and ethnicity, socioeconomic, sociodemographic characteristic or geographic region. |
| **CLINICAL COMPONENTS** | | |
| **Eligible Population** | **Adjustments Allowed (Yes/No)** | **Notes** |
| Event/diagnosis | NA | There is no event/diagnosis for this measure. |
| **Denominator Exclusions** | **Adjustments Allowed (Yes/No)** | **Notes** |
| Exclusions | No | Only specified exclusions may be applied. Value sets may not be changed. |
| Exclusions: Hospice, palliative care, I-SNP, LTI, frailty or advanced illness | Yes | These exclusions are not required. Refer to *Exclusions* in the *Guidelines for the Rules for Allowable Adjustments.* |
| **Numerator Criteria** | **Adjustments Allowed (Yes/No)** | **Notes** |
| Mammogram | No | Value sets and logic may not be changed. |

# CAHPS Clinician & Group Survey

## Version: 3.1

## Population: Adult

## Language: English

**Notes**

- **Release of 3.1 version:** The CAHPS team updated this survey in the fall of 2020. To reflect the fact that patients are receiving health care in person, by phone, and by video, the team made minor changes to the wording of instructions and a few survey items. Learn more at https://www.ahrq.gov/cahps/surveys-guidance/cg/index.html.
- **Supplemental items:** The Adult Clinician & Group Survey 3.1 includes core items only. Users may customize this instrument by adding questions.
    - A searchable list of supplemental items developed by the CAHPS team is available at https://www.ahrq.gov/cahps/surveys-guidance/item-sets/search.html.
    - Descriptions of major item sets are available at https://www.ahrq.gov/cahps/surveys-guidance/item-sets/index.html.
- **Front cover**: Users should replace the cover of this document with their own front cover, with a user-friendly title and their own logo.

For assistance with this survey, please contact the CAHPS Help Line at 800-492-9261 or cahps1@westat.com.

## Visits with your Provider in Person, by Phone, or by Video

**1.** A health care provider can care for patients in person, by phone, or by video. Our records show that you got care from the provider named below in the last 6 months.

Name of provider label goes here

Is that right?

[1] ☐ Yes
[2] ☐ No → **If No, go to #23 on page 4**

The questions in this survey will refer to the provider named in Question 1 as "this provider." As you answer these questions, please think of the in-person, phone, and video visits you had with that person in the last 6 months.

**2.** Is this the provider you usually see if you need a check-up, want advice about a health problem, or get sick or hurt?

[1] ☐ Yes
[2] ☐ No

**3.** How long have you been going to this provider?

[1] ☐ Less than 6 months
[2] ☐ At least 6 months but less than 1 year
[3] ☐ At least 1 year but less than 3 years
[4] ☐ At least 3 years but less than 5 years
[5] ☐ 5 years or more

## Your Care from This Provider in the Last 6 Months

These questions ask about **your own** health care. Do **not** include care you got when you stayed overnight in a hospital. Do **not** include the times you went for dental care visits.

**4.** In the last 6 months, how many times did you visit this provider to get care for yourself?

☐ None → **If None, go to #23 on page 4**
☐ 1 time
☐ 2
☐ 3
☐ 4
☐ 5 to 9
☐ 10 or more times

**5.** In the last 6 months, did you contact this provider's office to get an appointment for an illness, injury, or condition that **needed care right away**?

[1] ☐ Yes
[2] ☐ No → **If No, go to #7**

**6.** In the last 6 months, when you contacted this provider's office to get an appointment for **care you needed right away**, how often did you get an appointment as soon as you needed?

[1] ☐ Never
[2] ☐ Sometimes
[3] ☐ Usually
[4] ☐ Always

**7.** In the last 6 months, did you make any appointments for a **check-up or routine care** with this provider?

1 ☐ Yes
2 ☐ No → **If No, go to #9**

**8.** In the last 6 months, when you made an appointment for a **check-up or routine care** with this provider, how often did you get an appointment as soon as you needed?

1 ☐ Never
2 ☐ Sometimes
3 ☐ Usually
4 ☐ Always

**9.** In the last 6 months, did you contact this provider's office with a medical question during regular office hours?

1 ☐ Yes
2 ☐ No → **If No, go to #11**

**10.** In the last 6 months, when you contacted this provider's office during regular office hours, how often did you get an answer to your medical question that same day?

1 ☐ Never
2 ☐ Sometimes
3 ☐ Usually
4 ☐ Always

**11.** In the last 6 months, how often did this provider explain things in a way that was easy to understand?

1 ☐ Never
2 ☐ Sometimes
3 ☐ Usually
4 ☐ Always

**12.** In the last 6 months, how often did this provider listen carefully to you?

1 ☐ Never
2 ☐ Sometimes
3 ☐ Usually
4 ☐ Always

**13.** In the last 6 months, how often did this provider seem to know the important information about your medical history?

1 ☐ Never
2 ☐ Sometimes
3 ☐ Usually
4 ☐ Always

**14.** In the last 6 months, how often did this provider show respect for what you had to say?

- [1] ☐ Never
- [2] ☐ Sometimes
- [3] ☐ Usually
- [4] ☐ Always

**15.** In the last 6 months, how often did this provider spend enough time with you?

- [1] ☐ Never
- [2] ☐ Sometimes
- [3] ☐ Usually
- [4] ☐ Always

**16.** In the last 6 months, did this provider order a blood test, x-ray, or other test for you?

- [1] ☐ Yes
- [2] ☐ No → **If No, go to #18**

**17.** In the last 6 months, when this provider ordered a blood test, x-ray, or other test for you, how often did someone from this provider's office follow up to give you those results?

- [1] ☐ Never
- [2] ☐ Sometimes
- [3] ☐ Usually
- [4] ☐ Always

**18.** Using any number from 0 to 10, where 0 is the worst provider possible and 10 is the best provider possible, what number would you use to rate this provider?

- ☐ 0 Worst provider possible
- ☐ 1
- ☐ 2
- ☐ 3
- ☐ 4
- ☐ 5
- ☐ 6
- ☐ 7
- ☐ 8
- ☐ 9
- ☐ 10 Best provider possible

**19.** In the last 6 months, did you take any prescription medicine?

- [1] ☐ Yes
- [2] ☐ No → **If No, go to #21**

**20.** In the last 6 months, how often did you and someone from this provider's office talk about all the prescription medicines you were taking?

- [1] ☐ Never
- [2] ☐ Sometimes
- [3] ☐ Usually
- [4] ☐ Always

## Clerks and Receptionists at This Provider's Office

**21.** In the last 6 months, how often were clerks and receptionists at this provider's office as helpful as you thought they should be?

- [1] ☐ Never
- [2] ☐ Sometimes
- [3] ☐ Usually
- [4] ☐ Always

**22.** In the last 6 months, how often did clerks and receptionists at this provider's office treat you with courtesy and respect?

- [1] ☐ Never
- [2] ☐ Sometimes
- [3] ☐ Usually
- [4] ☐ Always

## About You

**23.** In general, how would you rate your overall health?

- [1] ☐ Excellent
- [2] ☐ Very good
- [3] ☐ Good
- [4] ☐ Fair
- [5] ☐ Poor

**24.** In general, how would you rate your overall **mental or emotional** health?

- [1] ☐ Excellent
- [2] ☐ Very good
- [3] ☐ Good
- [4] ☐ Fair
- [5] ☐ Poor

**25.** What is your age?

- [1] ☐ 18 to 24
- [2] ☐ 25 to 34
- [3] ☐ 35 to 44
- [4] ☐ 45 to 54
- [5] ☐ 55 to 64
- [6] ☐ 65 to 74
- [7] ☐ 75 or older

**26.** Are you male or female?

- [1] ☐ Male
- [2] ☐ Female

**27.** What is the highest grade or level of school that you have completed?

- [1] ☐ 8th grade or less
- [2] ☐ Some high school, but did not graduate
- [3] ☐ High school graduate or GED
- [4] ☐ Some college or 2-year degree
- [5] ☐ 4-year college graduate
- [6] ☐ More than 4-year college degree

**28.** Are you of Hispanic or Latino origin or descent?

- [1] ☐ Yes, Hispanic or Latino
- [2] ☐ No, not Hispanic or Latino

**29.** What is your race? Mark one or more.

- [1] ☐ White
- [2] ☐ Black or African American
- [3] ☐ Asian
- [4] ☐ Native Hawaiian or Other Pacific Islander
- [5] ☐ American Indian or Alaska Native
- [6] ☐ Other

**30.** In the last 6 months, were any of your visits with this provider...

| | Yes | No |
|---|---|---|
| **a.** In person? | ☐ | ☐ |
| **b.** By phone? | ☐ | ☐ |
| **c.** By video call? | ☐ | ☐ |

**31.** Did someone help you complete this survey?

- [1] ☐ Yes
- [2] ☐ No → **Thank you.**
  **Please return the completed survey in the postage-paid envelope.**

**32.** How did that person help you? Mark one or more.

- [1] ☐ Read the questions to me
- [2] ☐ Wrote down the answers I gave
- [3] ☐ Answered the questions for me
- [4] ☐ Translated the questions into my language
- [5] ☐ Helped in some other way

**Thank you.**

**Please return the completed survey in the postage-paid envelope.**

# CAHPS Clinician & Group Survey

## Version: 3.1

## Population: Child

## Language: English

**Notes**

- **Release of 3.1 version:** The CAHPS team updated this survey in the fall of 2020. To reflect the fact that patients are receiving health care in person, by phone, and by video, the team made minor changes to the wording of instructions and a few survey items. Learn more at https://www.ahrq.gov/cahps/surveys-guidance/cg/index.html.
- **Supplemental items:** The Child Clinician & Group Survey 3.1 includes core items only. Users may customize this instrument by adding questions.
    - A searchable list of supplemental items developed by the CAHPS team is available at https://www.ahrq.gov/cahps/surveys-guidance/item-sets/search.html.
    - Descriptions of major item sets are available at https://www.ahrq.gov/cahps/surveys-guidance/item-sets/index.html.
- **Front cover**: Users should replace the cover of this document with their own front cover, with a user-friendly title and their own logo.

For assistance with this survey, please contact the CAHPS Help Line at 800-492-9261 or cahps1@westat.com.

Please answer the questions for the child listed on the envelope. Please do not answer for any other children.

## Visits with your Child's Provider in Person, by Phone, or by Video

**1.** A health care provider can care for patients in person, by phone, or by video. Our records show that your child got care from the provider named below in the last 6 months.

Name of provider label goes here

Is that right?

[1] ☐ Yes
[2] ☐ No → **If No, go to #28 on page 5**

The questions in this survey will refer to the provider named in Question 1 as "this provider." As you answer these questions, please think of the in-person, phone, and video visits your child had with that person in the last 6 months.

**2.** Is this the provider you usually see if your child needs a check-up, has a health problem, or gets sick or hurt?

[1] ☐ Yes
[2] ☐ No

**3.** How long has your child been going to this provider?

[1] ☐ Less than 6 months
[2] ☐ At least 6 months but less than 1 year
[3] ☐ At least 1 year but less than 3 years
[4] ☐ At least 3 years but less than 5 years
[5] ☐ 5 years or more

## Your Child's Care from This Provider in the Last 6 Months

These questions ask about **your child's** health care. Do **not** include care your child got when he or she stayed overnight in a hospital. Do **not** include the times your child went for dental care visits.

**4.** In the last 6 months, how many times did your child visit this provider for care?

☐ None → **If None, go to #28 on page 5**
☐ 1 time
☐ 2
☐ 3
☐ 4
☐ 5 to 9
☐ 10 or more times

**5.** In the last 6 months, were you with your child when they were talking with this provider?

[1] ☐ Yes → **If Yes, go to #7**
[2] ☐ No

**6.** Did this provider give you enough information about what was discussed during the visit when you were not there?

[1] ☐ Yes → **If Yes, go to #10**
[2] ☐ No → **If No, go to #10**

**7.** Is your child able to talk with providers about his or her health care?

[1] ☐ Yes
[2] ☐ No → **If No, go to #10**

**8.** In the last 6 months, how often did this provider explain things in a way that was easy for **your child** to understand?

[1] ☐ Never
[2] ☐ Sometimes
[3] ☐ Usually
[4] ☐ Always

**9.** In the last 6 months, how often did this provider listen carefully to **your child**?

[1] ☐ Never
[2] ☐ Sometimes
[3] ☐ Usually
[4] ☐ Always

**10.** Did this provider tell you that you needed to do anything to follow up on the care your child got during the visit?

[1] ☐ Yes
[2] ☐ No → **If No, go to #12**

**11.** Did this provider give you enough information about what you needed to do to follow up on your child's care?

[1] ☐ Yes
[2] ☐ No

**12.** In the last 6 months, did you contact this provider's office to get an appointment for your child for an illness, injury, or condition that **needed care right away**?

[1] ☐ Yes
[2] ☐ No → **If No, go to #14**

**13.** In the last 6 months, when you contacted this provider's office to get an appointment for **care your child needed right away**, how often did you get an appointment as soon as your child needed?

[1] ☐ Never
[2] ☐ Sometimes
[3] ☐ Usually
[4] ☐ Always

**14.** In the last 6 months, did you make any appointments for a **check-up or routine care** for your child with this provider?

[1] ☐ Yes
[2] ☐ No → **If No, go to #16**

**15.** In the last 6 months, when you made an appointment for a **check-up or routine care** for your child with this provider, how often did you get an appointment as soon as your child needed?

[1] ☐ Never
[2] ☐ Sometimes
[3] ☐ Usually
[4] ☐ Always

**16.** In the last 6 months, did you contact this provider's office with a medical question about your child during regular office hours?

[1] ☐ Yes
[2] ☐ No → **If No, go to #18**

**17.** In the last 6 months, when you contacted this provider's office during regular office hours, how often did you get an answer to your medical question that same day?

1 ☐ Never
2 ☐ Sometimes
3 ☐ Usually
4 ☐ Always

**18.** In the last 6 months, how often did this provider explain things about your child's health in a way that was easy to understand?

1 ☐ Never
2 ☐ Sometimes
3 ☐ Usually
4 ☐ Always

**19.** In the last 6 months, how often did this provider listen carefully to you?

1 ☐ Never
2 ☐ Sometimes
3 ☐ Usually
4 ☐ Always

**20.** In the last 6 months, how often did this provider seem to know the important information about your child's medical history?

1 ☐ Never
2 ☐ Sometimes
3 ☐ Usually
4 ☐ Always

**21.** In the last 6 months, how often did this provider show respect for what you had to say?

1 ☐ Never
2 ☐ Sometimes
3 ☐ Usually
4 ☐ Always

**22.** In the last 6 months, how often did this provider spend enough time with your child?

1 ☐ Never
2 ☐ Sometimes
3 ☐ Usually
4 ☐ Always

**23.** In the last 6 months, did this provider order a blood test, x-ray, or other test for your child?

1 ☐ Yes
2 ☐ No → **If No, go to #25**

**24.** In the last 6 months, when this provider ordered a blood test, x-ray, or other test for your child, how often did someone from this provider's office follow up to give you those results?

1 ☐ Never
2 ☐ Sometimes
3 ☐ Usually
4 ☐ Always

**25.** Using any number from 0 to 10, where 0 is the worst provider possible and 10 is the best provider possible, what number would you use to rate this provider?

- ☐ 0 Worst provider possible
- ☐ 1
- ☐ 2
- ☐ 3
- ☐ 4
- ☐ 5
- ☐ 6
- ☐ 7
- ☐ 8
- ☐ 9
- ☐ 10 Best provider possible

## Clerks and Receptionists at This Provider's Office

**26.** In the last 6 months, how often were clerks and receptionists at this provider's office as helpful as you thought they should be?

- [1] ☐ Never
- [2] ☐ Sometimes
- [3] ☐ Usually
- [4] ☐ Always

**27.** In the last 6 months, how often did clerks and receptionists at this provider's office treat you with courtesy and respect?

- [1] ☐ Never
- [2] ☐ Sometimes
- [3] ☐ Usually
- [4] ☐ Always

## About Your Child and You

**28.** In general, how would you rate your child's overall health?

- [1] ☐ Excellent
- [2] ☐ Very Good
- [3] ☐ Good
- [4] ☐ Fair
- [5] ☐ Poor

**29.** In general, how would you rate your child's overall **mental or emotional** health?

- [1] ☐ Excellent
- [2] ☐ Very Good
- [3] ☐ Good
- [4] ☐ Fair
- [5] ☐ Poor

**30.** What is **your child's** age?

☐ Less than 1 year old

_____ YEARS OLD *(write in)*

**31.** Is your child male or female?

- [1] ☐ Male
- [2] ☐ Female

**32.** Is your child of Hispanic or Latino origin or descent?

- [1] ☐ Yes, Hispanic or Latino
- [2] ☐ No, not Hispanic or Latino

**33.** What is your child's race? Mark one or more.

- [1] ☐ White
- [2] ☐ Black or African American
- [3] ☐ Asian
- [4] ☐ Native Hawaiian or Other Pacific Islander
- [5] ☐ American Indian or Alaska Native
- [6] ☐ Other

**34.** What is **your** age?

- [0] ☐ Under 18
- [1] ☐ 18 to 24
- [2] ☐ 25 to 34
- [3] ☐ 35 to 44
- [4] ☐ 45 to 54
- [5] ☐ 55 to 64
- [6] ☐ 65 to 74
- [7] ☐ 75 or older

**35.** Are you male or female?

- [1] ☐ Male
- [2] ☐ Female

**36.** What is the highest grade or level of school that you have completed?

- [1] ☐ 8th grade or less
- [2] ☐ Some high school, but did not graduate
- [3] ☐ High school graduate or GED
- [4] ☐ Some college or 2-year degree
- [5] ☐ 4-year college graduate
- [6] ☐ More than 4-year college degree

**37.** How are you related to the child?

- [1] ☐ Mother or father
- [2] ☐ Grandparent
- [3] ☐ Aunt or uncle
- [4] ☐ Older brother or sister
- [5] ☐ Other relative
- [6] ☐ Legal guardian
- [7] ☐ Someone else

**38.** In the last 6 months, were any of your child's visits with this provider...

| | Yes | No |
|---|---|---|
| **a.** In person? | ☐ | ☐ |
| **b.** By phone? | ☐ | ☐ |
| **c.** By video call? | ☐ | ☐ |

**39.** Did someone help you complete this survey?

- [1] ☐ Yes
- [2] ☐ No → **Thank you. Please return the completed survey in the postage-paid envelope.**

**40.** How did that person help you? Mark one or more

- [1] ☐ Read the questions to me
- [2] ☐ Wrote down the answers I gave
- [3] ☐ Answered the questions for me
- [4] ☐ Translated the questions into my language
- [5] ☐ Helped in some other way

**Thank you.**

**Please return the completed survey in the postage-paid envelope.**

# Hospital Consumer Assessment of Healthcare Providers and Systems

| | |
|---|---|
| **NQF Endorsement Status** | Endorsed |
| **NQF ID** | 0166 |
| **Measure Type** | Patient-Reported Outcome-Based Performance Measure (PRO-PM) |
| **Measure Content Last Updated** | 2021-02-01 |
| **Info As Of** | Not Available |

## Properties

**Description**

HCAHPS is a 32-item survey instrument that produces 11 publicly reported measures:

7 multi-item measures (communication with doctors, communication with nurses, responsiveness of hospital staff, pain control, communication about medicines, discharge information and care transition); and

4 single-item measures (cleanliness of the hospital environment, quietness of the hospital environment, overall rating of the hospital, and recommendation of hospital).

Please note: The FY 2020 Final Rule finalized the removal of the three Pain Management questions beginning with 10/1/19 discharges.

**Numerator**

The HCAHPS Survey asks recently discharged patients about aspects of their hospital experience that they are uniquely suited to address. The core of the survey contains 21 items that ask how often or whether patients experienced a critical aspect of hospital care, rather than whether they were satisfied with their care. Also included in the survey are four screener items that direct patients to relevant questions, five items to adjust for the mix of patients across hospitals, and two items that support Congressionally-mandated reports. Hospitals may include additional questions after the core HCAHPS items.

HCAHPS is administered to a random sample of adult inpatients between 48 hours and six weeks after discharge. Patients admitted in the medical, surgical

# Hospital Consumer Assessment of Healthcare Providers and Systems

and maternity care service lines are eligible for the survey; HCAHPS is not restricted to Medicare beneficiaries. Hospitals may use an approved survey vendor or collect their own HCAHPS data if approved by CMS to do so. HCAHPS can be implemented in four survey modes: mail, telephone, mail with telephone follow-up, or active interactive voice recognition (IVR), each of which requires multiple attempts to contact patients. Hospitals must survey patients throughout each month of the year. IPPS hospitals must achieve at least 300 completed surveys over four calendar quarters.

For full details, see the current HCAHPS Quality Assurance Guidelines, V.13.0, pp. 55-63,
under the Quality Assurance button on the official HCAHPS On-Line Web site at

http://www.hcahpsonline.org/globalassets/hcahps/quality-assurance/2018_qag_v13.0.pdf

**Denominator**

Eligibility for the HCAHPS Survey.
The HCAHPS Survey is broadly intended for patients of all payer types who meet the following criteria:

Eighteen (18) years or older at the time of admission

Admission includes at least one overnight stay in the hospital

An overnight stay is defined as an inpatient admission in which the patient's admission date is different from the patient's discharge date. The admission need not be 24 hours in length. For example, a patient had an overnight stay if he or she was admitted at 11:00 PM on Day 1, and discharged at 10:00 AM on Day 2. Patients who did not have an overnight stay should not be included in the sample frame (e.g., patients who were admitted for a short period of time solely for observation; patients admitted for same day diagnostic tests as part of outpatient care).

Non-psychiatric MS-DRG/principal diagnosis at discharge

Note: Patients whose principal diagnosis falls within the Maternity Care, Medical, or Surgical service lines and who also have a secondary psychiatric diagnosis are still eligible for the survey.

Alive at the time of discharge

# Hospital Consumer Assessment of Healthcare Providers and Systems

Note: Pediatric patients (under 18 years old at admission) and patients with a primary psychiatric diagnosis are ineligible because the current HCAHPS instrument is not designed to address the unique situation of pediatric patients and their families, or the behavioral health issues pertinent to psychiatric patients.

Exclusions from the HCAHPS Survey
There is a two-stage process for determining whether a discharged patient can be included in the HCAHPS Sample Frame. The first stage is to determine whether the discharged patient meets the HCAHPS eligibility criteria, listed above. If the patient meets the eligibility criteria, then a second set of criteria is applied: Exclusions from the HCAHPS Survey.

Patients who meet the eligible population criteria outlined above are to be included in the HCAHPS Sample Frame. However, there are a few categories of otherwise eligible patients who are excluded from the sample frame. These are:

No-Publicity patients who request that they not be contacted (see below)

Court/Law enforcement patients (i.e., prisoners); this does not include patients residing in halfway houses

Patients with a foreign home address (the U.S. territories Virgin Islands, Puerto Rico, Guam, American Samoa, and Northern Mariana Islands are not considered foreign addresses and therefore, are not excluded)

Patients discharged to hospice care (Hospice-home or Hospice-medical facility)

Patients who are excluded because of state regulations

Patients discharged to nursing homes and skilled nursing facilities

No-Publicity patients are defined as those who voluntarily sign a no-publicity request while hospitalized or who directly request a survey vendor or hospital not to contact them ( Do Not Call List ). These patients should be excluded from the HCAHPS Survey. However, documentation of patients no-publicity status must be retained for a minimum of three years.

Court/Law enforcement patients (i.e., prisoners) are excluded from HCAHPS

# Hospital Consumer Assessment of Healthcare Providers and Systems

| | |
|---|---|
| | because of both the logistical difficulties in administering the survey to them in a timely manner, and regulations governing surveys of this population. These individuals can be identified by the admission source (UB-04 field location 15) 8 Court/Law enforcement, patient discharge status code (UB-04 field location 17) 21 Discharged/transferred to court/law enforcement, or patient discharge status code 87 Discharged/transferred to court/law enforcement with a planned acute care hospital inpatient readmission. This does not include patients residing in halfway houses.<br><br>Patients with a foreign home address are excluded from HCAHPS because of the logistical difficulty and added expense of calling or mailing outside of the United States (the U.S. territories - Virgin Islands, Puerto Rico, Guam, American Samoa, and Northern Mariana Islands are not considered foreign address |
| **Denominator Exclusions** | There is a two-stage process for determining whether a discharged patient can be included in the HCAHPS Sample Frame. The first stage is to determine whether the discharged patient meets the HCAHPS eligibility criteria, listed above. If the patient meets the eligibility criteria, then a second set of criteria is applied: Exclusions from the HCAHPS Survey.<br><br>Patients who meet the eligible population criteria outlined above are to be included in the HCAHPS Sample Frame. However, there are a few categories of otherwise eligible patients who are excluded from the sample frame. These are:<br>No-Publicity patients Patients who request that they not be contacted (see below)<br>Court/Law enforcement patients (i.e., prisoners); this does not include patients residing in halfway houses<br>Patients with a foreign home address (the U.S. territories Virgin Islands, Puerto Rico, Guam, American Samoa, and Northern Mariana Islands are not considered foreign addresses and therefore, are not excluded)<br>Patients discharged to hospice care (Hospice-home or Hospice-medical facility)<br>Patients who are excluded because of state regulations<br>Patients discharged to nursing homes and skilled nursing facilities |

# Hospital Consumer Assessment of Healthcare Providers and Systems

No-Publicity patients are defined as those who voluntarily sign a no-publicity request while hospitalized or who directly request a survey vendor or hospital not to contact them ( Do Not Call List ). These patients should be excluded from the HCAHPS Survey. However, documentation of patients no-publicity status must be retained for a minimum of three years.

Court/Law enforcement patients (i.e., prisoners) are excluded from HCAHPS because of both the logistical difficulties in administering the survey to them in a timely manner, and regulations governing surveys of this population. These individuals can be identified by the admission source (UB-04 field location 15) 8 Court/Law enforcement, patient discharge status code (UB-04 field location 17) 21 Discharged/transferred to court/law enforcement, or patient discharge status code 87 Discharged/transferred to court/law enforcement with a planned acute care hospital inpatient readmission. This does not include patients residing in halfway houses.

Patients with a foreign home address are excluded from HCAHPS because of the logistical difficulty and added expense of calling or mailing outside of the United States (the U.S. territories - Virgin Islands, Puerto Rico, Guam, American Samoa, and Northern Mariana Islands are not considered foreign addresses and therefore, are not excluded).

Patients discharged to hospice care are excluded from HCAHPS because of the heightened likelihood that they will expire before the survey process can be completed. Patients with a Discharge Status of 50 Hospice home or 51 Hospice medical facility would not be included in the sample frame. Discharge Status is the same as the UB-04 field location 17.

Some state regulations place further restrictions on patients who may be contacted after discharge. It is the responsibility of the hospital/survey vendor to identify any applicable regulations and to exclude those patients as required by law or regulation in the state in which the hospital operates.

Patients discharged to nursing homes and skilled nursing facilities are excluded from HCAHPS. This applies to patients with a Discharge Status (UB-04 field location 17) of:

03 Skilled nursing facility

# Hospital Consumer Assessment of Healthcare Providers and Systems

| | |
|---|---|
| | 61 SNF Swing bed within hospital<br>64 Certified Medicaid nursing facility<br>83 Skilled nursing facility with a planned acute care hospital inpatient readmission<br>92 Certified Medicaid nursing facility with a planned acute care hospital inpatient readmission<br><br>Hospitals/Survey vendors must retain documentation that verifies all exclusions and ineligible patients. This documentation is subject to review.<br><br>Note: Patients must be included in the HCAHPS Survey sample frame unless the hospital/ survey vendor has positive evidence that a patient is ineligible or fits |
| **Rationale** | The HCAHPS (Hospital Consumer Assessment of Healthcare Providers and Systems) Survey is the first national, standardized, publicly reported survey of patients' perspectives of hospital care. HCAHPS (pronounced H-caps ), also known as the CAHPS Hospital Survey*, is a 32-item survey instrument and data collection methodology for measuring patients perceptions of their hospital experience. While many hospitals have collected information on patient satisfaction for their own internal use, until HCAHPS there were no common metrics and no national standards for collecting and publicly reporting information about patient experience of care. Since 2008, HCAHPS has allowed valid comparisons to be made across hospitals locally, regionally and nationally.<br>Three broad goals have shaped HCAHPS. First, the standardized survey and implementation protocol produce data that allow objective and meaningful comparisons of hospitals on topics that are important to consumers. Second, public reporting of HCAHPS results creates new incentives for hospitals to improve quality of care. Third, public reporting enhances accountability in health care by increasing transparency of the quality of hospital care provided in return for the public investment. With these goals in mind, the Centers for Medicare & Medicaid Services (CMS) and the HCAHPS Project Team have taken substantial steps to assure that the survey is credible, practical and actionable. |
| **Evidence** | Not Available |

# Hospital Consumer Assessment of Healthcare Providers and Systems

## Developer/Steward

| | |
|---|---|
| **Steward** | Centers for Medicare & Medicaid Services (CMS) |
| **Contact** | Not Available |
| **Measure Developer** | Not Available |
| **Development Stage** | Fully Developed |

## Characteristics

| | |
|---|---|
| **Measure Type** | Patient-Reported Outcome-Based Performance Measure (PRO-PM) |
| **Meaningful Measure Area** | Patient's Experience of Care |
| **Healthcare Priority** | Strengthen Person & Family Engagement as Partners in their Care |
| **eCQM Spec Available** | No |
| **NQF Endorsement Status** | Endorsed |
| **NQF ID** | 0166 |
| **Last NQF Update** | 2019-10-25 |
| **Target Population Age** | 18+ |
| **Target Population Age (High)** | Not Available |
| **Target Population Age (Low)** | 18 |
| **Reporting Level** | Facility |
| **Conditions** | Not Available |
| **Subconditions** | Not Available |
| **Care Settings** | Hospital Inpatient; Hospital/Acute Care Facility |

# Hospital Consumer Assessment of Healthcare Providers and Systems

## Groups

| | |
|---|---|
| **Core Measure Set** | Not Available |

| **Measure Group** | **Group Identifier** |
|---|---|
| HCAHPS | |

## Measure Links

### Measure Program: Prospective Payment System-Exempt Cancer Hospital Quality Reporting

| | |
|---|---|
| **Info As Of** | Not Available |
| **Program / Model Notes** | |
| **Data Sources** | Not Available |
| **Purposes** | Not Available |
| **Quality Domain** | Not Available |
| **Reporting Frequency** | Not Available |
| **Impacts Payment** | Not Available |
| **Reporting Status** | Active |
| **Data Reporting Begin Date** | 2016-01-01 |
| **Data Reporting End Date** | 2022-01-01 |

# Hospital Consumer Assessment of Healthcare Providers and Systems

## Measure Program Links

https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HospitalQualityInits/PCHQR.html

## Milestones

### Milestone: Implemented

| | |
|---|---|
| **Effective Date** | 2015-10-01 |
| **Comments** | Not Available |
| **Milestone Links** | https://www.federalregister.gov/articles/2013/08/19/2013-18956/medicare-program-hospital-inpatient-prospective-payment-systems-for-acute-care-hospitals-and-the |

### Milestone: Finalized

| | |
|---|---|
| **Effective Date** | 2013-08-19 |
| **Comments** | Not Available |
| **Milestone Links** | https://www.federalregister.gov/articles/2013/08/19/2013-18956/medicare-program-hospital-inpatient-prospective-payment-systems-for-acute-care-hospitals-and-the |

### Milestone: Proposed

| | |
|---|---|
| **Effective Date** | 2013-05-10 |
| **Comments** | Not Available |

### Milestone: Reference

| | |
|---|---|
| **Effective Date** | 1900-01-01 |
| **Comments** | Not Available |

# Hospital Consumer Assessment of Healthcare Providers and Systems

| | |
|---|---|
| **Milestone Links** | https://qualitynet.org/dcs/ContentServer?cid=1228772864217&pagename=QnetPublic%2FPage%2FQnetTier2&c=Page |

## Measure Program: Hospital Inpatient Quality Reporting

| | |
|---|---|
| **Info As Of** | Not Available |
| **Program / Model Notes** | |
| **Data Sources** | Not Available |
| **Purposes** | Not Available |
| **Quality Domain** | Not specified |
| **Reporting Frequency** | Not Available |
| **Impacts Payment** | No |
| **Reporting Status** | Active |
| **Data Reporting Begin Date** | 2011-01-01 |
| **Data Reporting End Date** | Not Available |

## Measure Program Links

https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HospitalQualityInits/HospitalRHQDAPU.html

## Milestones

### Milestone: Implemented

| | |
|---|---|
| **Effective Date** | 2010-10-01 |
| **Comments** | Not Available |
| **Milestone Links** | http://www.gpo.gov/fdsys/search/pagedetails.action?browsePath=2010% |

# Hospital Consumer Assessment of Healthcare Providers and Systems

| | |
|---|---|
| | 2F08%2F08-16%5C%2F2%2FHealth+and+Human+Services+Department&granuleId=2010-19092&packageId=FR-2010-08-16&fromBrowse=true |

**Milestone: Finalized**

| | |
|---|---|
| **Effective Date** | 2010-08-16 |
| **Comments** | Not Available |
| **Milestone Links** | http://www.gpo.gov/fdsys/search/pagedetails.action?browsePath=2010%2F08%2F08-16%5C%2F2%2FHealth+and+Human+Services+Department&granuleId=2010-19092&packageId=FR-2010-08-16&fromBrowse=true |

## Measure Program: Hospital Value-Based Purchasing

| | |
|---|---|
| **Info As Of** | Not Available |
| **Program / Model Notes** | |
| **Data Sources** | Not Available |
| **Purposes** | Not Available |
| **Quality Domain** | Person and Community Engagement Domain |
| **Reporting Frequency** | Not Available |
| **Impacts Payment** | Not Available |
| **Reporting Status** | Active |
| **Data Reporting Begin Date** | 2012-01-01 |
| **Data Reporting End Date** | Not Available |

## Measure Program Links

https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-

# Hospital Consumer Assessment of Healthcare Providers and Systems

Programs/HVBP/Hospital-Value-Based-Purchasing

## Milestones

### Milestone: Implemented

| | |
|---|---|
| **Effective Date** | 2012-10-01 |
| **Comments** | Not Available |
| **Milestone Links** | http://www.gpo.gov/fdsys/pkg/FR-2011-05-06/pdf/2011-10568.pdf |

### Milestone: Finalized

| | |
|---|---|
| **Effective Date** | 2011-05-06 |
| **Comments** | Not Available |
| **Milestone Links** | http://www.gpo.gov/fdsys/pkg/FR-2011-05-06/pdf/2011-10568.pdf |

## Measure Program: Hospital Compare

| | |
|---|---|
| **Info As Of** | Not Available |
| **Program / Model Notes** | |
| **Data Sources** | Not Specified; Patient Reported Data and Surveys |
| **Purposes** | Not Available |
| **Quality Domain** | Not Available |
| **Reporting Frequency** | Not Available |
| **Impacts Payment** | Not Available |
| **Reporting Status** | Active |
| **Data Reporting Begin Date** | 2020-01-01 |
| **Data Reporting End Date** | Not Available |

# Hospital Consumer Assessment of Healthcare Providers and Systems

## Measure Program Links

https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HospitalQualityInits/HospitalCompare

## Milestones

### Milestone: Implemented

| | |
|---|---|
| **Effective Date** | 2015-10-01 |
| **Comments** | Not Available |
| **Milestone Links** | https://www.federalregister.gov/articles/2013/08/19/2013-18956/medicare-program-hospital-inpatient-prospective-payment-systems-for-acute-care-hospitals-and-the |

### Milestone: Finalized

| | |
|---|---|
| **Effective Date** | 2013-08-19 |
| **Comments** | Not Available |
| **Milestone Links** | https://www.federalregister.gov/articles/2013/08/19/2013-18956/medicare-program-hospital-inpatient-prospective-payment-systems-for-acute-care-hospitals-and-the |

### Milestone: Proposed

| | |
|---|---|
| **Effective Date** | 2013-05-10 |
| **Comments** | Not Available |

### Milestone: Reference

| | |
|---|---|
| **Effective Date** | 1900-01-01 |
| **Comments** | Not Available |

# Hospital Consumer Assessment of Healthcare Providers and Systems

| | |
|---|---|
| **Milestone Links** | https://www.cms.gov/medicare/quality-initiatives-patient-assessment-instruments/hospitalqualityinits/hospitalcompare.html<br><br>https://qualitynet.org/dcs/ContentServer?cid=1228772864217&pagename=QnetPublic%2FPage%2FQnetTier2&c=Page |

# Consumer Assessment of Healthcare Providers and Systems (CAHPS) for the Merit-based Incentive Payment System (MIPS) Survey

## 2022 Survey

# Medicare Provider Experience Survey

**Survey Instructions**

This survey asks about you and the health care you received in the last six months during visits that were in-person, by phone or by video call. Answer each question thinking about yourself. Please take the time to complete this survey. Your answers are very important to us. Please return the survey with your answers in the enclosed postage-paid envelope to [VENDOR NAME].

Answer all the questions by putting an "X" in the box to the left of your answer, like this:

☒ Yes

Be sure to read all the answer choices given before marking your answer.

You are sometimes told not to answer some questions in this survey. When this happens you will see an arrow with a note that tells you what question to answer next, like this:
[➔ **If No, go to #3**]. See the example below:

**EXAMPLE**

1. Do you wear a hearing aid now?
   ☐ Yes
   ☒ No ➔ **If No, go to #3**

2. How long have you been wearing a hearing aid?
   ☐ Less than one year
   ☐ 1 to 3 years
   ☐ More than 3 years
   ☐ I don't wear a hearing aid

3. In the last 6 months, did you have any headaches?
   ☒ Yes
   ☐ No



According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1222 (Expiration date: 7/31/2022). The time required to complete this information collection is estimated to average 13.1 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850. ****CMS Disclosure**** Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact QPP@cms.hhs.gov.

## Your Provider

**1.** Our records show that you visited the provider named below in the last 6 months.

Name of provider label goes here

Is that right?

- ☐ Yes
- ☐ No ➔ **If No, go to #24**

The questions in this survey will refer to the provider named in Question 1 as "this provider." Please think of that person as you answer the survey.

**2.** Is this the provider you usually see if you need a check-up, want advice about a health problem, or get sick or hurt?

- ☐ Yes
- ☐ No

**3.** How long have you been going to this provider?

- ☐ Less than 6 months
- ☐ At least 6 months but less than 1 year
- ☐ At least 1 year but less than 3 years
- ☐ At least 3 years but less than 5 years
- ☐ 5 years or more

## Your Care From This Provider in the Last 6 Months

These questions ask about **your own** health care. Do **not** include care you got when you stayed overnight in a hospital. Do **not** include the times you went for dental care visits.

**4.** In the last 6 months, how many times did you visit this provider to get care for yourself?

- ☐ None ➔ **If None, go to #24**
- ☐ 1 time
- ☐ 2
- ☐ 3
- ☐ 4
- ☐ 5 to 9
- ☐ 10 or more times

**5.** In the last 6 months, did you contact this provider's office to get an appointment for an illness, injury or condition that **needed care right away**?

- ☐ Yes
- ☐ No ➔ **If No, go to #7**

**6.** In the last 6 months, when you contacted this provider's office to get an appointment for **care you needed right away**, how often did you get an appointment as soon as you needed?

- ☐ Never
- ☐ Sometimes
- ☐ Usually
- ☐ Always

**7.** In the last 6 months, did you make any appointments for a **check-up or routine care** with this provider?

- ☐ Yes
- ☐ No ➔ **If No, go to #9**

**8.** In the last 6 months, when you made an appointment for a **check-up or routine care** with this provider, how often did you get an appointment as soon as you needed?

- ☐ Never
- ☐ Sometimes
- ☐ Usually
- ☐ Always

**9.** In the last 6 months, did you contact this provider's office with a medical question during regular office hours?

- ☐ Yes
- ☐ No ➔ **If No, go to #11**

**10.** In the last 6 months, when you contacted this provider's office during regular office hours, how often did you get an answer to your medical question that same day?

- ☐ Never
- ☐ Sometimes
- ☐ Usually
- ☐ Always

**11.** In the last 6 months, how often did this provider explain things in a way that was easy to understand?

- ☐ Never
- ☐ Sometimes
- ☐ Usually
- ☐ Always

**12.** In the last 6 months, how often did this provider listen carefully to you?

- ☐ Never
- ☐ Sometimes
- ☐ Usually
- ☐ Always

**13.** In the last 6 months, how often did this provider seem to know the important information about your medical history?

- ☐ Never
- ☐ Sometimes
- ☐ Usually
- ☐ Always

**14.** In the last 6 months, how often did this provider show respect for what you had to say?

- ☐ Never
- ☐ Sometimes
- ☐ Usually
- ☐ Always

**15.** In the last 6 months, how often did this provider spend enough time with you?

- ☐ Never
- ☐ Sometimes
- ☐ Usually
- ☐ Always

**16.** In the last 6 months, did this provider order a blood test, x-ray, or other test for you?

- ☐ Yes
- ☐ No ➔ **If No, go to #18**

**17.** In the last 6 months, when this provider ordered a blood test, x-ray, or other test for you, how often did someone from this provider's office follow up to give you those results?

- ☐ Never
- ☐ Sometimes
- ☐ Usually
- ☐ Always

**18.** In the last 6 months, did you and this provider talk about starting or stopping a prescription medicine?

- ☐ Yes
- ☐ No ➔ **If No, go to #20**

**19.** When you and this provider talked about starting or stopping a prescription medicine, did this provider ask what you thought was best for you?

- ☐ Yes
- ☐ No

**20.** In the last 6 months, did you and this provider talk about how much of your personal health information you wanted shared with your family or friends?

- ☐ Yes
- ☐ No

**21.** Using any number from 0 to 10, where 0 is the worst provider possible and 10 is the best provider possible, what number would you use to rate this provider?

- ☐ 0 Worst provider possible
- ☐ 1
- ☐ 2
- ☐ 3
- ☐ 4
- ☐ 5
- ☐ 6
- ☐ 7
- ☐ 8
- ☐ 9
- ☐ 10 Best provider possible

## Clerks and Receptionists at This Provider's Office

**22.** In the last 6 months, how often were clerks and receptionists at this provider's office as helpful as you thought they should be?

- ☐ Never
- ☐ Sometimes
- ☐ Usually
- ☐ Always

**23.** In the last 6 months, how often did clerks and receptionists at this provider's office treat you with courtesy and respect?

- ☐ Never
- ☐ Sometimes
- ☐ Usually
- ☐ Always

## Your Care From Specialists in the Last 6 Months

**24.** Specialists are doctors like surgeons, heart doctors, allergy doctors, skin doctors, and other doctors who specialize in one area of health care. Is the **provider named in Question 1** of this survey a specialist?

- ☐ Yes ➔ **If Yes, Please include this provider as you answer these questions about specialists**
- ☐ No

**25.** In the last 6 months, did you try to make any appointments with specialists?

- ☐ Yes
- ☐ No ➔ **If No, go to #27**

**26**. In the last 6 months, how often was it easy to get appointments with specialists?

- ☐ Never
- ☐ Sometimes
- ☐ Usually
- ☐ Always

## All Your Care in the Last 6 Months

These questions ask about **all your** health care. Include all the providers you saw for health care in the last 6 months. Do **not** include the times you went for dental care visits.

**27.** Your health care team includes all the doctors, nurses and other people you see for health care. In the last 6 months, did you and anyone on your health care team talk about a healthy diet and healthy eating habits?

- ☐ Yes
- ☐ No

**28.** In the last 6 months, did you and anyone on your health care team talk about the exercise or physical activity you get?

- ☐ Yes
- ☐ No

**29**. In the last 6 months, did you take any prescription medicine?

- ☐ Yes
- ☐ No ➔ **If No, go to #32**

**30**. In the last 6 months, how often did you and anyone on your health care team talk about all the prescription medicines you were taking?

- ☐ Never
- ☐ Sometimes
- ☐ Usually
- ☐ Always

**31**. In the last 6 months, did you and anyone on your health care team talk about how much your prescription medicines cost?

- ☐ Yes
- ☐ No

**32**. In the last 6 months, did anyone on your health care team ask you if there was a period of time when you felt sad, empty, or depressed?

- ☐ Yes
- ☐ No

**33.** In the last 6 months, did you and anyone on your health care team talk about things in your life that worry you or cause you stress?

- ☐ Yes
- ☐ No

## About You

**34.** In general, how would you rate your overall health?

- ☐ Excellent
- ☐ Very good
- ☐ Good
- ☐ Fair
- ☐ Poor

**35.** In general, how would you rate your overall **mental or emotional** health?

- ☐ Excellent
- ☐ Very good
- ☐ Good
- ☐ Fair
- ☐ Poor

**36.** In the **last 12 months**, have you seen a doctor or other health provider 3 or more times for the same condition or problem?

- ☐ Yes
- ☐ No ➔ **If No, go to #38**

**37.** Is this a condition or problem that has lasted for at least 3 months?

- ☐ Yes
- ☐ No

**38.** Do you now need or take medicine prescribed by a doctor?

- ☐ Yes
- ☐ No ➔ **If No, go to #40**

**39.** Is this medicine to treat a condition that has lasted for at least 3 months?

- ☐ Yes
- ☐ No

**40.** In the last 6 months, were any of your visits for your own health care…

| | Yes | No |
|---|---|---|
| **a.** In person? | ☐ | ☐ |
| **b.** By phone? | ☐ | ☐ |
| **c.** By video call? | ☐ | ☐ |

**41.** During the last 4 weeks, how much of the time did your physical health interfere with your social activities (like visiting with friends, relatives, etc.)?

- ☐ All of the time
- ☐ Most of the time
- ☐ Some of the time
- ☐ A little of the time
- ☐ None of the time

**42.** What is your age?

- ☐ 18 to 24
- ☐ 25 to 34
- ☐ 35 to 44
- ☐ 45 to 54
- ☐ 55 to 64
- ☐ 65 to 69
- ☐ 70 to 74
- ☐ 75 to 79
- ☐ 80 to 84
- ☐ 85 or older

**43.** Are you male or female?

- ☐ Male
- ☐ Female

**44.** What is the highest grade or level of school that you have completed?

- ☐ 8th grade or less
- ☐ Some high school, but did not graduate
- ☐ High school graduate or GED
- ☐ Some college or 2-year degree
- ☐ 4-year college graduate
- ☐ More than 4-year college degree

**45.** How well do you speak English?

- ☐ Very well
- ☐ Well
- ☐ Not well
- ☐ Not at all

**46.** Do you speak a language other than English at home?

- ☐ Yes
- ☐ No ➔ **If No, go to #48**

**47.** What is the language you speak at home?

- ☐ Spanish
- ☐ Chinese
- ☐ Korean
- ☐ Russian
- ☐ Vietnamese
- ☐ Some other language

↓

*Please print:* _____

**48.** Are you deaf or do you have serious difficulty hearing?

- ☐ Yes
- ☐ No

**49.** Are you blind or do you have serious difficulty seeing, even when wearing glasses?

- ☐ Yes
- ☐ No

**50.** Because of a physical, mental, or emotional condition, do you have serious difficulty concentrating, remembering, or making decisions?

- ☐ Yes
- ☐ No

**51.** Do you have serious difficulty walking or climbing stairs?

- ☐ Yes
- ☐ No

**52.** Do you have difficulty dressing or bathing?

- ☐ Yes
- ☐ No

**53.** Because of a physical, mental, or emotional condition, do you have difficulty doing errands alone such as visiting a doctor's office or shopping?

- ☐ Yes
- ☐ No

**54.** Do you ever use the internet at home?

- ☐ Yes
- ☐ No

**55.** Are you of Hispanic, Latino, or Spanish origin?

- ☐ Yes, Hispanic, Latino, or Spanish
- ☐ No, not Hispanic, Latino, or Spanish
  ➔ **If No, go to #57**

**56.** Which group best describes you?

- ☐ Mexican, Mexican American, Chicano
  ➔ **Go to #57**
- ☐ Puerto Rican ➔ **Go to #57**
- ☐ Cuban ➔ **Go to #57**
- ☐ Another Hispanic, Latino, or Spanish origin ➔ **Go to #57**

**57.** What is your race? Mark one or more.

- ☐ White
- ☐ Black or African American
- ☐ American Indian or Alaska Native
- ☐ Asian Indian
- ☐ Chinese
- ☐ Filipino
- ☐ Japanese
- ☐ Korean
- ☐ Vietnamese
- ☐ Other Asian
- ☐ Native Hawaiian
- ☐ Guamanian or Chamorro
- ☐ Samoan
- ☐ Other Pacific Islander

**58.** Did someone help you complete this survey?

- ☐ Yes
- ☐ No ➔ **Thank you.**
  **Please return the completed survey in the postage-paid envelope.**

**59.** How did that person help you? Mark one or more.

- ☐ Read the questions to me
- ☐ Wrote down the answers I gave
- ☐ Answered the questions for me
- ☐ Translated the questions into my language
- ☐ Helped in some other way

*Please print:* _____

**Thank you**
**Please return the completed survey in the postage-paid envelope.**
[VENDOR NAME AND ADDRESS HERE]

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

# Questions

| Question # | Question | Adult/Child |
|---|---|---|
| PCMH1 | Patient got information about what to do if care is needed on evenings, weekends, or holidays | Adult |
| PCMH2 | Patient saw a specialist for a particular health problem | Adult |
| PCMH3 | Provider seemed informed and up-to-date about care from specialists | Adult |
| PCMH4 | Someone from provider's office talked with patient about specific health goals | Adult |
| PCMH5 | Someone from provider's office asked if there were things that made it hard for patient to take care of health | Adult |
| PCMH6 | Someone from provider's office talked about worrying/stressful aspects of patient's life | Adult |
| PCMH1 | Respondent got information about what to do if child needed care on evenings, weekends, or holidays | Child |
| PCMH2 | Child saw a specialist for a particular health problem | Child |
| PCMH3 | Provider seemed informed and up-to-date about care from specialists | Child |
| PCMH4 | Respondent and provider talked about age-appropriate behaviors | Child |
| PCMH5 | Respondent and provider talked about child's physical development | Child |
| PCMH6 | Respondent and provider talked about child's moods and emotions | Child |
| PCMH7 | Respondent and provider talked about injury prevention | Child |
| PCMH8 | Respondent and provider talked about child's eating habits | Child |
| PCMH9 | Respondent and provider talked about child's eating habits | Child |
| PCMH10 | Respondent and provider talked about how child gets along with others | Child |

# Composites

# Adult Version

## Talking With You About Taking Care of Your Own Health

PCMH4. Someone from provider's office talked with patient about specific health goals

PCMH5. Someone from provider's office asked if there were things that made it hard for patient to take care of health

# Child Version

## Provider's Attention to Your Child's Growth and Development

PCMH4. Respondent and provider talked about age-appropriate behaviors

PCMH5. Respondent and provider talked about child's physical development

PCMH6. Respondent and provider talked about child's moods and emotions

PCMH10. Respondent and provider talked about how child gets along with others

## Provider's Advice on Keeping Your Child Safe and Healthy

PCMH7. Respondent and provider talked about injury prevention

PCMH8. Respondent and provider talked about child's eating habits

PCMH9. Respondent and provider talked about child's physical activity

# Cervical Cancer Screening (CCS)

## SUMMARY OF CHANGES TO HEDIS MY 2023

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

## Description

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

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

## Eligible Population

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

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

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

## Administrative Specification

**Denominator** The eligible population.

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

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

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

## Hybrid Specification

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

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

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

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

- Women 24–64 years of age as of December 31 of the measurement year who had cervical cytology during the measurement year or the 2 years prior to the measurement year.
  - Documentation in the medical record must include both of the following:

- A note indicating the date when the cervical cytology was performed.
- The result or finding.

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

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

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

- Women 30–64 years of age as of December 31 of the measurement year who had cervical high-risk human papillomavirus (hrHPV) testing during the measurement year or the 4 years prior to the measurement year ***and*** who were 30 years or older as of the date of testing.

– Documentation in the medical record must include both of the following:

- A note indicating the date when the hrHPV test was performed. Generic documentation of "HPV test" can be counted as evidence of hrHPV test.
- The results or findings.

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

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

## Data Elements for Reporting

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

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

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

## Rules for Allowable Adjustments of HEDIS

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

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

***Rules for Allowable Adjustments of Cervical Cancer Screening***

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

# Child and Adolescent Well-Care Visits (WCV)

## SUMMARY OF CHANGES TO HEDIS MY 2023

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

## Description

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

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

## Eligible Population

**Product lines**

Commercial, Medicaid (report each product line separately).

**Stratifications**

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

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

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

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

## Administrative Specification

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

### *Note*

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

## Data Elements for Reporting

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

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

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

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

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

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

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

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

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

## Rules for Allowable Adjustments of HEDIS

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

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

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

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

# *Chlamydia Screening in Women (CHL)*

## SUMMARY OF CHANGES TO HEDIS MY 2023

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

## Description

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

## Eligible Population

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

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

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

The total is the sum of the age stratifications.

**Continuous enrollment** The measurement year.

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

**Anchor date** December 31 of the measurement year.

**Benefit** Medical.

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

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

*Claim/encounter data*. Members who had a claim or encounter indicating sexual activity during the measurement year. A code from any of the following meets criteria:

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

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

***Contraceptive Medications***

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

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

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

***Retinoid Medications***

| Description | Prescription |
|---|---|
| Retinoid | Isotretinoin |

**Required exclusions**

Exclude members who meet either of the following criteria:

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

## Administrative Specification

**Denominator** The eligible population.

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

## Data Elements for Reporting

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

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

| Metric | Age | Data Element | Reporting Instructions |
|---|---|---|---|
| ChlamydiaScreening | 16-20 | EligiblePopulation | For each Stratification |
| | 21-24 | ExclusionAdminRequired | For each Stratification |
| | Total | NumeratorByAdmin | For each Stratification |
| | | NumeratorBySupplemental | For each Stratification |
| | | Rate | (Percent) |

## Rules for Allowable Adjustments of HEDIS

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

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

***Rules for Allowable Adjustments of Chlamydia Screening in Women***

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

# Colorectal Cancer Screening (COL)

## SUMMARY OF CHANGES TO HEDIS MY 2023

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

## Description

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

### *Note*

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

## Eligible Population

**Product lines**

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

**Stratifications**

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

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

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

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

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

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

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

**Ages**

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

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

The total is the sum of the age stratifications.

**Continuous enrollment**

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

**Allowable gap**

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

**Anchor date**

December 31 of the measurement year.

**Benefit**

Medical.

**Event/diagnosis**

None.

**Required exclusions**

Exclude members who meet any of the following criteria:

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

**Exclusions**

Exclude members who meet any of the following criteria:

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

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

***Dementia Medications***

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

## Administrative Specification

**Denominator** The eligible population.

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

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

## Hybrid Specification

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

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

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

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

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

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

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

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

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

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

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

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

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

## Data Elements for Reporting

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

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

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

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

| Metric | Age | Data Element | Reporting Instructions | A |
|---|---|---|---|---|
| ColorectalCancerScreening | 46-49 | CollectionMethod | Repeat per Stratification | ✓ |
| | 50-75 | EligiblePopulation | For each Stratification | ✓ |
| | Total | ExclusionAdminRequired | For each Stratification | ✓ |
| | | NumeratorByAdminElig | For each Stratification | |
| | | CYAR | Only for Total (Percent) | |
| | | MinReqSampleSize | Repeat per Stratification | |
| | | OversampleRate | Repeat per Stratification | |
| | | OversampleRecordsNumber | (Count) | |
| | | ExclusionValidDataErrors | Repeat per Stratification | |
| | | ExclusionEmployeeOrDep | Repeat per Stratification | |
| | | OversampleRecsAdded | Repeat per Stratification | |
| | | Denominator | For each Stratification | |
| | | NumeratorByAdmin | For each Stratification | ✓ |
| | | NumeratorByMedicalRecords | For each Stratification | |
| | | NumeratorBySupplemental | For each Stratification | ✓ |
| | | Rate | (Percent) | ✓ |

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

| Metric | Age | SES Stratification | Data Element | Reporting Instructions | A |
|---|---|---|---|---|---|
| ColorectalCancerScreening | 46-49 | NonLisDeNondisability | CollectionMethod | Repeat per Stratification | ✓ |
| | 50-75 | LisDe | EligiblePopulation | For each Stratification | ✓ |
| | Total | Disability | ExclusionAdminRequired | For each Stratification | ✓ |
| | | LisDeAndDisability | NumeratorByAdminElig | For each Stratification | |
| | | Other | CYAR | Only for Total (Percent) | |
| | | Unknown | MinReqSampleSize | Repeat per Stratification | |
| | | Total | OversampleRate | Repeat per Stratification | |
| | | | OversampleRecordsNumber | (Count) | |
| | | | ExclusionValidDataErrors | Repeat per Stratification | |
| | | | ExclusionEmployeeOrDep | Repeat per Stratification | |
| | | | OversampleRecsAdded | Repeat per Stratification | |
| | | | Denominator | For each Stratification | |
| | | | NumeratorByAdmin | For each Stratification | ✓ |
| | | | NumeratorByMedicalRecords | For each Stratification | |
| | | | NumeratorBySupplemental | For each Stratification | ✓ |
| | | | Rate | (Percent) | ✓ |

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

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

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

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

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

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

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

## Rules for Allowable Adjustments of HEDIS

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

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

***Rules for Allowable Adjustments of Colorectal Cancer Screening***

| NONCLINICAL COMPONENTS | | |
|---|---|---|
| **Eligible Population** | **Adjustments Allowed (Yes/No)** | **Notes** |
| Product lines | Yes | Organizations are not required to use product line criteria; product lines may be combined and all (or no) product line criteria may be used. |
| Ages | Yes, with limits | The age determination dates may be changed (e.g., select, "age as of June 30").<br>The denominator age may not be expanded. |
| Continuous enrollment, allowable gap, anchor date | Yes | Organizations are not required to use enrollment criteria; adjustments are allowed. |
| Benefit | Yes | Organizations are not required to use a benefit; adjustments are allowed. |
| Other | Yes | Organizations may use additional eligible population criteria to focus on an area of interest defined by gender, race, ethnicity, socioeconomic or sociodemographic characteristics, geographic region or another characteristic. |
| **CLINICAL COMPONENTS** | | |
| **Eligible Population** | **Adjustments Allowed (Yes/No)** | **Notes** |
| Event/diagnosis | NA | There is no event/diagnosis for this measure. |
| **Denominator Exclusions** | **Adjustments Allowed (Yes/No)** | **Notes** |
| Required exclusions | Yes, with limits | Apply required exclusions according to specified value sets.<br>The hospice, deceased member and palliative care exclusions are not required. Refer to *Exclusions* in the *Guidelines for the Rules for Allowable Adjustments* |
| Exclusions: I-SNP, LTI, frailty or advanced illness | Yes | These exclusions are not required. Refer to *Exclusions* in the *Guidelines for the Rules for Allowable Adjustments*. |
| **Numerator Criteria** | **Adjustments Allowed (Yes/No)** | **Notes** |
| Colorectal Cancer Screening | No | The value sets and the logic may not be changed. |

# MEASURE COB-AD: CONCURRENT USE OF OPIOIDS AND BENZODIAZEPINES

Pharmacy Quality Alliance

## A. DESCRIPTION

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

Note: A lower rate indicates better performance.

Data Collection Method: Administrative

Guidance for Reporting:

- This measure applies to beneficiaries age 18 and older. For the purpose of Adult Core Set reporting, states should calculate and report this measure for two age groups (as applicable): ages 18 to 64 and age 65 and older. Age groups should be based on age as of January 1 of the measurement year.
- The opioid medications used to calculate this measure are in the "Value Sets – Medications" tab of the value set directory, available at https://www.medicaid.gov/medicaid/quality-of-care/downloads/2021-adult-COB-OHD-value-set-NDC-directory.zip. The only opioids that should be included when calculating this measure are those in the "Value Sets – Medications" tab.
- Beneficiaries with a cancer diagnosis, a sickle cell disease diagnosis, or in hospice at any point during the measurement year are excluded from this measure. Individuals with a cancer diagnosis or sickle cell disease diagnosis may be identified using the ICD-10 codes in the Cancer Value Set and Sickle Cell Disease Value Set and beneficiaries in hospice may be identified using the codes in the Hospice Encounter Value Set and Hospice Intervention Value Set available in the "Value Sets – Other" tab of the value set directory, available at https://www.medicaid.gov/medicaid/quality-of-care/downloads/2021-adult-COB-OHD-value-set-NDC-directory.zip.
- More information on the Pharmacy Quality Alliance value set directory is available at https://www.pqaalliance.org/assets/Measures/PQA_Value_Set_Redesign_FAQs.pdf.
- The exclusion criteria are for beneficiaries with a diagnosis code for cancer or sickle cell disease during the measurement year. Their initial diagnosis may have occurred previously; however, the diagnosis code for cancer or sickle cell disease must be present during the measurement year for the beneficiary to be excluded.
- When determining the eligible population, under Step 1 of the Event/Diagnosis, the process for counting the total days' supply when there are multiple prescriptions with overlapping days of supply depends on whether the prescriptions are filled on the same day or on different days.
  - If prescriptions are filled on the **same day**, states should count only the days' supply for the prescription filled with the longest supply toward the total. For example, if an individual had two prescriptions filled on October 15 during the measurement year, one with a 7-day supply and the other with a 30-day supply, of the two claims filled, the state should count only the 30 days' supply claim toward the cumulative days' supply.
  - If prescriptions are dispensed on **different days** with overlapping days' supply, states should not account for overlapping days' supply. Each day of overlap should be counted separately towards the total days' supply. For example, if a beneficiary has two claims that were dispensed during the measurement year, the first on

January 15, 2019 for a 30-day supply, and the second, on January 20, 2019 for a 7-day supply, then the beneficiary's cumulative days' supply is 37 days.

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

The following coding systems are used in this measure: ICD-10-CM and NDC. Refer to the Acknowledgments section at the beginning of the manual for copyright information.

## B. DEFINITIONS

| | |
|---|---|
| Measurement year | January 1 to December 31 of the measurement year. |
| Opioid | See medications listed in Table COB-A. |
| Benzodiazepine | See medications listed in Table COB-B. |
| Concurrent Use | Overlapping supply for an opioid and a benzodiazepine for 30 or more cumulative days. Concurrent use is identified using the dates of service and days' supply of a beneficiary's prescription claims. The days of concurrent use is the count of days with overlapping days' supply for an opioid and a benzodiazepine. |
| Prescription claims | Only paid, non-reversed prescription claims are included in the data set to calculate the measure. |
| Index Prescription Start Date (IPSD) | The earliest date of service for an opioid prescription during the measurement year.<br>The IPSD must occur at least 30 days before the end of the measurement year. (i.e., January 1 – December 2). |
| Hospice | Any beneficiary in hospice care at any time during the measurement year. Beneficiaries in hospice are identified by the presence of specific hospice codes in the Hospice Encounter Value Set and Hospice Intervention Value Set in the "Value Sets – Other" tab of the value set directory, available at https://www.medicaid.gov/medicaid/quality-of-care/downloads/2021-adult-COB-OHD-value-set-NDC-directory.zip. |
| Cancer Diagnosis | Any beneficiary with an ICD-10-CM diagnosis code for cancer, including primary diagnosis or any other diagnosis fields, any time during the measurement year in the Cancer Value Set in the "Value Sets – Other" tab of the value set directory, available at https://www.medicaid.gov/medicaid/quality-of-care/downloads/2021-adult-COB-OHD-value-set-NDC-directory.zip. |
| Sickle Cell Disease Diagnosis | Any beneficiary with an ICD-10 diagnosis code for sickle cell disease, including primary diagnosis or any other diagnosis fields, any time during the measurement year in the Sickle Cell Disease Value Set in the "Value Sets – Other" tab of the value set directory, available at https://www.medicaid.gov/medicaid/quality-of-care/downloads/2021-adult-COB-OHD-value-set-NDC-directory.zip. |

## C. ELIGIBLE POPULATION

| | |
|---|---|
| Age | Age 18 and older as of January 1 of the measurement year. |
| Continuous enrollment | The measurement year with one allowable gap, as defined, below. |
| Allowable gap | No more than one gap in continuous enrollment of up to 31 days during the measurement year. When enrollment is verified monthly, the beneficiary may not have more than a 1-month gap in coverage (e.g., a beneficiary whose coverage lapses for 2 months [60 consecutive days] is not considered continuously enrolled). |
| Anchor date | December 31 of the measurement year. |
| Benefit | Medical and pharmacy. |
| Event/Diagnosis | Use the steps below to determine the eligible population.<br>Step 1<br>Identify beneficiaries with 2 or more prescription claims for opioid medications (Table COB-A) on different dates of service and with a cumulative days' supply of 15 or more days during the measurement year.<br>Exclude days' supply that occur after the end of the measurement year.<br>NOTE:<br>• The prescription can be for the same or different opioids.<br>• If multiple prescriptions for opioids are dispensed on the same day, calculate the number of days covered by an opioid using the prescriptions with the longest days' supply.<br>• If multiple prescriptions for opioids are dispensed on different days, sum the days' supply for all the prescription claims, regardless of overlapping days' supply.<br>Step 2<br>Identify beneficiaries with an IPSD on January 1 through December 2 of the measurement year.<br>Step 3<br>Exclude beneficiaries who met at least one of the following during the measurement year:<br>• Hospice<br>• Cancer Diagnosis<br>• Sickle Cell Disease Diagnosis |

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

| | | | |
|---|---|---|---|
| Benzohydrocodone | Hydrocodone | Morphine | Oxymorphone |
| Buprenorphine[c] | Hydromorphone | Opium | Pentazocine |
| Butorphanol | Levorphanol | Oxycodone | Tapentadol |
| Codeine | Meperidine | | Tramadol |
| Dihydrocodeine | Methadone | | |
| Fentanyl | | | |

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

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

## D. ADMINISTRATIVE SPECIFICATION

**Denominator**

The eligible population as defined above.

**Numerator**

The number of beneficiaries from the denominator with:

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

Follow the steps below to identify beneficiaries for the numerator.

Step 1

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

Step 2

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

NOTE:

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

Step 3

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

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

| | | | |
|---|---|---|---|
| Alprazolam<br>Chlordiazepoxide<br>Clobazam<br>Clonazepam | Clorazepate<br>Diazepam<br>Estazolam<br>Flurazepam | Lorazepam<br>Midazolam<br>Oxazepam<br>Quazepam | Temazepam<br>Triazolam |

[a] Excludes injectable formulations.

[b] Includes combination products.

**Rate**

Divide the numerator by the denominator and multiply by 100.

## E. ADDITIONAL NOTES

**This measure is not intended for clinical-decision-making**. This measure is intended for retrospective evaluation of populations of patients and should not be used to guide clinical decisions for individual patients. For clinical guidance on opioid prescribing, see the Center for Disease Control and Prevention CDC Guideline for Prescribing Opioids for Chronic Pain and Guideline Resources.

# Controlling High Blood Pressure (CBP)

## SUMMARY OF CHANGES TO HEDIS MY 2023

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

## Description

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

## Definitions

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

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

## Eligible Population

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

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

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

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

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

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

**Continuous enrollment** The measurement year.

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

**Anchor date** December 31 of the measurement year.

**Benefit** Medical.

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

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

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

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

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

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

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

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

**Exclusions**

Exclude members who meet any of the following criteria:

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

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

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

***Dementia Medications***

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

## Administrative Specification

**Denominator** The eligible population.

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

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

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

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

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

## Hybrid Specification

**Denominator**

A systematic sample drawn from the eligible population.

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

**Identifying the medical record**

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

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

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

**Numerator**

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

**Administrative**

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

**Medical record**

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

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

Do not include BP readings:

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

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

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

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

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

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

### *Note*

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

## Data Elements for Reporting

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

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

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

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

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

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

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

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

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

## Rules for Allowable Adjustments of HEDIS

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

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

***Rules for Allowable Adjustments of Controlling High Blood Pressure***

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

# *Depression Remission or Response for Adolescents and Adults (DRR-E)**

***Adapted with financial support from the Agency for Healthcare Research and Quality (AHRQ) and the Centers for Medicare & Medicaid Services (CMS) under the CHIPRA Pediatric Quality Measures Program Centers of Excellence grant number U18HS020503, and with permission from the measure developer, Minnesota Community Measurement.**

## SUMMARY OF CHANGES TO HEDIS MY 2023

- Refer to the Technical Release Notes file in the Digital Measures Package for a comprehensive list of changes.
- Revised the "Other" criteria in the Nonclinical Components table under *Rules for Allowable Adjustments of HEDIS.*

| | |
|---|---|
| **Description** | The percentage of members 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 4–8 months of the elevated score.<br>• *Follow-Up PHQ-9*. The percentage of members who have a follow-up PHQ-9 score documented within 4–8 months after the initial elevated PHQ-9 score.<br>• *Depression Remission*. The percentage of members who achieved remission within 4–8 months after the initial elevated PHQ-9 score.<br>• *Depression Response*. The percentage of members who showed response within 4–8 months after the initial elevated PHQ-9 score. |
| **Measurement period** | January 1–December 31. |
| **Clinical recommendation statement** | 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 (Kessler, 2016).<br>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 (Cheung, 2018). |
| **Citations** | Cheung A. H., R. A. Zuckerbrot, P. S. Jensen, K. Ghalib, D. Laraque, and R.E.K. Stein. "Guidelines for Adolescent Depression in Primary Care (GLAD-PC): II. Treatment and Ongoing Management." **Pediatrics** 120, no. 5 (January 2007). https://doi.org/10.1542/peds.2006-1395.<br>Trangle, M., J. Gursky, R. Haight, J. Hardwig, T. Hinnenkamp, D. Kessler, N. Mack, M. Myszkowski. Institute for Clinical Systems Improvement. **Adult Depression in Primary Care**. Updated March 2013. |

| **Characteristics** | |
|---|---|
| **Scoring** | Proportion. |
| **Type** | Outcome. |
| **Stratification** | • Depression Follow-Up.<br>– Product line:<br>▪ Commercial.<br>▪ Medicaid.<br>▪ Medicare.<br>– Age (as of the start of the intake period, for each product line):<br>▪ 12–17 years (for commercial and Medicaid only).<br>▪ 18–44 years.<br>▪ 45–64 years.<br>▪ 65 years and older.<br>• Depression Remission.<br>– Product line:<br>▪ Commercial.<br>▪ Medicaid.<br>▪ Medicare.<br>– Age (as of the start of the intake period, for each product line):<br>▪ 12–17 years (for commercial and Medicaid only).<br>▪ 18–44 years.<br>▪ 45–64 years.<br>▪ 65 years and older.<br>• Depression Response.<br>– Product line:<br>▪ Commercial.<br>▪ Medicaid.<br>▪ Medicare.<br>– Age (as of the start of the intake period, for each product line):<br>▪ 12–17 years (for commercial and Medicaid only).<br>▪ 18–44 years.<br>▪ 45–64 years.<br>▪ 65 years and older. |
| **Risk adjustment** | None. |
| **Improvement notation** | A higher rate indicates better performance. |

| | |
|---|---|
| **Guidance** | **Allocation:**<br>The member was enrolled with a medical benefit throughout the participation period.<br><br>A gap in enrollment is allowed only in the measurement period. No gaps in enrollment are allowed from May 1 of the year prior to the measurement period through December 31 of the year prior to the measurement period.<br><br>When identifying members in hospice, the requirements described in *General Guideline 15* for identification of hospice members using the monthly membership detail data files are not included in the measure calculation logic and need to be programmed manually.<br><br>**Requirements:**<br>The measure allows two PHQ-9 assessments. Selection of the appropriate assessment should be based on the member's age.<br>• *PHQ-9:* 12 years of age and older.<br>• *PHQ-9 Modified for Teens:* 12–17 years of age.<br><br>The PHQ-9 assessment does not need to occur during a face-to-face encounter; it may be completed over the telephone or through a web-based portal.<br><br>**Reporting:**<br>The total is the sum of the age stratifications.<br><br>Product line stratifications are not included in the measure calculation logic and need to be programmed manually. |
| **Definitions** | |
| **Participation** | The identifiers and descriptors for each organization's coverage used to define members' eligibility for measure reporting. Allocation for reporting is based on eligibility during the participation period. |
| **Participation period** | May 1 of the year prior to the measurement period through December 31 of the measurement period. |
| **Intake period** | May 1 of the year prior to the measurement period through April 30 of the measurement period. |
| **Depression follow-up period** | The 120−240-day period after the IESD. |
| **IESD** | Index episode start date. The earliest date during the intake period where a member has a PHQ-9 total score >9 documented within a 31-day period including and around (15 days before and 15 days after) an interactive outpatient encounter with a diagnosis of major depression or dysthymia. |
| **Interactive outpatient encounter** | 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. |

| | |
|---|---|
| **Initial population** | **Initial population 1**<br>Members 12 years and older as of the start of the intake period who meet **both** of the following criteria:<br>• The depression encounter and PHQ-9 total score requirements as described by the IESD.<br>• Participation.<br>**Initial population 2**<br>Same as the initial population 1.<br>**Initial population 3**<br>Same as the initial population 1. |
| **Exclusions** | **Exclusions 1**<br>Members with any of the following any time during the member's history through the end of the measurement period:<br>• Bipolar disorder.<br>• Personality disorder.<br>• Psychotic disorder.<br>• Pervasive developmental disorder.<br>***OR***<br>• Members in hospice or using hospice services any time during the measurement period.<br>**Exclusions 2**<br>Same as exclusions 1.<br>**Exclusions 3**<br>Same as exclusions 1. |
| **Denominator** | **Denominator 1**<br>Initial population, minus exclusions.<br>**Denominator 2**<br>Same as denominator 1.<br>**Denominator 3**<br>Same as denominator 1. |
| **Numerator** | **Numerator 1—Depression Follow-Up**<br>A PHQ-9 total score in the member's record during the depression follow-up period.<br>**Numerator 2—Depression Remission**<br>Members who achieve remission of depression symptoms, as demonstrated by the most recent PHQ-9 score of <5 during the depression follow-up period. |

| | |
|---|---|
| | **Numerator 3—Depression Response**<br>Members who indicate a response to treatment for depression, as demonstrated by the most recent PHQ-9 total score being at least 50 percent lower than the PHQ-9 score associated with the IESD, documented during the depression follow-up period. |

**Data criteria (element level)**

***Value Sets:***

- **DRRE_HEDIS_MY2023-2.0.0**
  - Bipolar Disorder (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1044)
  - Interactive Outpatient Encounter (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1347)
  - Major Depression or Dysthymia (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1351)
  - Other Bipolar Disorder (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1399)
  - Personality Disorder (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1355)
  - Pervasive Developmental Disorder (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1356)
  - Psychotic Disorders (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1352)
- **NCQA_Hospice-2.0.0**
  - Hospice Encounter (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1761)
  - Hospice Intervention (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1762)

***Direct reference codes and codesystems:***

- **DRRE_HEDIS_MY2023-2.0.0**
  - codesystem "LOINC": 'http://loinc.org'
  - code "Patient Health Questionnaire 9 item (PHQ-9) total score [Reported]": '44261-6' from "LOINC" display 'Patient Health Questionnaire 9 item (PHQ-9) total score [Reported]'
  - code "Patient Health Questionnaire-9: Modified for Teens total score [Reported.PHQ.Teen]": '89204-2' from "LOINC" display 'Patient Health Questionnaire-9: Modified for Teens total score [Reported.PHQ.Teen]'
- **NCQA_Terminology-2.0.0**
  - codesystem "ActCode": 'http://terminology.hl7.org/CodeSystem/v3-ActCode'
  - codesystem "ConditionClinicalStatusCodes": 'http://terminology.hl7.org/CodeSystem/condition-clinical'
  - code "active": 'active' from "ConditionClinicalStatusCodes"
  - code "managed care policy": 'MCPOL' from "ActCode"
  - code "retiree health program": 'RETIRE' from "ActCode"
  - code "subsidized health program": 'SUBSIDIZ' from "ActCode"

## Data Elements for Reporting

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

***Table DRR-E-1/2: Data Elements for Depression Remission or Response for Adolescents and Adults***

| Metric | Age | Data Element | Reporting Instructions |
|---|---|---|---|
| FollowUp | 12-17 | InitialPopulationByEHR | For each Stratification, repeat per Metric |
| Remission | 18-44 | InitialPopulationByCaseManagement | For each Stratification, repeat per Metric |
| Response | 45-64 | InitialPopulationByHIERegistry | For each Stratification, repeat per Metric |
| | 65+ | InitialPopulationByAdmin | For each Stratification, repeat per Metric |
| | Total | InitialPopulation | (Sum over SSoRs) |
| | | ExclusionsByEHR | For each Stratification, repeat per Metric |
| | | ExclusionsByCaseManagement | For each Stratification, repeat per Metric |
| | | ExclusionsByHIERegistry | For each Stratification, repeat per Metric |
| | | ExclusionsByAdmin | For each Stratification, repeat per Metric |
| | | Exclusions | (Sum over SSoRs) |
| | | Denominator | For each Stratification, repeat per Metric |
| | | NumeratorByEHR | For each Metric and Stratification |
| | | NumeratorByCaseManagement | For each Metric and Stratification |
| | | NumeratorByHIERegistry | For each Metric and Stratification |
| | | NumeratorByAdmin | For each Metric and Stratification |
| | | Numerator | (Sum over SSoRs) |
| | | Rate | (Percent) |

*Table DRR-E-3: Data Elements for Depression Remission or Response for Adolescents and Adults*

| Metric | Age | Data Element | Reporting Instructions |
|---|---|---|---|
| FollowUp | 18-44 | InitialPopulationByEHR | For each Stratification, repeat per Metric |
| Remission | 45-64 | InitialPopulationByCaseManagement | For each Stratification, repeat per Metric |
| Response | 65+ | InitialPopulationByHIERegistry | For each Stratification, repeat per Metric |
| | Total | InitialPopulationByAdmin | For each Stratification, repeat per Metric |
| | | InitialPopulation | (Sum over SSoRs) |
| | | ExclusionsByEHR | For each Stratification, repeat per Metric |
| | | ExclusionsByCaseManagement | For each Stratification, repeat per Metric |
| | | ExclusionsByHIERegistry | For each Stratification, repeat per Metric |
| | | ExclusionsByAdmin | For each Stratification, repeat per Metric |
| | | Exclusions | (Sum over SSoRs) |
| | | Denominator | For each Stratification, repeat per Metric |
| | | NumeratorByEHR | For each Metric and Stratification |
| | | NumeratorByCaseManagement | For each Metric and Stratification |
| | | NumeratorByHIERegistry | For each Metric and Stratification |
| | | NumeratorByAdmin | For each Metric and Stratification |
| | | Numerator | (Sum over SSoRs) |
| | | Rate | (Percent) |

## Rules for Allowable Adjustments of HEDIS

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

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

***Rules for Allowable Adjustments of Depression Remission or Response for Adolescents and Adults***

| NONCLINICAL COMPONENTS | | |
|---|---|---|
| **Eligible Population** | **Adjustments Allowed (Yes/No)** | **Notes** |
| Product lines | Yes | Organizations are not required to use product line criteria; product lines may be combined and all (or no) product line criteria may be used. |
| Ages | Yes, with limits | The age determination dates may be changed (e.g., select, "age as of June 30").<br>Changing the denominator age range is allowed if the limits are within the specified age range (12 years and older).<br>The denominator age may not be expanded. |
| Allocation | Yes | Organizations are not required to use enrollment criteria; adjustments are allowed. |
| Benefits | Yes | Using a benefit is not required; adjustments are allowed. |
| Other | Yes | Organizations may use additional eligible population criteria to focus on an area of interest defined by gender, race, ethnicity, socioeconomic or sociodemographic characteristics, geographic region or another characteristic. |
| **CLINICAL COMPONENTS** | | |
| **Eligible Population** | **Adjustments Allowed (Yes/No)** | **Notes** |
| Event/diagnosis | No | 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. |
| **Denominator Exclusions** | **Adjustments Allowed (Yes/No)** | **Notes** |
| Exclusions | No | Apply exclusions according to specified value sets. |
| Exclusion: Hospice | Yes | The hospice exclusion is not required. Refer to *Exclusions* in the *Guidelines for the Rules for Allowable Adjustments*. |
| **Numerator Criteria** | **Adjustments Allowed (Yes/No)** | **Notes** |
| • PHQ-9 Score<br>• Depression Remission<br>• Depression Response | No | Value sets, direct reference codes and logic may not be changed. |

# *Unhealthy Alcohol Use Screening and Follow-Up (ASF-E)**

***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).**

## SUMMARY OF CHANGES FOR HEDIS MY 2023

- Refer to the Technical Release Notes file in the Digital Measures Package for a comprehensive list of changes.
- Revised the "Other" criteria in the Nonclinical Components table under *Rules for Allowable Adjustments of HEDIS.*

| | |
|---|---|
| **Description** | The percentage of members 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.<br>• *Unhealthy Alcohol Use Screening*. The percentage of members who had a systematic screening for unhealthy alcohol use.<br>• *Follow-Up Care on Positive Screen*. The percentage of members receiving brief counseling or other follow-up care within 2 months of screening positive for unhealthy alcohol use. |
| **Measurement period** | January 1–December 31. |
| **Clinical recommendation statement** | 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) |
| **Citations** | U.S. Preventive Services Task Force. 2018. "Unhealthy Alcohol Use in Adolescents and Adults: Screening and Behavioral Counseling Interventions." JAMA 320(18):1899–1909. DOI:10.1001/jama.2018.16789. |
| **Characteristics** | |
| **Scoring** | Proportion. |
| **Type** | Process. |
| **Stratification** | • Unhealthy Alcohol Use Screening.<br>– Product line:<br>▪ Commercial.<br>▪ Medicaid.<br>▪ Medicare.<br>– Age (as of the start of the measurement period, for each product line):<br>▪ 18–44 years.<br>▪ 45–64 years.<br>▪ 65 years and older. |

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

- Follow-Up on Care Positive Screen.
  - Product line:
    - Commercial.
    - Medicaid.
    - Medicare.
  - Age (as of the start of the measurement period, for each product line):
    - 18–44 years.
    - 45–64 years.
    - 65 years and older.

</td></tr>
<tr><td>Risk adjustment</td><td>None.</td></tr>
<tr><td>Improvement notation</td><td>A higher rate indicates better performance.</td></tr>
<tr><td>Guidance</td><td>Allocation:<br>The member was enrolled with a medical benefit throughout the participation period.<br><br>When identifying members in hospice, the requirements described in General Guideline 15 for identification of hospice members using the monthly membership detail data files are not included in the measure calculation logic and need to be programmed manually.<br><br>Reporting:<br>The total is the sum of the age stratifications.<br><br>Product line stratifications are not included in the measure calculation logic and need to be programmed manually.</td></tr>
<tr><td colspan="2">Definitions</td></tr>
<tr><td>Participation</td><td>The identifiers and descriptors for each organization’s coverage used to define members’ eligibility for measure reporting. Allocation for reporting is based on eligibility during the participation period.</td></tr>
<tr><td>Participation period</td><td>The measurement period.</td></tr>
<tr><td>Unhealthy Alcohol Use Screening</td><td>A standard assessment instrument that has been normalized and validated for the adult patient population. Eligible screening instruments with thresholds for positive findings include:
<table>
<tr><th>Screening Instrument</th><th>Positive Finding</th></tr>
<tr><td>Alcohol Use Disorders Identification Test (AUDIT) screening instrument</td><td>Total score ≥8</td></tr>
<tr><td>Alcohol Use Disorders Identification Test Consumption (AUDIT-C) screening instrument</td><td>Total score ≥4 for men<br>Total score ≥3 for women</td></tr>
</table>
</td></tr>
</table>

<table>
<tr><td>Alcohol Counseling or Other Follow-Up Care</td><td>
<table>
<tr><th>Screening Instrument</th><th>Positive Finding</th></tr>
<tr><td>Single-question screen:<br>“How many times in the past year have you had 5 (for men) or 4 (for women and all adults older than 65 years) or more drinks in a day?”</td><td>Total score ≥1</td></tr>
</table>
Any of the following on or up to 60 days after the first positive screen:
<ul>
<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>
</td></tr>
<tr><td>Initial population</td><td>Initial population 1<br>Members 18 years and older at the start of the measurement period who also meet criteria for participation.<br><br>Initial population 2<br>Same as the initial population 1.</td></tr>
<tr><td>Exclusions</td><td>Exclusions 1
<ul>
<li>Members with alcohol use disorder that starts during the year prior to the measurement period.</li>
<li>Members with history of dementia any time during the member’s history through the end of the measurement period.</li>
<li>Members in hospice or using hospice services any time during the measurement period.</li>
</ul>
Exclusions 2<br>Same as exclusions 1.</td></tr>
<tr><td>Denominator</td><td>Denominator 1<br>The initial population, minus exclusions.<br><br>Denominator 2<br>All members in numerator 1 with a positive finding for unhealthy alcohol use screening between January 1 and November 1 of the measurement period.</td></tr>
<tr><td>Numerator</td><td>Numerator 1—Unhealthy Alcohol Use Screening<br>Members with a documented result for unhealthy alcohol use screening performed between January 1 and November 1 of the measurement period.<br><br>Numerator 2—Follow-Up Care on Positive Screen<br>Members receiving alcohol counseling or other follow-up care on or up to 60 days after the date of the first positive screen (61 days total).</td></tr>
</table>

**Data criteria (element level)**

***Value Sets:***

- **ASFE_HEDIS_MY2023-2.0.0**
  - Alcohol Counseling or Other Follow Up Care (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1437)
  - Alcohol Use Disorder (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1339)
  - Dementia (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1074)
- **NCQA_Hospice-2.0.0**
  - Hospice Encounter (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1761)
  - Hospice Intervention (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1762)

***Direct reference codes and codesystems:***

- **ASFE_HEDIS_MY2023-2.0.0**
  - codesystem "ICD-10-CM": 'http://hl7.org/fhir/sid/icd-10-cm'
  - codesystem "LOINC": 'http://loinc.org'
  - code "Alcohol abuse counseling and surveillance of alcoholic": 'Z71.41' from "ICD-10-CM" display 'Alcohol abuse counseling and surveillance of alcoholic'
  - code "How often have you had five or more drinks in one day during the past year [Reported]": '88037-7' from "LOINC" display 'How often have you had five or more drinks in one day during the past year [Reported]'
  - code "How often have you had four or more drinks in one day during the past year [Reported]": '75889-6' from "LOINC" display 'How often have you had four or more drinks in one day during the past year [Reported]'
  - code "Total score [AUDIT-C]": '75626-2' from "LOINC" display 'Total score [AUDIT-C]'
  - code "Total score [AUDIT]": '75624-7' from "LOINC" display 'Total score [AUDIT]'
- **NCQA_Terminology-2.0.0**
  - codesystem "ActCode": 'http://terminology.hl7.org/CodeSystem/v3-ActCode'
  - codesystem "ConditionClinicalStatusCodes": 'http://terminology.hl7.org/CodeSystem/condition-clinical'
  - code "active": 'active' from "ConditionClinicalStatusCodes"
  - code "managed care policy": 'MCPOL' from "ActCode"
  - code "retiree health program": 'RETIRE' from "ActCode"
  - code "subsidized health program": 'SUBSIDIZ' from "ActCode"

## Data Elements for Reporting

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

***Table ASF-E-1/2/3: Data Elements for Unhealthy Alcohol Use Screening and Follow-Up***

| Metric | Age | Data Element | Reporting Instructions |
|---|---|---|---|
| Screening | 18-44 | InitialPopulation | For each Metric and Stratification |
| FollowUp | 45-64 | ExclusionsByEHR | For each Metric and Stratification |
| | 65+ | ExclusionsByCaseManagement | For each Metric and Stratification |
| | Total | ExclusionsByHIERegistry | For each Metric and Stratification |
| | | ExclusionsByAdmin | For each Metric and Stratification |
| | | Exclusions | (Sum over SSoRs) |
| | | Denominator | For each Metric and Stratification |
| | | NumeratorByEHR | For each Metric and Stratification |
| | | NumeratorByCaseManagement | For each Metric and Stratification |
| | | NumeratorByHIERegistry | For each Metric and Stratification |
| | | NumeratorByAdmin | For each Metric and Stratification |
| | | Numerator | (Sum over SSoRs) |
| | | Rate | (Percent) |

## Rules for Allowable Adjustments of HEDIS

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

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

***Rules for Allowable Adjustments of Unhealthy Alcohol Use Screening and Follow-Up***

| NONCLINICAL COMPONENTS | | |
|---|---|---|
| **Eligible Population** | **Adjustments Allowed (Yes/No)** | **Notes** |
| Product lines | Yes | Organizations are not required to use product line criteria; product lines may be combined and all (or no) product line criteria may be used. |
| Ages | Yes, with limits | The age determination dates may be changed (e.g., select, "age as of June 30").<br>Changing the denominator age range is allowed if the limits are within the specified age range (18 years and older).<br>Organizations must consult UPSTSF guidelines when considering whether to expand the age ranges outside of the current thresholds. |
| Allocation | Yes | Organizations are not required to use enrollment criteria; adjustments are allowed. |
| Benefits | Yes | Using a benefit is not required; adjustments are allowed. |
| Other | Yes | Organizations may use additional eligible population criteria to focus on an area of interest defined by gender, race, ethnicity, socioeconomic or sociodemographic characteristics, geographic region or another characteristic. |
| **CLINICAL COMPONENTS** | | |
| **Eligible Population** | **Adjustments Allowed (Yes/No)** | **Notes** |
| Event/diagnosis | No | Value sets, direct reference codes and logic may not be changed for denominator 2. |
| **Denominator Exclusions** | **Adjustments Allowed (Yes/No)** | **Notes** |
| Exclusions | No | Apply exclusions according to specified direct reference codes. |
| Exclusion: Hospice | Yes | The hospice exclusion is not required. Refer to *Exclusions* in the *Guidelines for the Rules for Allowable Adjustments*. |
| **Numerator Criteria** | **Adjustments Allowed (Yes/No)** | **Notes** |
| • Unhealthy Alcohol Use Screening<br>• Counseling Or Other Follow-Up On Positive Screen | No | Value sets, direct reference codes and logic may not be changed. |

# *Depression Screening and Follow-Up for Adolescents and Adults (DSF-E)**

***Adapted with financial support from the Centers for Medicare & Medicaid Services (CMS).**

## SUMMARY OF CHANGES TO HEDIS MY 2023

- Refer to the Technical Release Notes file in the Digital Measures Package for a comprehensive list of changes.
- Revised the "Other" criteria in the Nonclinical Components table under *Rules for Allowable Adjustments of HEDIS.*

| | |
|---|---|
| **Description** | The percentage of members 12 years of age and older who were screened for clinical depression using a standardized instrument and, if screened positive, received follow-up care.<br>• *Depression Screening.* The percentage of members who were screened for clinical depression using a standardized instrument.<br>• *Follow-Up on Positive Screen.* The percentage of members who received follow-up care within 30 days of a positive depression screen finding. |
| **Measurement period** | January 1–December 31. |
| **Clinical recommendation statement** | The U.S. Preventive Services Task Force (USPSTF) recommends screening for depression among adolescents 12–18 years and the general adult population, including pregnant and postpartum women. (B recommendation)<br>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) |
| **Citations** | U.S. Preventive Services Task Force. 2016. "Screening for Depression in Children and Adolescents: U.S. Preventive Services Task Force Recommendation Statement." *Annals of Internal Medicine* 164:360–6.<br>U.S. Preventive Services Task Force. 2016. "Screening for Major Depressive Disorder in Adults: US Preventive Services Task Force Recommendation Statement." *Journal of the American Medical Association* 315(4):380–7. |
| **Characteristics** | |
| **Scoring** | Proportion. |
| **Type** | Process. |

| | |
|---|---|
| **Stratification** | • Depression Screening.<br>– Product line:<br>▪ Commercial.<br>▪ Medicaid.<br>▪ Medicare.<br>– Age (as of the start of the measurement period, for each product line):<br>▪ 12–17 years (for commercial and Medicaid only).<br>▪ 18–64 years.<br>▪ 65 years and older.<br>• Follow-Up on Positive Screen.<br>– Product line:<br>▪ Commercial.<br>▪ Medicaid.<br>▪ Medicare.<br>– Age (as of the start of the measurement period, for each product line):<br>▪ 12–17 years (for commercial and Medicaid only).<br>▪ 18–64 years.<br>▪ 65 years and older. |
| **Risk adjustment** | None. |
| **Improvement notation** | A higher rate indicates better performance. |
| **Guidance** | **Allocation:**<br>The member was enrolled with a medical benefit throughout the participation period.<br><br>When identifying members in hospice, the requirements described in *General Guideline 15* for identification of hospice members using the monthly membership detail data files are not included in the measure calculation logic and need to be programmed manually.<br><br>**Requirements:**<br>• This measure requires the use of an age-appropriate screening instrument. The member's age is used to select the appropriate depression screening instrument.<br>• Depression screening captured in health risk assessments or other types of health assessments are allowed if the questions align with a specific instrument that is validated for depression screening. For example, if a health risk assessment includes questions from the PHQ-2, it counts as screening if the member answered the questions and a total score is calculated.<br><br>**Reporting:**<br>The total is the sum of the age stratifications.<br><br>Product line stratifications are not included in the measure calculation logic and need to be programmed manually. |

## Definitions

**Participation**

The identifiers and descriptors for each organization's coverage used to define members' eligibility for measure reporting. Allocation for HEDIS reporting is based on eligibility during the participation period.

**Participation period**

The measurement period.

**Depression screening instrument**

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

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

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

| Instruments for Adults (18+ years) | Positive Finding |
|---|---|
| Patient Health Questionnaire (PHQ-9)® | Total score ≥10 |
| Patient Health Questionnaire-2 (PHQ-2)®[1] | Total score ≥3 |
| Beck Depression Inventory-Fast Screen (BDI-FS)®[1,2] | Total score ≥8 |
| Beck Depression Inventory (BDI-II) | Total score ≥20 |
| Center for Epidemiologic Studies Depression Scale-Revised (CESD-R) | Total score ≥17 |
| Duke Anxiety-Depression Scale (DUKE-AD)®[2] | Total score ≥30 |
| Geriatric Depression Scale Short Form (GDS)[1] | Total score ≥5 |
| Geriatric Depression Scale Long Form (GDS) | Total score ≥10 |
| Edinburgh Postnatal Depression Scale (EPDS) | Total score ≥10 |

<table>
<tr><td></td><td>
<table>
<tr><th>Instruments for Adults (18+ years)</th><th>Positive Finding</th></tr>
<tr><td>My Mood Monitor (M-3)®</td><td>Total score ≥5</td></tr>
<tr><td>PROMIS Depression</td><td>Total score (T Score) ≥60</td></tr>
<tr><td>Clinically Useful Depression Outcome Scale (CUDOS)</td><td>Total score ≥31</td></tr>
</table>
[1]Brief screening instrument. All other instruments are full-length.<br>
[2]Proprietary; may be cost or licensing requirement associated with use.
</td></tr>
<tr><td>Initial population</td><td>Initial population 1<br>Members 12 years of age and older at the start of the measurement period who also meet criteria for participation.<br><br>Initial population 2<br>Same as the initial population 1.</td></tr>
<tr><td>Exclusions</td><td>Exclusions 1<br>• Members with a history of bipolar disorder any time during the member's history through the end of the year prior to the measurement period.<br>• Members with depression that starts during the year prior to the measurement period.<br>• Members in hospice or using hospice services any time during the measurement period.<br><br>Exclusions 2<br>Same as exclusions 1.</td></tr>
<tr><td>Denominator</td><td>Denominator 1<br>The initial population, minus exclusions.<br><br>Denominator 2<br>All members from numerator 1 with a positive depression screen finding between January 1 and December 1 of the measurement period.</td></tr>
<tr><td>Numerator</td><td>Numerator 1—Depression Screening<br>Members with a documented result for depression screening, using an age-appropriate standardized instrument, performed between January 1 and December 1 of the measurement period.<br><br>Numerator 2—Follow-Up on Positive Screen<br>Members who received follow-up care on or up to 30 days after the date of the first positive screen (31 total days).<br><br>Any of the following on or up to 30 days after the first positive screen:<br>• An outpatient, telephone, e-visit or virtual check-in follow-up visit with a diagnosis of depression or other behavioral health condition.<br>• A depression case management encounter that documents assessment for symptoms of depression or a diagnosis of depression or other behavioral health condition.</td></tr>
</table>

| | |
|---|---|
| | • A behavioral health encounter, including assessment, therapy, collaborative care or medication management.<br>• A dispensed antidepressant medication.<br>***OR***<br>• 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.<br>***Note:*** *For example, if there is a positive screen resulting from a PHQ-2 score, documentation of a negative finding from a PHQ-9 performed on the same day qualifies as evidence of follow-up.* |

**Data criteria (element level)**

***Value Sets:***

- **DSFE_HEDIS_MY2023-2.0.0**
  - Bipolar Disorder (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1044)
  - Depression (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1390)
  - Other Bipolar Disorder (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1399)
- **NCQA_Hospice-2.0.0**
  - Hospice Encounter (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1761)
  - Hospice Intervention (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1762)
- **NCQA_Screening-1.0.0**
  - Antidepressant Medications (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1503)
  - Behavioral Health Encounter (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1383)
  - Depression Case Management Encounter (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1389)
  - Depression or Other Behavioral Health Condition (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1501)
  - Follow Up Visit (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1385)
  - Symptoms of Depression (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.2392)

***Direct reference codes and codesystems:***

- **DSFE_HEDIS_MY2023-2.0.0**
  - codesystem "LOINC": 'http://loinc.org'
  - code "Beck Depression Inventory Fast Screen total score [BDI]": '89208-3' from "LOINC" display 'Beck Depression Inventory Fast Screen total score [BDI]'
  - code "Beck Depression Inventory II total score [BDI]": '89209-1' from "LOINC" display 'Beck Depression Inventory II total score [BDI]'
  - code "Center for Epidemiologic Studies Depression Scale-Revised total score [CESD-R]": '89205-9' from "LOINC" display 'Center for Epidemiologic Studies Depression Scale-Revised total score [CESD-R]'

- code "Edinburgh Postnatal Depression Scale [EPDS]": '71354-5' from "LOINC" display 'Edinburgh Postnatal Depression Scale [EPDS]'
- code "Final score [DUKE-AD]": '90853-3' from "LOINC" display 'Final score [DUKE-AD]'
- code "Geriatric depression scale (GDS) short version total": '48545-8' from "LOINC" display 'Geriatric depression scale (GDS) short version total'
- code "Geriatric depression scale (GDS) total": '48544-1' from "LOINC" display 'Geriatric depression scale (GDS) total'
- code "Patient Health Questionnaire 2 item (PHQ-2) total score [Reported]": '55758-7' from "LOINC" display 'Patient Health Questionnaire 2 item (PHQ-2) total score [Reported]'
- code "Patient Health Questionnaire 9 item (PHQ-9) total score [Reported]": '44261-6' from "LOINC" display 'Patient Health Questionnaire 9 item (PHQ-9) total score [Reported]'
- code "Patient Health Questionnaire-9: Modified for Teens total score [Reported.PHQ.Teen]": '89204-2' from "LOINC" display 'Patient Health Questionnaire-9: Modified for Teens total score [Reported.PHQ.Teen]'
- code "PROMIS-29 Depression score T-score": '71965-8' from "LOINC" display 'PROMIS-29 Depression score T-score'
- code "Total score [CUDOS]": '90221-3' from "LOINC" display 'Total score [CUDOS]'
- code "Total score [M3]": '71777-7' from "LOINC" display 'Total score [M3]'

- **NCQA_Screening-1.0.0**
  - codesystem "ICD-10-CM": 'http://hl7.org/fhir/sid/icd-10-cm'
  - code "Exercise counseling": 'Z71.82' from "ICD-10-CM" display 'Exercise counseling'
- **NCQA_Terminology-2.0.0**
  - codesystem "ActCode": 'http://terminology.hl7.org/CodeSystem/v3-ActCode'
  - codesystem "ConditionClinicalStatusCodes": 'http://terminology.hl7.org/CodeSystem/condition-clinical'
  - code "active": 'active' from "ConditionClinicalStatusCodes"
  - code "managed care policy": 'MCPOL' from "ActCode"
  - code "retiree health program": 'RETIRE' from "ActCode"
  - code "subsidized health program": 'SUBSIDIZ' from "ActCode"

## Data Elements for Reporting

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

***Table DSF-E-1/2: Data Elements for Depression Screening and Follow-Up for Adolescents and Adults***

| Metric | Age | Data Element | Reporting Instructions |
|---|---|---|---|
| Screening | 12-17 | InitialPopulation | For each Metric and Stratification |
| FollowUp | 18-64 | ExclusionsByEHR | For each Metric and Stratification |
| | 65+ | ExclusionsByCaseManagement | For each Metric and Stratification |
| | Total | ExclusionsByHIERegistry | For each Metric and Stratification |
| | | ExclusionsByAdmin | For each Metric and Stratification |
| | | Exclusions | (Sum over SSoRs) |
| | | Denominator | For each Metric and Stratification |
| | | NumeratorByEHR | For each Metric and Stratification |
| | | NumeratorByCaseManagement | For each Metric and Stratification |
| | | NumeratorByHIERegistry | For each Metric and Stratification |
| | | NumeratorByAdmin | For each Metric and Stratification |
| | | Numerator | (Sum over SSoRs) |
| | | Rate | (Percent) |

***Table DSF-E-3: Data Elements for Depression Screening and Follow-Up for Adolescents and Adults***

| Metric | Age | Data Element | Reporting Instructions |
|---|---|---|---|
| Screening | 18-64 | InitialPopulation | For each Metric and Stratification |
| FollowUp | 65+ | ExclusionsByEHR | For each Metric and Stratification |
| | Total | ExclusionsByCaseManagement | For each Metric and Stratification |
| | | ExclusionsByHIERegistry | For each Metric and Stratification |
| | | ExclusionsByAdmin | For each Metric and Stratification |
| | | Exclusions | (Sum over SSoRs) |
| | | Denominator | For each Metric and Stratification |
| | | NumeratorByEHR | For each Metric and Stratification |
| | | NumeratorByCaseManagement | For each Metric and Stratification |
| | | NumeratorByHIERegistry | For each Metric and Stratification |
| | | NumeratorByAdmin | For each Metric and Stratification |
| | | Numerator | (Sum over SSoRs) |
| | | Rate | (Percent) |

## Rules for Allowable Adjustments of HEDIS

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

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

***Rules for Allowable Adjustments of Depression Screening and Follow-Up for Adolescents and Adults***

| NONCLINICAL COMPONENTS | | |
|---|---|---|
| **Eligible Population** | **Adjustments Allowed (Yes/No)** | **Notes** |
| Product lines | Yes | Organizations are not required to use product line criteria; product lines may be combined and all (or no) product line criteria may be used. |
| Ages | Yes, with limits | The age determination dates may be changed (e.g., select, "age 12 during the measurement year).<br>The denominator age may be changed if the range is within the specified age range (12 years and older).<br>The denominator age may not be expanded. |
| Allocation | Yes | Organizations are not required to use enrollment criteria; adjustments are allowed. |
| Benefits | Yes | Organizations are not required to use a benefit; adjustments are allowed. |
| Other | Yes | Organizations may use additional eligible population criteria to focus on an area of interest defined by gender, race, ethnicity, socioeconomic or sociodemographic characteristics, geographic region or another characteristic. |
| **CLINICAL COMPONENTS** | | |
| **Eligible Population** | **Adjustments Allowed (Yes/No)** | **Notes** |
| Event/diagnosis | No | Value sets and logic may not be changed for Denominator 2. |
| **Denominator Exclusions** | **Adjustments Allowed (Yes/No)** | **Notes** |
| Exclusions | No | Apply exclusions according to specified value sets. |
| Exclusion: Hospice | Yes | The hospice exclusion is not required. Refer to *Exclusions* in the *Guidelines for the Rules for Allowable Adjustments*. |
| **Numerator Criteria** | **Adjustments Allowed (Yes/No)** | **Notes** |
| • Depression Screening<br>• Follow-Up on Positive Screen | No | Value sets, direct reference codes and logic may not be changed. |

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

Oregon Health and Sciences University

## A. DESCRIPTION

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

Data Collection Method: Administrative or Hybrid

Guidance for Reporting:

- This measure includes three age-specific indicators assessing whether children are screened before or on their first, second or third birthdays. Four rates, one for each age group and a combined rate, are to be calculated and reported.
- The code 96110 has been shown to have questionable validity in states that do not have policies clarifying the standardized tools meeting the criterion stated in the specification (see Section C).
  - The measure steward recommends that such policies be in place if a state uses the administrative data component of the specifications. It is recommended (although not required) that states assess the accuracy of their claims/encounter data compared to medical charts.
  - For example, a state may conduct a chart review on a sample of records where the CPT code was used to determine whether the developmental screening occurred and whether the tools used met the criteria for a standardized developmental screening.
  - Additionally, states may encourage use of an ICD-10-CM code or other modifiers most commonly reported by pediatricians in providing preventive care to distinguish among tools. For example, Z13.42 can be used to indicate an "Encounter for screening for global developmental delays." Additional guidance on coding is available at: https://www.aap.org/en-us/Documents/coding_factsheet_developmentalscreeningtestingandEmotionalBehavioraassessment.pdf.
- To facilitate CMS's understanding of the data reported for this measure, states should use the "Additional Notes/Comments on Measure" section to document whether a medical chart review was conducted to validate the use of the 96110 CPT code for this measure.
- States may calculate this measure using either the administrative specification (which depends on the 96110 CPT code) or the hybrid specification (which does not rely solely on this code).
  - More information about the developmental screening tools that meet the measure criteria is available at: https://pediatrics.aappublications.org/content/pediatrics/suppl/2019/12/13/peds.2019-3449.DCSupplemental/PEDS_20193449SupplementaryData.pdf.
- During the development of this measure, it was determined that the ASQ:SE and M-CHAT screening tools were too specific because they screen for a domain-specific

condition (social emotional development or autism, respectively), rather than a full, general assessment of developmental delays.

- States should use the "Deviations from Measure Specifications" field to document any deviations from the specifications for this measure.
- The Bright Futures/American Academy of Pediatrics periodicity schedule includes more information about the recommendations for developmental screening and is available at https://downloads.aap.org/AAP/PDF/periodicity_schedule.pdf.

The following coding system is used in this measure: CPT. Refer to the Acknowledgments section at the beginning of the manual for copyright information.

## B. ELIGIBLE POPULATION

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

## C. ADMINISTRATIVE SPECIFICATION

**Denominator**

Denominator 1

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

Denominator 2

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

Denominator 3

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

Denominator 4

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

**Numerators**

The numerators identify children who were screened for risk of developmental, behavioral, and social delays using a standardized tool. National recommendations call for children to

be screened three times in the first three years of life. This measure is based on three, age-specific indicators.

Numerator 1

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

Numerator 2

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

Numerator 3

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

Numerator 4

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

Claims data

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

Important note about appropriate use of claims data

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

Claims NOT included in this measure

It is important to note that modified 96110 claims (for example, where modifiers are added to claims indicating standardized screening for a specific domain of development such as social emotional screening via the ASQ-SE, autism screening) should not be included as this measure is anchored to recommendations focused on global developmental screening using tools that focus on identifying risk for developmental, behavioral, and social delays.

**Exclusions**

None.

## D. MEDICAL RECORD SPECIFICATION

**Denominator**

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

Denominator 1

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

Denominator 2

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

Denominator 3

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

Denominator 4

The entire sample of 411 children.

**Numerators**

Numerator 1

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

Numerator 2

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

Numerator 3

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

Numerator 4

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

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

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

Tools must meet the following criteria:

1. Developmental domains: The following domains must be included in the standardized developmental screening tool: motor (fine and gross), language, cognitive, and social-emotional.
2. Established Reliability: Reliability scores of approximately 0.70 or above.
3. Established Findings Regarding the Validity: Validity scores for the tool must be approximately 0.70 or above. Measures of validity must be conducted on a significant number of children and using an appropriate standardized developmental or social-emotional assessment instrument(s).
4. Established Sensitivity/Specificity: Sensitivity and specificity scores of approximately 0.70 or above.

The following tools meet the above criteria and are included in the Bright Futures Recommendations for Preventive Care, which reference the updated January 2020 American Academy of Pediatrics (AAP) Statement.[1]

- Ages and Stages Questionnaire - 3rd Edition (ASQ-3)
- Parents' Evaluation of Developmental Status (PEDS) - Birth to age 8

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

- Parent's Evaluation of Developmental Status - Developmental Milestones (PEDS-DM)
- Survey of Well-Being in Young Children (SWYC)

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

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

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

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

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

**Exclusions**

None.

## E. CALCULATION ALGORITHM

Step 1

Determine the denominators.

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

Step 2

Determine the numerators.

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

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

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

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

Step 3

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

Step 4

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

Total Numerator: Numerator 1 + Numerator 2 + Numerator 3

Total Denominator: Denominator 1 + Denominator 2 + Denominator 3

Sampling Methodology

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

## F. OPTIONAL AGE-SPECIFIC OVERSAMPLING FOR THE DENOMINATOR

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

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

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

## SUMMARY OF CHANGES TO HEDIS MY 2023

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

## Description

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

## Eligible Population

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

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

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

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

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

**Continuous enrollment** The measurement year.

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

**Anchor date** December 31 of the measurement year.

**Benefit** Medical.

**Event/diagnosis** There are two ways to identify members with diabetes: by claim/encounter data and by pharmacy data. The organization must use both methods to identify the eligible population, but a member only needs to be identified by one method to be

included in the measure. Members may be identified as having diabetes during the measurement year or the year prior to the measurement year.

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

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

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

***Diabetes Medications***

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

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

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

**Required exclusions**

Exclude members who meet any of the following criteria:

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

**Exclusions**

Exclude members who meet any of the following criteria:

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

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

***Dementia Medications***

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

## Administrative Specification

**Denominator** The eligible population.

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

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

Any of the following meet criteria:

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

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

## Hybrid Specification

**Denominator**

A systematic sample drawn from the eligible population.

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

Organizations that use the Hybrid Method to report the Hemoglobin A1c Control for Patients With Diabetes (HBD), Eye Exam for Patients With Diabetes (EED) and Blood Pressure Control for Patients With Diabetes (BPD) measures may use the same sample for all three measures. If the same sample is used for the three diabetes measures, the organization must first take the inverse of the HbA1c poor control >9.0% rate (100 minus the HbA1c poor control rate) before reducing the sample.

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

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

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

**Numerator**

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

- A retinal or dilated eye exam by an eye care professional (optometrist or ophthalmologist) in the measurement year.
- A negative retinal or dilated exam (negative for retinopathy) by an eye care professional (optometrist or ophthalmologist) in the year prior to the measurement year.

Bilateral eye enucleation any time during the member's history through December 31 of the measurement year.

***Administrative***

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

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

- A note or letter prepared by an ophthalmologist, optometrist, PCP or other health care professional indicating that an ophthalmoscopic exam was completed by an eye care professional (optometrist or ophthalmologist), the date when the procedure was performed and the results.
- A chart or photograph indicating the date when the fundus photography was performed and one of the following:
  - Evidence that an eye care professional (optometrist or ophthalmologist) reviewed the results.
  - Evidence results were read by a qualified reading center that operates under the direction of a medical director who is a retinal specialist.

Evidence results were read by a system that provides an artificial intelligence (AI) interpretation.

- Evidence that the member had bilateral eye enucleation or acquired absence of both eyes. Look as far back as possible in the member's history through December 31 of the measurement year.
- Documentation of a negative retinal or dilated exam by an eye care professional (optometrist or ophthalmologist) in the year prior to the measurement year, where results indicate retinopathy was not present (e.g., documentation of normal findings).
  - Documentation does not have to state specifically "no diabetic retinopathy" to be considered negative for retinopathy; however, it must be clear that the patient had a dilated or retinal eye exam by an eye care professional (optometrist or ophthalmologist) and that retinopathy was not present. Notation limited to a statement that indicates "diabetes without complications" does not meet criteria.

### *Note*

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

## Data Elements for Reporting

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

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

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

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

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

## Rules for Allowable Adjustments of HEDIS

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

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

***Rules for Allowable Adjustments of Eye Exam for Patients With Diabetes***

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

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

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

## SUMMARY OF CHANGES TO HEDIS MY 2023

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

## Description

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

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

## Eligible Population

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

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

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

The total is the sum of the age stratifications.

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

**Allowable gap** None.

**Anchor date** None.

**Benefit** Medical and mental health.

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

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

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

***Multiple visits in a 31-day period***

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

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

***ED visits followed by inpatient admission***

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

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

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

**Required exclusions**

Exclude members who meet either of the following criteria:

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

## Administrative Specification

**Denominator**

The eligible population.

**Numerators**

***30-Day Follow-Up***

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

***7-Day Follow-Up***

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

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

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

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

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

### *Note*

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

## Data Elements for Reporting

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

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

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

## Rules for Allowable Adjustments of HEDIS

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

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

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

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

# *Follow-Up After Emergency Department Visit for People With Multiple High-Risk Chronic Conditions (FMC)*

## SUMMARY OF CHANGES FOR HEDIS MY 2023

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

## Description

The percentage of emergency department (ED) visits for members 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.

## Eligible Population

**Product lines** Medicare.

**Ages** 18 years and older as of the ED visit. Report two age stratifications and a total rate:

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

**Continuous enrollment** 365 days prior to the ED visit through 7 days after the ED visit.

**Allowable gap** No more than one gap in enrollment of up to 45 days during the 365 days prior to the ED visit and no gap during the 7 days following the ED visit.

**Anchor date** None.

**Benefits** Medical.

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

***Step 1*** An ED visit (ED Value Set) on or between January 1 and December 24 of the measurement year where the member was 18 years or older on the date of the visit.

The denominator for this measure is based on ED visits, not on members. If a member has more than one ED visit, identify all ED visits between January 1 and December 24 of the measurement year.

***Step 2: ED visits resulting in inpatient stay***

Exclude ED visits that result in an inpatient stay. Exclude ED visits followed by admission to an acute or nonacute inpatient care setting on the date of the ED visit or within 7 days after the ED visit, regardless of the principal diagnosis for admission. To identify admissions to an acute or nonacute inpatient care setting:

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

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

***Step 3: Eligible chronic condition diagnoses***

Identify ED visits where the member had a chronic condition prior to the ED visit.

The following are eligible chronic condition diagnoses. Each bullet indicates an eligible chronic condition (for example, COPD and asthma are considered the same chronic condition):

- COPD and asthma (COPD Diagnosis Value Set; Asthma Diagnosis Value Set; Unspecified Bronchitis Value Set).
- Alzheimer's disease and related disorders (Dementia Value Set; Frontotemporal Dementia Value Set).
- Chronic kidney disease (Chronic Kidney Disease Value Set).
- Depression (Major Depression Value Set; Dysthymic Disorder Value Set).
- Heart failure (Chronic Heart Failure Value Set; Heart Failure Diagnosis Value Set).
- Acute myocardial infarction (MI Value Set; Old Myocardial Infarction Value Set).
- Atrial fibrillation (Atrial Fibrillation Value Set).
- Stroke and transient ischemic attack (Stroke Value Set).
  - Remove any visit with a principal diagnosis of encounter for other specified aftercare (Stroke Exclusion Value Set).
  - Remove any visit with any diagnosis of concussion with loss of consciousness or fracture of vault of skull, initial encounter (Other Stroke Exclusions Value Set).

Using the eligible chronic condition diagnoses above, identify members who had any of the following during the measurement year or the year prior to the measurement year, **but prior to the ED visit** (count services that occur over both years):

- At least two outpatient visits (Outpatient Value Set), observation visits (Observation Value Set), ED visits (ED Value Set), telephone visits (Telephone Visits Value Set), e-visits or virtual check-ins (Online Assessments Value Set), nonacute inpatient encounters (Nonacute Inpatient Value Set) or nonacute inpatient discharges (instructions below; the diagnosis must be on the discharge claim) on different dates of service, with an 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 identity 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 member had prior to the ED visit.

***Step 4: Identifying members with multiple chronic conditions*** Identify ED visits where the member had **two or more** different chronic conditions prior to the ED visit, that meet the criteria included in step 3. These are eligible ED visits.

***Step 5: Multiple visits in 8-day period*** If a member has more than one ED visit in an 8-day period, include only the first eligible ED visit. For example, if a member has an eligible ED visit on 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.

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

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

## Administrative Specification

**Denominator** The eligible population.

**Numerator**

***7-Day Follow-Up*** A follow-up service within 7 days after the ED visit (8 total days). Include visits that occur on the date of the ED visit. The following meet criteria for follow-up:

- An outpatient visit (Outpatient Value Set).
- A telephone visit (Telephone Visits Value Set).
- Transitional care management services (Transitional Care Management Services Value Set).
- Case management visits (Case Management Encounter Value Set).
- Complex Care Management Services (Complex Care Management Services Value Set).

- An outpatient or telehealth behavioral health visit (Visit Setting Unspecified Value Set ***with*** Outpatient POS Value Set).
- An outpatient or telehealth behavioral health visit (BH Outpatient Value Set).
- An intensive outpatient encounter or partial hospitalization (Visit Setting Unspecified Value Set ***with*** Partial Hospitalization POS Value Set).
- An intensive outpatient encounter or partial hospitalization (Partial Hospitalization or Intensive Outpatient Value Set).
- A community mental health center visit (Visit Setting Unspecified Value Set ***with*** Community Mental Health Center POS Value Set).
- Electroconvulsive therapy (Electroconvulsive Therapy Value Set) ***with*** (Ambulatory Surgical Center POS Value Set; Community Mental Health Center POS Value Set; Outpatient POS Value Set; Partial Hospitalization POS Value Set).
- A telehealth visit (Visit Setting Unspecified Value Set ***with*** Telehealth POS Value Set).
- An observation visit (Observation Value Set).
- A substance use disorder service (Substance Use Disorder Services Value Set).
- An e-visit or virtual check-in (Online Assessments Value Set).
- A domiciliary or rest home visit (Domiciliary or Rest Home Visit Value Set).

***Note***

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

## Data Elements for Reporting

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

***Table FMC-3: Data Elements for Follow-Up After Emergency Department Visit for People With High-Risk Multiple Chronic Conditions***

| Metric | Age | Data Element | Reporting Instructions |
|---|---|---|---|
| FollowUp7Day | 16-64 | EligiblePopulation | For each Stratification |
| | 65+ | ExclusionAdminRequired | For each Stratification |
| | Total | NumeratorByAdmin | For each Stratification |
| | | NumeratorBySupplemental | For each Stratification |
| | | Rate | (Percent) |

## Rules for Allowable Adjustments of HEDIS

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

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

***Rules for Allowable Adjustments of Follow-Up After Emergency Department Visit for People With High-Risk Multiple Chronic Conditions***

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

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

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

## SUMMARY OF CHANGES TO HEDIS MY 2023

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

## Description

The percentage of emergency department (ED) visits among members 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:

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

## Eligible Population

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

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

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

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

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

**Ages**

13 years and older as of the ED visit. Report two age stratifications and a total rate:

- 13–17 years.
- 18 years and older.
- Total.

The total is the sum of the age stratifications.

**Continuous enrollment**

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

**Allowable gap**

None.

**Anchor date**

None.

**Benefit**

Medical, chemical dependency and pharmacy.

***Note:*** *Members with withdrawal management/detoxification-only chemical dependency benefits do not meet these criteria.*

**Event/diagnosis**

An ED visit (ED Value Set) with a principal diagnosis of SUD (AOD Abuse and Dependence Value Set) ***or*** any diagnosis of drug overdose (Unintentional Drug Overdose Value Set) on or between January 1 and December 1 of the measurement year, where the member was 13 years or older on the date of the visit.

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

***Multiple visits in a 31-day period***

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

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

***ED visits followed by inpatient admission***

Exclude ED visits that result in an inpatient stay. Exclude ED visits followed by 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:

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

***ED visits followed by residential treatment***

Exclude ED visits followed by residential treatment on the date of the ED visit or within the 30 days after the ED visit. A code from any of the following meets criteria for residential treatment:

- Residential Behavioral Health Treatment Value Set.
- Psychiatric Residential Treatment Center (POS code 56).
- Residential Substance Abuse Treatment Facility (POS code 55).
- Residential Program Detoxification Value Set.

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

**Required exclusions**

Exclude members who meet either of the following criteria:

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

## Administrative Specification

**Denominator**

The eligible population.

**Numerators**

***30-Day Follow-Up***

A follow-up visit or a pharmacotherapy dispensing event within 30 days after the ED visit (31 total days). Include visits and pharmacotherapy events that occur on the date of the ED visit.

***7-Day Follow-Up***

A follow-up visit or a pharmacotherapy dispensing event within 7 days after the ED visit (8 total days). Include visits and pharmacotherapy events that occur on the date of the ED visit.

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

- An outpatient visit (Visit Setting Unspecified Value Set) ***with*** (Outpatient POS Value Set) ***with*** 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 outpatient visit (Visit Setting Unspecified Value Set) ***with*** (Outpatient POS Value Set) ***with*** a mental health provider.
- An outpatient visit (BH Outpatient Value Set) ***with*** 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 outpatient visit (BH Outpatient Value Set) ***with*** a mental health provider.
- An intensive outpatient encounter or partial hospitalization (Visit Setting Unspecified Value Set) ***with*** (Partial Hospitalization POS Value Set) ***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 intensive outpatient encounter or partial hospitalization (Visit Setting Unspecified Value Set) ***with*** (Partial Hospitalization POS Value Set) ***with*** a mental health provider.
- An intensive outpatient encounter or partial hospitalization (Partial Hospitalization or Intensive Outpatient 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 intensive outpatient encounter or partial hospitalization (Partial Hospitalization or Intensive Outpatient Value Set) ***with*** a mental health provider.
- A non-residential substance abuse treatment facility visit (Visit Setting Unspecified Value Set) ***with*** (Non-residential Substance Abuse Treatment Facility 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 non-residential substance abuse treatment facility visit (Visit Setting Unspecified Value Set) ***with*** (Non-residential Substance Abuse Treatment Facility POS Value Set) ***with*** a mental health provider.
- A community mental health center visit (Visit Setting Unspecified Value Set) ***with*** (Community Mental Health Center 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 community mental health center visit (Visit Setting Unspecified Value Set) ***with*** (Community Mental Health Center POS Value Set) ***with*** a mental health provider.
- An observation visit (Observation 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 observation visit (Observation Value Set) ***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).
- 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).
- A pharmacotherapy dispensing event (Alcohol Use Disorder Treatment Medications List; Opioid Use Disorder Treatment Medications List) or medication treatment event (AOD Medication Treatment Value Set; OUD Weekly Drug Treatment Service Value Set).

***Alcohol Use Disorder Treatment Medications***

| Description | Prescription |
|---|---|
| Aldehyde dehydrogenase inhibitor | • Disulfiram (oral) |
| Antagonist | • Naltrexone (oral and injectable) |
| Other | • Acamprosate (oral; delayed-release tablet) |

***Opioid Use Disorder Treatment Medications***

| Description | Prescription | Medication Lists |
|---|---|---|
| Antagonist | • Naltrexone (oral) | • Naltrexone Oral Medications List |
| Antagonist | • Naltrexone (injectable) | • Naltrexone Injection Medications List |
| Partial agonist | • Buprenorphine (sublingual tablet) | • Buprenorphine Oral Medications List |
| Partial agonist | • Buprenorphine (injection) | • Buprenorphine Injection Medications List |
| Partial agonist | • Buprenorphine (implant) | • Buprenorphine Implant Medications List |
| Partial agonist | • Buprenorphine/naloxone (sublingual tablet, buccal film, sublingual film) | • Buprenorphine Naloxone Medications List |

## *Note*

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

## Data Elements for Reporting

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

***Table FUA-A-1/2/3: Data Elements for Follow-Up After Emergency Department Visit for Substance Use***

| Metric | Age | Data Element | Reporting Instructions |
|---|---|---|---|
| FollowUp30Day | 13-17 | Benefit | Metadata |
| FollowUp7Day | 18+ | EligiblePopulation | For each Stratification, repeat per Metric |
| | Total | ExclusionAdminRequired | For each Stratification, repeat per Metric |
| | | NumeratorByAdmin | For each Metric and Stratification |
| | | NumeratorBySupplemental | For each Metric and Stratification |
| | | Rate | (Percent) |

***Table FUA-B-1/2/3: Data Elements for Follow-Up After Emergency Department Visit for Substance Use: Stratifications by Race***

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

***Table FUA-C-1/2/3: Data Elements for Follow-Up After Emergency Department Visit for Substance Use: Stratifications by Ethnicity***

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

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

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

## Rules for Allowable Adjustments of HEDIS

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

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

***Rules for Allowable Adjustments of Follow-Up After Emergency Department Visit for Substance Use***

| NONCLINICAL COMPONENTS | | |
|---|---|---|
| **Eligible Population** | **Adjustments Allowed (Yes/No)** | **Notes** |
| Product lines | Yes | Organizations are not required to use product line criteria; product lines may be combined and all (or no) product line criteria may be used. |
| Ages | Yes | The age determination date(s) may be changed (i.e., age 13 as of ED visit).<br>Changing denominator age range is allowed. |
| Continuous enrollment, allowable gap, anchor date | Yes | Organizations are not required to use enrollment criteria; adjustments are allowed. |
| Benefits | Yes | Organizations are not required to use a benefit; adjustments are allowed. |
| Other | Yes | Organizations may use additional eligible population criteria to focus on an area of interest defined by gender, race, ethnicity, socioeconomic or sociodemographic characteristics, geographic region or another characteristic. |
| **CLINICAL COMPONENTS** | | |
| **Eligible Population** | **Adjustments Allowed (Yes/No)** | **Notes** |
| Event/diagnosis | Yes, with limits | Only events 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.<br>***Note:*** *Organizations may assess at the member level by applying measure logic appropriately (i.e., percentage of members with documentation of an emergency department visit with a principal diagnosis of SUD or any diagnosis of unintentional drug overdose, who had a follow-up visit).* |
| **Denominator Exclusions** | **Adjustments Allowed (Yes/No)** | **Notes** |
| Required exclusions | Yes | The hospice and deceased member exclusions are not required. Refer to *Exclusions* in the *Guidelines for the Rules for Allowable Adjustments*. |
| **Numerator Criteria** | **Adjustments Allowed (Yes/No)** | **Notes** |
| • 30-Day Follow-Up<br>• 7-Day Follow-Up | No | Value sets and logic may not be changed. |

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

## SUMMARY OF CHANGES TO HEDIS MY 2023

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

## Description

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

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

## Eligible Population

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

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

***Acute readmission or direct transfer***

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

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

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

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

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

***Nonacute readmission or direct transfer***

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

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

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

**Required exclusions**

Exclude members who meet either of the following criteria:

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

## Administrative Specification

**Denominator**

The eligible population.

**Numerators**

***30-Day Follow-Up***

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

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

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

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

### *Note*

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

## Data Elements for Reporting

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

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

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

## Rules for Allowable Adjustments of HEDIS

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

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

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

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

# Hemoglobin A1c Control for Patients With Diabetes (HBD)

## SUMMARY OF CHANGES TO HEDIS MY 2023

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

## Description

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

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

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

## Eligible Population

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

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

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

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

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

**Continuous enrollment** The measurement year.

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

**Anchor date** December 31 of the measurement year.

**Benefit** Medical.

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

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

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

3. Identify the discharge date for the stay.

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

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

***Diabetes Medications***

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

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

**Required exclusions**

Exclude members who meet any of the following criteria:

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

**Exclusions**

Exclude members who meet any of the following criteria:

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

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

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

***Dementia Medications***

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

## Administrative Specification

**Denominator** The eligible population.

**Numerators**

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

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

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

***HbA1c Poor Control >9%***

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

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

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

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

## Hybrid Specification

**Denominator**

A systematic sample drawn from the eligible population.

Organizations that use the Hybrid Method to report the Hemoglobin A1c Control for Patients With Diabetes (HBD), Eye Exam for Patients With Diabetes (EED) and Blood Pressure Control for Patients With Diabetes (BPD) measures may use the same sample for all three measures. If the same sample is used for the three diabetes measures, the organization must first take the inverse of the HbA1c poor control >9.0% rate (100 minus the HbA1c poor control rate) before reducing the sample.

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

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

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

**Numerators**

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

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

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

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

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

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

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

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

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

## *Note*

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

## Data Elements for Reporting

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

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

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

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

| Metric |
|---|
| AdequateHbA1cControl |
| PoorHbA1cControl |

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

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

| Metric |
|---|
| AdequateHbA1cControl |
| PoorHbA1cControl |

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

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

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

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

## Rules for Allowable Adjustments of HEDIS

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

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

***Rules for Allowable Adjustments of Hemoglobin A1c Control for Patients With Diabetes***

| NONCLINICAL COMPONENTS | | |
|---|---|---|
| **Eligible Population** | **Adjustments Allowed (Yes/No)** | **Notes** |
| Product lines | Yes | Organizations are not required to use product line criteria; product lines may be combined and all (or no) product line criteria may be used. |
| Ages | Yes, with limits | Age determination dates may be changed (e.g., select, "age as of June 30").<br>Changing denominator age range is allowed within a specified age range (ages 18–75 years).<br>The denominator age may not be expanded. |
| Continuous enrollment, allowable gap, anchor date | Yes | Organizations are not required to use enrollment criteria; adjustments are allowed. |
| Benefits | Yes | Organizations are not required to use a benefit; adjustments are allowed. |
| Other | Yes | Organizations may use additional eligible population criteria to focus on an area of interest defined by gender, race, ethnicity, socioeconomic or sociodemographic characteristics, geographic region or another characteristic. |
| **CLINICAL COMPONENTS** | | |
| **Eligible Population** | **Adjustments Allowed (Yes/No)** | **Notes** |
| Event/diagnosis | No | Only events or diagnoses that contain (or map to) codes in the medication lists and value sets may be used to identify visits. Medication lists, value sets and logic may not be changed. |
| **Denominator Exclusions** | **Adjustments Allowed (Yes/No)** | **Notes** |
| Required exclusions | Yes, with limits | Apply required exclusions according to specified value sets.<br>The hospice, deceased member and palliative care exclusions are not required. Refer to *Exclusions* in the *Guidelines for the Rules for Allowable Adjustments*. |
| Exclusions: I-SNP, LTI, frailty or advanced illness | Yes | These exclusions are not required. Refer to *Exclusions* in the *Guidelines for the Rules for Allowable Adjustments*. |
| **Numerator Criteria** | **Adjustments Allowed (Yes/No)** | **Notes** |
| • HbA1c Control (<8.0%)<br>• HbA1c Poor Control (>9.0%) | No | Value sets and logic may not be changed. |

# Hospital-Wide, 30-day All-Cause Unplanned Readmission (HWR) Rate for MIPS Eligible Clinician

| | |
|---|---|
| **NQF Endorsement Status** | Not Endorsed |
| **NQF ID** | 9999 |
| **Measure Type** | Outcome |
| **Measure Content Last Updated** | 2021-02-01 |
| **Info As Of** | Not Available |

## Properties

| | |
|---|---|
| **Description** | This measure is a re-specified version of the measure, “Risk-adjusted readmission rate (RARR) of unplanned readmission within 30 days of hospital discharge for any condition” (NQF 1789), which was developed for patients 65 years and older using Medicare claims. This re-specified measure attributes outcomes to MIPS participating clinician groups and assesses each group’s readmission rate. The measure comprises a single summary score, derived from the results of five models, one for each of the following specialty cohorts (groups of discharge condition categories or procedure categories): medicine, surgery/gynecology, cardio-respiratory, cardiovascular, and neurology. |
| **Numerator** | The outcome for this measure is unplanned all-cause 30-day readmission. Readmission is defined as a subsequent inpatient admission to any acute care facility which occurs within 30 days of the discharge date of an eligible index admission. Any readmission is eligible to be counted as an outcome, except those that are considered planned. To align with data years used, the planned readmission algorithm version 4.0 was used to classify readmissions as planned or unplanned |
| **Denominator** | Patients eligible for inclusion in the measure have an index admission hospitalization to which the readmission outcome is attributed and includes admissions for patients: Enrolled in Medicare Fee-For-Service (FFS) Part A for the 12 months prior to the date of admission; Aged 65 or over; Discharged alive from a non-federal short- |

# Hospital-Wide, 30-day All-Cause Unplanned Readmission (HWR) Rate for MIPS Eligible Clinician

| | |
|---|---|
| | term acute care hospital; and, Not transferred to another acute care facility. |
| **Denominator Exclusions** | 1. Patients discharged against medical advice (AMA) are excluded. 2. Admissions for patients to a PPS-exempt cancer hospital are excluded. 3. Admissions primarily for medical treatment of cancer are excluded. 4. Admissions primarily for psychiatric disease are excluded. 5. Admissions for “rehabilitation care; fitting of prostheses and adjustment devices” (CCS 254) are excluded. 6. Admissions where patient cannot be attributed to a clinician group. |
| **Rationale** | This risk-adjusted administrative claims measure was proposed to address unplanned readmissions at the physician group level of Medicare aged > 65 patients. This measure is a re-specified version of the hospital-level measure, “Hospital-Wide All-Cause, Unplanned Readmission Measure” (NQF #1789), which has been in the MIPS program since 2017. In the event we did not finalize this measure, we would have maintained the current measure Q458: All-Cause Hospital Readmission. The respecification of this measure promotes a systems-level approach by clinicians and focus on high-risk conditions, such as COPD and heart failure. The measure was evaluated by the MAP and was conditionally supported pending NQF endorsement. While we agreed with the MAP that NQF endorsement of measures is preferred, NQF endorsement is not a requirement for measures to be considered for MIPS if the measure has an evidence-based focus as required in section 1848(q)(2)(D)(v) of the Act. A riskadjusted readmission rate of 15.3 percent at the physician group level was provided by the measure developer. The readmission rate indicates a substantial need to reduce the expected rate and variation of rates across eligible physician groups. Physician groups have the capability to influence unplanned readmission outcomes by appropriate medication reconciliation at discharge, reduction of infection risk, and ensuring proper outpatient follow-up. As an administrative claims measure, there is no separate reporting burden. To maintain continuity with the existing measure Q458: All- |

# Hospital-Wide, 30-day All-Cause Unplanned Readmission (HWR) Rate for MIPS Eligible Clinician

| | |
|---|---|
| | Cause Hospital Readmission, the case minimum will remain at 200 cases for consistency in implementation. For 2023 payment determination, the performance period will include administrative claims from January 1, 2021 to December 31, 2021. For further information regarding the implementation of this measure, please see section IV.A.3.c.(1)(e)(i) of this final rule. |
| **Evidence** | Not Available |

## Developer/Steward

| | |
|---|---|
| **Steward** | Centers for Medicare & Medicaid Services (CMS) |
| **Contact** | Not Available |
| **Measure Developer** | Not Available |
| **Development Stage** | Fully Developed |

## Characteristics

| | |
|---|---|
| **Measure Type** | Outcome |
| **Meaningful Measure Area** | Admissions and Readmissions to Hospitals |
| **Healthcare Priority** | Promote Effective Communication & Coordination of Care |
| **eCQM Spec Available** | No |
| **NQF Endorsement Status** | Not Endorsed |
| **NQF ID** | 9999 |
| **Last NQF Update** | Not Available |
| **Target Population Age** | 65+ |
| **Target Population Age (High)** | Not Available |

# Hospital-Wide, 30-day All-Cause Unplanned Readmission (HWR) Rate for MIPS Eligible Clinician

| | |
|---|---|
| **Target Population Age (Low)** | 65 |
| **Reporting Level** | Accountable Care Organization |
| **Conditions** | Not Available |
| **Subconditions** | Not Available |
| **Care Settings** | Hospital/Acute Care Facility |

## Groups

| | |
|---|---|
| **Core Measure Set** | Not Available |

| Measure Group | Group Identifier |
|---|---|
| qpp quality id | 479 |
| ACO | 8 |

## Measure Links

## Measure Program: Medicare Shared Savings Program

| | |
|---|---|
| **Info As Of** | Not Available |
| **Program / Model Notes** | |
| **Data Sources** | Claims Data |
| **Purposes** | Not Available |
| **Quality Domain** | Communication and Care Coordination |
| **Reporting Frequency** | Not Available |

# Hospital-Wide, 30-day All-Cause Unplanned Readmission (HWR) Rate for MIPS Eligible Clinician

| | |
|---|---|
| **Impacts Payment** | No |
| **Reporting Status** | Active |
| **Data Reporting Begin Date** | 2021-01-01 |
| **Data Reporting End Date** | Not Available |

## Measure Program Links

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/about

## Milestones

### Milestone: Implemented

| | |
|---|---|
| **Effective Date** | 2012-04-01 |
| **Comments** | Not Available |
| **Milestone Links** | https://www.govinfo.gov/content/pkg/FR-2011-11-02/pdf/2011-27461.pdf |

### Milestone: Finalized

| | |
|---|---|
| **Effective Date** | 2011-11-02 |
| **Comments** | Not Available |
| **Milestone Links** | https://www.govinfo.gov/content/pkg/FR-2011-11-02/pdf/2011-27461.pdf |

# *Immunizations for Adolescents (IMA)**

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

## SUMMARY OF CHANGES TO HEDIS MY 2023

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

## Description

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

## Eligible Population

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

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

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

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

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

**Continuous enrollment** 12 months prior to the member's 13th birthday.

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

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

**Benefit** Medical.

**Event/diagnosis** None.

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

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

## Administrative Specification

**Denominator** The eligible population.

**Numerators**

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

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

***Tdap*** Any of the following meet criteria:

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

***HPV*** Any of the following meet criteria:

- At least two HPV vaccines (HPV Immunization Value Set; HPV Vaccine Procedure Value Set), on or between the member's 9th and 13th birthdays and with dates of service at least 146 days apart. For example, if the service date for the first vaccine was March 1, then the service date for the second vaccine must be on or after July 25.
- At least three HPV vaccines (HPV Immunization Value Set; HPV Vaccine Procedure Value Set), with different dates of service on or between the member's 9th and 13th birthdays.
- Anaphylaxis due to the HPV vaccine (SNOMED CT code 428241000124101) any time on or before the member's 13th birthday.

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

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

## Hybrid Specification

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

**Numerators** For meningococcal, Tdap and HPV, count *either:*

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

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

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

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

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

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

For meningococcal, *do not count* meningococcal recombinant (serogroup B) (MenB) vaccines. Immunizations documented under a generic header of

"meningococcal" and generic documentation that "meningococcal vaccine," "meningococcal conjugate vaccine" or "meningococcal polysaccharide vaccine" were administered meet criteria.

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

***Note***

- *To align with Advisory Committee on Immunization Practices (ACIP) recommendations, only the quadrivalent meningococcal vaccine (serogroups A, C, W and Y) is included in the measure.*
- *To align with ACIP recommendations, the minimum interval for the two-dose HPV vaccination schedule is 150 days (5 months), with a 4-day grace period (146 days).*

## Data Elements for Reporting

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

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

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

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

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

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

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

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

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

## Rules for Allowable Adjustments of HEDIS

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

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

***Rules for Allowable Adjustments of Immunizations for Adolescents***

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

# Initiation and Engagement of Substance Use Disorder Treatment (IET)

## SUMMARY OF CHANGES TO HEDIS MY 2023

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

## Description

The percentage of new substance use disorder (SUD) episodes that result in treatment initiation and engagement. Two rates are reported:

- *Initiation of SUD Treatment.* 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.
- *Engagement of SUD Treatment.* The percentage of new SUD episodes that have evidence of treatment engagement within 34 days of initiation.

## Definitions

**Intake period** — November 15 of the year prior to the measurement year–November 14 of the measurement year. The intake period is used to capture new SUD episodes.

**SUD episode** — An encounter during the intake period with a diagnosis of SUD.

*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).

**SUD episode date** — The date of service for an encounter during the intake period with a diagnosis of SUD.

For a visit (not resulting in an inpatient stay), *the SUD episode date is the date of service.*

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.*

For withdrawal management (i.e., detoxification), other than those that occurred during an inpatient stay, *the SUD episode date is the date of service.*

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).

**Date of service for services billed weekly or monthly**

For an opioid treatment service that bills monthly or weekly (OUD Weekly Non Drug Service Value Set; OUD Monthly Office Based Treatment Value Set; OUD Weekly Drug Treatment Service Value Set), 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).

**Direct transfer**

A direct transfer is when the discharge date from the first inpatient setting precedes the admission date to a second inpatient setting by one calendar day or less. For example:

- An inpatient discharge on June 1, followed by an admission to another inpatient setting on June 1, *is a direct transfer.*
- An inpatient discharge on June 1, followed by an admission to an inpatient setting on June 2, *is a direct transfer.*
- 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.

Use the following method to identify admissions to and discharges from inpatient settings.

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

## Eligible Population

**Product lines**

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

**Stratifications**

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

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

- Asked but No Answer.
- Unknown.
- Total.

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

**Age**

13 years and older as of the SUD episode date. Report three age stratifications and a total:

- 13–17 years.
- 18–64 years.
- 65+ years.
- Total.

The total is the sum of the age stratifications.

**SUD diagnosis cohort stratification**

Report the following SUD diagnosis cohort stratifications and a total:

- Alcohol use disorder.
- Opioid use disorder.
- Other substance use disorder.
- Total.

The total is the sum of the SUD diagnosis cohort stratifications.

**Continuous enrollment**

194 days prior to the SUD episode date through 47 days after the SUD episode date (242 total days).

**Allowable gap**

None.

**Anchor date**

None.

**Benefits**

Medical, pharmacy and chemical dependency (inpatient and outpatient).

***Note:*** *Members with withdrawal management/detoxification-only chemical dependency benefits do not meet these criteria.*

**Event/diagnosis**

New episode of SUD during the intake period.

Follow the steps below to identify the denominator for both rates.

***Step 1***

Identify all SUD episodes. Any of the following meet criteria:

- An outpatient visit (Visit Setting Unspecified Value Set) ***with*** (Outpatient POS Value Set) and ***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*** (Partial Hospitalization POS Value Set) and ***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*** (Non-residential Substance Abuse Treatment Facility POS Value Set) and ***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*** (Community Mental Health Center POS Value Set) and ***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) and ***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.
- A withdrawal management event (Detoxification 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 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 observation visit (Observation 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 there was an encounter in any setting other than an ED visit (ED Value Set) or a withdrawal management event (Detoxification Value Set) ***with*** a diagnosis of SUD (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.

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).
- An SUD medication administration event (Naltrexone Injection Value Set, Buprenorphine Oral Value Set; Buprenorphine Oral Weekly Value Set; Buprenorphine Injection Value Set; Buprenorphine Naloxone Value Set; Buprenorphine Implant Value Set; Methadone Oral Value Set; Methadone Oral Weekly Value Set).

***Step 4*** Remove SUD episodes that do not meet continuous enrollment criteria. Members must be continuously enrolled from 194 days before the SUD episode date through 47 days after the SUD episode date (242 total days), with no gaps.

***Note:*** *The denominator for this measure is based on episodes, not on members. All eligible episodes that were not removed remain in the denominator.*

***Step 5*** Identify the SUD diagnosis cohort for each SUD episode.

- If the SUD episode has a diagnosis of alcohol use disorder (Alcohol Abuse and Dependence Value Set), include the episode in the alcohol use disorder cohort.
- If the SUD episode has a diagnosis of opioid use disorder (Opioid Abuse and Dependence Value Set), include the episode in the opioid use disorder cohort.
- If the SUD episode has a diagnosis of SUD that is neither for opioid nor alcohol (Other Drug Abuse and Dependence Value Set), place the member in the other substance use disorder cohort.

Include SUD episodes in all SUD diagnosis cohorts for which they meet criteria. 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.

**Required exclusions**

Exclude members who meet either of the following criteria:

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

## Administrative Specification

**Denominator**

The eligible population.

**Numerator**

***Initiation of SUD Treatment***

Initiation of SUD treatment within 14 days of the SUD episode date. Follow the steps below to identify numerator compliance.

***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*** (Partial Hospitalization 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 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*** (Non-residential 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*** (Community Mental Health Center 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 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.
- Observation 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 member from the denominator for both indicators *(*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 year.

***Engagement of SUD Treatment***

Follow the steps below to identify numerator compliance.

If Initiation of SUD Treatment was an inpatient admission, the 34-day period for engagement begins the day after discharge.

***Step 1*** Identify all SUD episodes compliant for the Initiation of SUD Treatment numerator. SUD episodes that are not compliant for Initiation of SUD Treatment are not compliant for 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 they 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 (there is no requirement that they be with different providers).

Refer to the descriptions below to identify engagement visits and engagement medication treatment events.

***Engagement visits*** 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*** (Partial Hospitalization 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 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*** (Non-residential 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*** (Community Mental Health Center 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 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.
- Observation 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).

***Engagement medication treatment events***

Either of the following meets criteria for a medication treatment event:

- For SUD episodes in the alcohol use disorder cohort, an alcohol use disorder medication treatment dispensing event (Alcohol Use Disorder Treatment Medications List).
- For SUD episodes in the opioid use disorder cohort, an opioid use disorder medication treatment dispensing event (Naltrexone Oral Medications List; Buprenorphine Oral Medications List; Buprenorphine Naloxone Medications List) or a medication administration event (Buprenorphine Oral Value Set; Buprenorphine Oral Weekly Value Set; Buprenorphine Naloxone Value Set; Methadone Oral Value Set; Methadone Oral Weekly Value Set).

***Alcohol Use Disorder Treatment Medications***

| Description | Prescription |
|---|---|
| Aldehyde dehydrogenase inhibitor | • Disulfiram (oral) |
| Antagonist | • Naltrexone (oral and injectable) |
| Other | • Acamprosate (oral; delayed-release tablet) |

***Opioid Use Disorder Treatment Medications***

| Description | Prescription | Medication Lists |
|---|---|---|
| Antagonist | • Naltrexone (oral) | • Naltrexone Oral Medications List |
| Antagonist | • Naltrexone (injectable) | • Naltrexone Injection Medications List |
| Partial agonist | • Buprenorphine (sublingual tablet) | • Buprenorphine Oral Medications List |
| Partial agonist | • Buprenorphine (injection) | • Buprenorphine Injection Medications List |
| Partial agonist | • Buprenorphine (implant) | • Buprenorphine Implant Medications List |
| Partial agonist | • Buprenorphine/naloxone (sublingual tablet, buccal film, sublingual film) | • Buprenorphine Naloxone Medications List |

### *Note*

- *Organizations may have different methods for billing intensive outpatient encounters and partial hospitalizations. Some organizations may bill comparable to outpatient billing, with separate claims for each date of service; others may bill comparable to inpatient billing, with an admission date, a discharge date and units of service. Organizations whose billing is 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.*

- *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 be indicative of treatment for pain rather than OUD.*

## Data Elements for Reporting

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

***Table IET-A-1/2/3: Data Elements for Initiation and Engagement of Substance Use Disorder Treatment***

| Metric | Diagnosis | Age | Data Element | Reporting Instructions |
|---|---|---|---|---|
| Initiation | Alcohol | 13-17 | Benefit | Metadata |
| Engagement | Opioid | 18-64 | EligiblePopulation | For each Stratification, repeat per Metric |
| | Other | 65+ | ExclusionAdminRequired | For each Stratification, repeat per Metric |
| | Total | Total | NumeratorByAdmin | For each Metric and Stratification |
| | | | Rate | (Percent) |

***Table IET-B-1/2/3: Data Elements for Initiation and Engagement of Substance Use Disorder Treatment: Stratifications by Race***

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

***Table IET-C-1/2/3: Data Elements for Initiation and Engagement of Substance Use Disorder Treatment: Stratifications by Ethnicity***

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

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

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

## Rules for Allowable Adjustments of HEDIS

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

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

***Rules for Allowable Adjustments of Initiation and Engagement of Substance Use Disorder Treatment***

| NONCLINICAL COMPONENTS | | |
|---|---|---|
| **Eligible Population** | **Adjustments Allowed (Yes/No)** | **Notes** |
| Product lines | Yes | Organizations are not required to use product line criteria; product lines may be combined and all (or no) product line criteria may be used. |
| Ages | Yes | The age determination dates may be changed (e.g., select, "age as of June 30").<br>Changing the denominator age range is allowed. |
| SUD diagnosis cohorts | Yes, with limits | Reporting each stratum or combined strata is allowed. |
| Continuous enrollment, allowable gap, anchor date | Yes | Organizations are not required to use enrollment criteria; adjustments are allowed. |
| Benefits | Yes | Organizations are not required to use a benefit; adjustments are allowed. |
| Other | Yes | Organizations may use additional eligible population criteria to focus on an area of interest defined by gender, race, ethnicity, socioeconomic or sociodemographic characteristics, geographic region or another characteristic. |
| **CLINICAL COMPONENTS** | | |
| **Eligible Population** | **Adjustments Allowed (Yes/No)** | **Notes** |
| Event/diagnosis | No | Only events that contain (or map to) codes in the medication lists and value sets may be used to identify visits. Medication lists and value sets and logic may not be changed. |
| **Denominator Exclusions** | **Adjustments Allowed (Yes/No)** | **Notes** |
| Required exclusions | Yes | The hospice and deceased member exclusions are not required. Refer to *Exclusions* in the *Guidelines for the Rules for Allowable Adjustments*. |
| **Numerator Criteria** | **Adjustments Allowed (Yes/No)** | **Notes** |
| • Initiation of SUD Treatment<br>• Engagement of SUD Treatment | No | Medication lists, value sets and logic may not be changed. |

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

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

## SUMMARY OF CHANGES TO HEDIS MY 2023

- Revised the optional exclusions for polycystic ovarian syndrome, gestational diabetes or steroid-induced diabetes to be required exclusions.
- Added a required exclusion for members who died during the measurement year.
- Added a direct reference code for palliative care.
- Updated the number of occurrences required for the frailty cross-cutting exclusion.
- Revised the "Other" criteria in the Nonclinical Components table under *Rules for Allowable Adjustments of HEDIS.*
- Revised the "Required exclusions" criteria in the Clinical Components table under *Rules for Allowable Adjustments of HEDIS*.

## Description

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

## Eligible Population

| | |
|---|---|
| **Product lines** | Commercial, Medicaid, Medicare (report each product line separately). |
| **Ages** | 18–85 years as of December 31 of the measurement year. Report three age stratifications and a total rate:<br>• 18–64.<br>• 65–74.<br>• 75–85.<br>• Total.<br>The total is the sum of the age stratifications. |
| **Continuous enrollment** | The measurement year. |
| **Allowable gap** | No more than one gap in enrollment of up to 45 days during the measurement year. To determine continuous enrollment for a Medicaid beneficiary for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage (e.g., a member whose coverage lapses for 2 months [60 days] is not considered continuously enrolled). |
| **Anchor date** | December 31 of the measurement year. |
| **Benefit** | Medical. |
| **Event/diagnosis** | There are two ways to identify members with diabetes: by claim/encounter data and by pharmacy data. The organization must use both methods to identify the eligible population, but a member only needs to be identified by one method to be included in the measure. Members may be identified as having diabetes during the measurement year or the year prior to the measurement year. |

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

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

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

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

***Diabetes Medications***

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

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

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

**Required exclusions**

Exclude members who meet any of the following criteria:

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

**Exclusions**

Exclude members who meet any of the following criteria:

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

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

***Dementia Medications***

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

## Administrative Specification

**Denominator** The eligible population.

**Numerator**

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

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

## Data Elements for Reporting

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

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

| Metric | Age | Data Element | Reporting Instructions |
|---|---|---|---|
| KidneyHealthEvaluation | 18-64 | EligiblePopulation | For each Stratification |
| | 65-74 | ExclusionAdminRequired | For each Stratification |
| | 75-85 | NumeratorByAdmin | For each Stratification |
| | Total | NumeratorBySupplemental | For each Stratification |
| | | Rate | (Percent) |

## Rules for Allowable Adjustments of HEDIS

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

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

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

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

# Lead Screening in Children (LSC)

## SUMMARY OF CHANGES TO HEDIS MY 2023

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

## Description

The percentage of children 2 years of age who had one or more capillary or venous lead blood test for lead poisoning by their second birthday.

## Eligible Population

| | |
|---|---|
| **Product line** | Medicaid. |
| **Age** | Children who turn 2 years old during the measurement year. |
| **Continuous enrollment** | 12 months prior to the child's second birthday. |
| **Allowable gap** | No more than one gap in enrollment of up to 45 days during the 12 months prior to the child's second birthday. To determine continuous enrollment for a Medicaid beneficiary for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage (e.g., a member whose coverage lapses for 2 months [60 days] is not considered continuously enrolled). |
| **Anchor date** | Enrolled on the child's second birthday. |
| **Benefit** | Medical. |
| **Event/diagnosis** | None. |
| **Required exclusions** | Exclude members who meet either of the following criteria:<br>• Members in hospice or using hospice services any time during the measurement year. Refer to *General Guideline 15: Members in Hospice*.<br>• Members who died any time during the measurement year. Refer to *General Guideline 16: Deceased Members.* |

## Administrative Specification

| | |
|---|---|
| **Denominator** | The eligible population. |
| **Numerator** | At least one lead capillary or venous blood test (Lead Tests Value Set) on or before the child's second birthday. |

## Hybrid Specification

**Denominator**

A systematic sample drawn from the eligible population.

Organizations that use the Hybrid Method to report the Childhood Immunization Status (CIS) and Lead Screening in Children (LSC) measures may use the same sample for both measures. Because required exclusions are applied to the CIS measure, if the organization uses the CIS systematic sample, the same children will be excluded from the LSC measure. Excluding these members will not create a statistically significant difference in the LSC eligible population.

Organizations may reduce the sample size based on the current year's administrative rate or prior year's audited, product line-specific rate for the lowest rate of all CIS antigens, CIS combinations and LSC rate.

If a separate sample from the CIS measure is used for LSC, 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 LSC.

**Numerator**

At least one lead capillary or venous blood test on or before the child's second birthday as documented through either administrative data or medical record review.

***Administrative***

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

***Medical record***

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

- A note indicating the date the test was performed.
- The result or finding.

## Data Elements for Reporting

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

***Table LSC-1: Data Elements for Lead Screening in Children***

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

## Rules for Allowable Adjustments of HEDIS

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

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

***Rules for Allowable Adjustments of Lead Screening in Children***

| NONCLINICAL COMPONENTS | | |
|---|---|---|
| **Eligible Population** | **Adjustments Allowed (Yes/No)** | **Notes** |
| Product lines | Yes | Organizations are not required to use product line criteria; product lines may be combined and all (or no) product line criteria may be used. |
| Ages | Yes | Age determination dates may be changed (e.g., select, "age 2 as of June 30").<br>Expanding the denominator age range is allowed. |
| Continuous enrollment, allowable gap, anchor date | Yes | Organizations are not required to use enrollment criteria; adjustments are allowed. |
| Benefit | Yes | Organizations are not required to use a benefit; adjustments are allowed. |
| Other | Yes | Organizations may use additional eligible population criteria to focus on an area of interest defined by gender, race, ethnicity, socioeconomic or sociodemographic characteristics, geographic region or another characteristic. |
| **CLINICAL COMPONENTS** | | |
| **Eligible Population** | **Adjustments Allowed (Yes/No)** | **Notes** |
| Event/diagnosis | NA | There is no event/diagnosis for this measure. |
| **Denominator Exclusions** | **Adjustments Allowed (Yes/No)** | **Notes** |
| Required exclusions | Yes | The hospice and deceased member exclusions are not required. Refer to *Exclusions* in the *Guidelines for the Rules for Allowable Adjustments*. |
| **Numerator Criteria** | **Adjustments Allowed (Yes/No)** | **Notes** |
| Lead Capillary or Venous Blood Test | No | Value sets and logic may not be changed. |

# Plan All-Cause Readmissions (PCR)

## SUMMARY OF CHANGES TO HEDIS MY 2023

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

## Description

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

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

## Definitions

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

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

## Eligible Population

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

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

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

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

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

## Administrative Specification

**Denominator** The eligible population.

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

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

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

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

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

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

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

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

***Step 4*** Exclude hospital stays for the following reasons:

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

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

***Step 5*** Calculate continuous enrollment.

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

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

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

## Risk Adjustment Determination

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

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

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

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

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

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

## Risk Adjustment Weighting

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

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

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

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

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

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

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

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

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

***OR***

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

## *Reporting:* Number of Members in Plan Population

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

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

## *Reporting:* Number of Outliers

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

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

### *Calculated:* Outlier Rate

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

### *Reporting:* Denominator

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

### *Reporting*: SES Stratification (Medicare only)

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

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

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

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

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

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

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

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

### *Reporting:* Numerator

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

### *Calculated:* Observed Readmission Rate

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

### *Reporting:* Count of Expected 30-Day Readmissions

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

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

### *Calculated:* Expected Readmission Rate

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

### *Reporting:* Variance

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

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

### *Calculated:* O/E Ratio

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

### *Note*

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

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

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

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

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

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

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

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

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

## Rules for Allowable Adjustments of HEDIS

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

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

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

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

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

## Rules for Allowable Adjustments of HEDIS

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

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

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

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

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

# SDOH Screening Measure Specifications

**Social Determinants of Health (SDOH) Screening**
**Steward: Rhode Island Executive Office of Health and Human Services**
**As of April 8, 2021**

**SUMMARY OF CHANGES FOR 2021 (PERFORMANCE YEAR 4)**

- Updated to include guidance on how to attribute patients and providers to AEs.
- Updated to include an example of ICD-10 Z codes in use by at least one AE to capture SDOH screening results electronically.
- Updated to include information about patient and provider attribution to AEs.

## Description

Social Determinants of Health are the "conditions in the places where people live, learn, work, and play [that] affect a wide range of health risks and outcomes."[1]

The percentage of attributed patients who were screened for Social Determinants of Health using a screening tool once per measurement year, where the primary care clinician has documented the completion of the screening and the results. Please note that for organizations participating in the Medicaid Accountable Entity (AE) program, the screening tool must be approved by EOHHS to count as meeting numerator requirements.

## Eligible Population

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

| | |
|---|---|
| **Product lines** | Medicaid, Commercial |
| **Stratification** | None |
| **Ages** | All ages |
| **Continuous enrollment** | Enrolled in the MCO for 11 out of 12 months during the measurement year. |
| **Allowable gap** | No break in coverage lasting more than 30 days. |
| **Anchor date** | December 31 of the measurement year. |
| **Lookback period** | 12 months |
| **Benefit** | Medical |
| **Event/diagnosis** | • The patient has been seen by an AE/ACO-affiliated primary care clinician anytime within the last 12 months<br>• For the purpose of this measure "primary care clinician" is any provider defined by the reporting managed care organization as a primary care clinician and holding a patient panel.<br>• Follow the below to determine a primary care visit:<br>  ○ The following are the eligible CPT/HCPCS office visit |

[1] Definition from the CDC: www.cdc.gov/socialdeterminants/index.htm. Last accessed on 3/18/19.

| | |
|---|---|
| | codes for determining a primary care visit: 99201-99205; 99212-99215; 99324-99337; 99341-99350; 99381 – 99387; 99391-99397; 99490; 99495-99496<br>○ The following are the eligible telephone visit, e-visit or virtual check-in codes for determining a primary care visit:<br>▪ CPT/HCPCS/SNOMED codes: 98966-98968, 98969-98972, 99421-99423, 99441-99443, 99444, 11797002, 185317003, 314849005, 386472008, 386473003, 386479004<br>▪ Any of the above CPT/HCPCS office visit codes for determining a primary care visit with the following POS codes: 02<br>▪ Any of the above CPT/HCPCS office visit codes for determining a primary care visit with the following modifiers: 95, GT |
| **Exclusions** | • Patients in hospice care (see Code List below)<br>• Refused to participate |

## Patient/Provider Attribution to AEs

| | |
|---|---|
| **Patient Attribution to AEs** | Attribute each member to a single AE, based on the AE to which the member is attributed in December of the performance year. If a member is not enrolled in Medicaid in December, do not attribute the member to any AE for measurement purposes. Determine attribution using the AE provider rosters that are in place as of December of the performance year. |
| **Provider Attribution to AEs** | Each primary care provider (PCP) bills under a Taxpayer Identification Number (TIN), typically the TIN of the entity that employs that PCP or through which the PCP contracts with public and/or private payers. Some PCPs may contract through more than one TIN. Each TIN is permitted to affiliate with at most one AE at any given time, and each PCP is permitted to affiliate with as most one AE at any given time. That is, even if a PCP contracts through more than one TIN and those TINs are affiliated with different AEs, the PCP may only be affiliated with one of the AEs. For more information about which primary care providers are eligible for attribution to an AE, please refer to "Attachment M: Attribution Guidance."[2] |

## Electronic Data Specifications

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

[2] https://eohhs.ri.gov/sites/g/files/xkgbur226/files/2021-03/Attachment%20M%20-%20PY4%20Attribution%20Guidance.pdf.

| | |
|---|---|
| **Denominator** | The eligible population |
| **Numerator** | Individuals attributed to the primary care clinician who were screened for Social Determinants of Health once per measurement year and for whom results are in the primary care clinician's EHR.<br><br>Notes:<br>• Screens may be rendered asynchronously, i.e., at a time and through a modality other than a visit with a primary care clinician that triggered inclusion in the denominator.<br>• Screens rendered during a telephone visit, e-visit or virtual check-in meet numerator criteria.<br><br>AEs can, but not required to, use ICD-10 Z codes to track performance for this measure electronically. An example of two Z codes in use by at least one AE is provided below:<br>• Z04<br>○ Definition: Encounter for examination and observation for other reasons<br>○ Meaning: SDOH screening completed<br>• Z53<br>○ Definition: Persons encountering health services for specific procedure and treatment, not carried out<br>○ Meaning: SDOH screening offered, but patient refused/declined to complete screen |
| **Unit of measurement** | Screens should be performed at the individual patient level for adults and adolescents. Screens may be performed at the individual patient level or the household level for all children 12 and under residing in one household, so long as the screening is documented in each child's medical record. |
| **Documentation requirements** | All screenings must be documented in the attributed primary care clinician's patient health record, regardless of if the primary care clinician screened the individual (or household, as applicable) or if the screen was performed by anyone else, including: another provider, the insurer or a community partner.<br><br>The screening results must either be embedded in the EHR or a PDF of the screening results must be accessible in the EHR, i.e., the primary care clinician must not be required to leave the EHR to access a portal or other electronic location to view the screening results.<br><br>Results for at least one question per required domain must be included for a screen to be considered numerator complaint. |
| **Approved screening tools** | For those participating in the AE program, all screening tools must be approved by EOHHS prior to the reporting period to be counted in the numerator. Screens performed with tools not approved by EOHHS shall not be included in the numerator of this measure. |

| | |
|---|---|
| **Required domains** | 1. Housing insecurity;<br>2. Food insecurity;<br>3. Transportation;<br>4. Interpersonal violence; and<br>5. Utility assistance.<br><br>Note: If primary care clinicians are conducting the screen during a telephone visit, e-visit or virtual check-in or independent of a visit, they may use their discretion whether to ask questions related to interpersonal violence. The interpersonal violence domain must, however, be included for screens administered during in-person visits. |

## Code List

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

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

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

# Statin Therapy for Patients With Cardiovascular Disease (SPC)

## SUMMARY OF CHANGES TO HEDIS MY 2023

- Clarified in the "Event/diagnosis" criteria that required exclusions are not a step.
- Replaced the reference to "female members" with "members" in the pregnancy required exclusion.
- Added a required exclusion for members who died during the measurement year.
- Added a direct reference code for palliative care.
- Updated the number of occurrences required for the frailty cross-cutting exclusion.
- Revised the "Other" criteria in the Nonclinical Components table under *Rules for Allowable Adjustments of HEDIS.*
- Revised the "Required exclusions" criteria in the Clinical Components table under *Rules for Allowable Adjustments of HEDIS*.

## Description

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

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

## Definitions

| | |
|---|---|
| **IPSD** | Index prescription start date. The earliest prescription dispensing date for any statin medication of at least moderate intensity during the measurement year. |
| **Treatment period** | The period of time beginning on the IPSD through the last day of the measurement year. |
| **PDC** | Proportion of days covered. The number of days the member is covered by at least one statin medication prescription of appropriate intensity, divided by the number of days in the treatment period. |
| **Calculating number of days covered for multiple prescriptions** | If multiple prescriptions for different medications are dispensed on the same day, calculate the number of days covered by a statin medication (for the numerator) using the prescriptions with the longest days supply. For multiple different prescriptions dispensed on different days with overlapping days supply, count each day in the treatment period only once toward the numerator.<br><br>If multiple prescriptions for the same medication are dispensed on the same day or on different days, sum the days supply and use the total to calculate the number of days covered by a statin medication (for the numerator). For example, three prescriptions for the same medication are dispensed on the same day, each with a 30-days supply. Sum the days supply for a total of 90 |

days covered by a statin. Subtract any days supply that extends beyond December 31 of the measurement year.

Use the medication lists to determine if drugs are the same or different. Drugs in different medication lists are considered different drugs. For example, a dispensing event from the Amlodipine Atorvastatin High Intensity Medications List and a dispensing event from the Amlodipine Atorvastatin Moderate Intensity Medications List are dispensing events for different medications.

## Eligible Population: *Rate 1*—Received Statin Therapy

**Product line**

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

**Age**

Report two age/gender stratifications and a total rate:

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

**Continuous enrollment**

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

**Allowable gap**

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

**Anchor date**

December 31 of the measurement year.

**Benefit**

Medical. Pharmacy during the measurement year.

**Event/diagnosis**

Members are identified for the eligible population in two ways: by event or by diagnosis. The organization must use *both* methods to identify the eligible population, but a member only needs to be identified by one method to be included in the measure.

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

- *MI.* Discharged from an inpatient setting with an MI (MI Value Set; Old Myocardial Infarction Value Set) on the discharge claim. To identify discharges:
  1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
  2. Identify the discharge date for the stay.
- *CABG.* Members who had CABG (CABG Value Set) in any setting.
- *PCI.* Members who had PCI (PCI Value Set) in any setting.
- *Other revascularization*. Members who had any other revascularization procedures (Other Revascularization Value Set) in any setting.

- *Diagnosis.* Identify members as having ischemic vascular disease (IVD) who met at least one of the following criteria during both the measurement year and the year prior to the measurement year. Criteria need not be the same across both years.
  - At least one outpatient visit (Outpatient Value Set) with an IVD diagnosis (IVD Value Set).
  - A telephone visit (Telephone Visits Value Set) with an IVD diagnosis (IVD Value Set).
  - An e-visit or virtual check-in (Online Assessments Value Set) with an IVD diagnosis (IVD Value Set).
  - At least one acute inpatient encounter (Acute Inpatient Value Set) with an IVD diagnosis (IVD Value Set) ***without*** telehealth (Telehealth Modifier Value Set; Telehealth POS Value Set).
  - At least one acute inpatient discharge with an IVD diagnosis (IVD Value Set) on the discharge claim. To identify an acute inpatient discharge:
    1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
    2. Exclude nonacute inpatient stays (Nonacute Inpatient Stay Value Set).
    3. Identify the discharge date for the stay.

**Required exclusions**

Exclude members who meet any of the following criteria:

- Members with a diagnosis of pregnancy (Pregnancy Value Set) during the measurement year or the year prior to the measurement year.
- In vitro fertilization (IVF Value Set) in the measurement year or the year prior to the measurement year.
- Dispensed at least one prescription for clomiphene (Estrogen Agonists Medications List) during the measurement year or the year prior to the measurement year.
- ESRD (ESRD Diagnosis Value Set) or dialysis (Dialysis Procedure Value Set) during the measurement year or the year prior to the measurement year.
- Cirrhosis (Cirrhosis Value Set) during the measurement year or the year prior to the measurement year.
- Myalgia, myositis, myopathy or rhabdomyolysis (Muscular Pain and Disease Value Set) during the measurement year.
- Members in hospice or using hospice services any time during the measurement year. Refer to *General Guideline 15: Members in Hospice*.
- Members who died any time during the measurement year. Refer to *General Guideline 16: Deceased Members.*
- Members receiving palliative care (Palliative Care Assessment Value Set; Palliative Care Encounter Value Set; Palliative Care Intervention Value Set; ICD-10-CM code Z51.5) any time during the measurement year.

***Estrogen Agonists Medications***

| Description | Prescription |
|---|---|
| Estrogen agonists | • Clomiphene |

**Exclusions**

Exclude members who meet any of the following criteria:

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

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

***Dementia Medications***

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

## Administrative Specification: Rate 1—Received Statin Therapy

**Denominator** The Rate 1 eligible population.

**Numerator** The number of members who had at least one dispensing event for a high-intensity or moderate-intensity statin medication during the measurement year. Use all the medication lists below to identify statin medication dispensing events.

***High- and Moderate-Intensity Statin Medications***

| Description | Prescription | Medication Lists |
|---|---|---|
| High-intensity statin therapy | • Atorvastatin 40-80 mg | Atorvastatin High Intensity Medications List |
| High-intensity statin therapy | • Amlodipine-atorvastatin 40-80 mg | Amlodipine Atorvastatin High Intensity Medications List |
| High-intensity statin therapy | • Rosuvastatin 20-40 mg | Rosuvastatin High Intensity Medications List |
| High-intensity statin therapy | • Simvastatin 80 mg | Simvastatin High Intensity Medications List |
| High-intensity statin therapy | • Ezetimibe-simvastatin 80 mg | Ezetimibe Simvastatin High Intensity Medications List |
| Moderate-intensity statin therapy | • Atorvastatin 10-20 mg | Atorvastatin Moderate Intensity Medications List |
| Moderate-intensity statin therapy | • Amlodipine-atorvastatin 10-20 mg | Amlodipine Atorvastatin Moderate Intensity Medications List |
| Moderate-intensity statin therapy | • Rosuvastatin 5-10 mg | Rosuvastatin Moderate Intensity Medications List |
| Moderate-intensity statin therapy | • Simvastatin 20-40 mg | Simvastatin Moderate Intensity Medications List |
| Moderate-intensity statin therapy | • Ezetimibe-simvastatin 20-40 mg | Ezetimibe Simvastatin Moderate Intensity Medications List |
| Moderate-intensity statin therapy | • Pravastatin 40-80 mg | Pravastatin Moderate Intensity Medications List |
| Moderate-intensity statin therapy | • Lovastatin 40 mg | Lovastatin Moderate Intensity Medications List |
| Moderate-intensity statin therapy | • Fluvastatin 40-80 mg | Fluvastatin Moderate Intensity Medications List |
| Moderate-intensity statin therapy | • Pitavastatin 1-4 mg | Pitavastatin Moderate Intensity Medications List |

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

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

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

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

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

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

**Anchor date** December 31 of the measurement year.

**Benefit** Medical. Pharmacy during the measurement year.

**Event/diagnosis** All members who meet the numerator criteria for Rate 1.

## Administrative Specification: *Rate 2*—Statin Adherence 80%

**Denominator** The Rate 2 eligible population.

**Numerator** The number of members who achieved a PDC of at least 80% during the treatment period.

Follow the steps below to identify numerator compliance.

***Step 1*** Identify the IPSD. The IPSD is the earliest dispensing event for any high-intensity or moderate-intensity statin medication during the measurement year. Use all the medications lists above to identify statin medication dispensing events.

***Step 2*** To determine the treatment period, calculate the number of days beginning on the IPSD through the end of the measurement year.

***Step 3*** Count the days covered by at least one prescription for any high-intensity or moderate-intensity statin medication during the treatment period. To ensure that days supply that extends beyond the measurement year is not counted, subtract any days supply that extends beyond December 31 of the measurement year.

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

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

***Step 5*** Sum the number of members whose PDC is ≥80% for the treatment period.

### *Note*

- *All members who are numerator compliant for Rate 1 must be used as the eligible population for Rate 2 (regardless of the data source used to capture the Rate 1 numerator). For example, if supplemental data were used to identify compliance for the Rate 1 numerator, then supplemental data will be included in identifying the Rate 2 eligible population.*

## Data Elements for Reporting

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

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

| Metric | Gender | Data Element | Reporting Instructions |
|---|---|---|---|
| ReceivedTherapy | F | Benefit | Metadata |
| Adherence | M | EligiblePopulation | For each Metric and Stratification |
| | Total | ExclusionAdminRequired | Only for ReceivedTherapy Metric |
| | | NumeratorByAdmin | For each Metric and Stratification |
| | | NumeratorBySupplemental | For each Metric and Stratification |
| | | Rate | (Percent) |

## Rules for Allowable Adjustments of HEDIS

The "Rules for Allowable Adjustments of HEDIS" (the "Rules") describe how NCQA's HEDIS measure specifications can be adjusted for other populations, if applicable. The Rules, reviewed and approved by NCQA measure experts, provide for expanded use of HEDIS measures without changing their clinical intent. **Adjusted HEDIS measures *may not* be used for HEDIS health plan reporting.**

***Rules for Allowable Adjustments of Statin Therapy for Patients With Cardiovascular Disease***

| NONCLINICAL COMPONENTS | | |
|---|---|---|
| **Eligible Population** | **Adjustments Allowed (Yes/No)** | **Notes** |
| Product lines | Yes | Using product line criteria is not required. Including any product line, combining product lines, or not including product line criteria is allowed. |
| Ages | Yes, with limits | Age determination dates may be changed (e.g., select, "age as of June 30").<br>The denominator age may be changed if the range is within the specified age range (ages 21–75 or 40–75 years).<br>The denominator age may not be expanded. |
| Continuous enrollment, allowable gap, anchor date | Yes | Organizations are not required to use enrollment criteria; adjustments are allowed. |
| Benefits | Yes | Organizations are not required to use enrollment criteria; adjustments are allowed. |
| Other | Yes | Organizations may use additional eligible population criteria to focus on an area of interest defined by gender, race, ethnicity, socioeconomic or sociodemographic characteristics, geographic region or another characteristic. |
| **CLINICAL COMPONENTS** | | |
| **Eligible Population** | **Adjustments Allowed (Yes/No)** | **Notes** |
| Event/diagnosis | No | Only events that contain (or map to) codes in the value sets may be used to identify discharges. Value sets and logic may not be changed. |
| **Denominator Exclusions** | **Adjustments Allowed (Yes/No)** | **Notes** |
| Required exclusions | Yes, with limits | Apply required exclusions according to specified value sets and medication lists.<br>The hospice, deceased member and palliative care exclusions are not required. Refer to *Exclusions* in the *Guidelines for the Rules for Allowable Adjustments.* |
| Exclusions: I-SNP, LTI, frailty or advanced illness | Yes | These exclusions are not required. Refer to *Exclusions* in the *Guidelines for the Rules for Allowable Adjustments*. |
| **Numerator Criteria** | **Adjustments Allowed (Yes/No)** | **Notes** |
| • Rate 1: Received Statin Therapy<br>• Rate 2: Statin Adherence 80% | No | Medication lists, value sets and logic may not be changed. |

***Definitions:***

**Screening** – Completion of a clinical or diagnostic tool used to identify people at risk of developing or having a certain disease or condition, even in the absence of symptoms.

**Standardized Depression Screening Tool** – A normalized and validated depression screening tool developed for the Member population in which it is being utilized. The name of the age appropriate standardized depression screening tool utilized must be documented in the medical record.

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

- **Adolescent Screening Tools (12-17 years):** Patient Health Questionnaire for Adolescents (PHQ-A), Beck Depression Inventory-Primary Care Version (BDI-PC), Mood Feeling Questionnaire (MFQ), Center for Epidemiologic Studies Depression Scale (CES-D), and PRIME MD-PHQ2
- **Adult Screening Tools (18 years and older):** Patient Health Questionnaire (PHQ-9 or PHQ-2), Beck Depression Inventory (BDI or BDI-II), Center for Epidemiologic Studies Depression Scale (CES-D), Depression Scale (DEPS), Duke Anxiety-Depression Scale (DADS), Geriatric Depression Scale (GDS), Cornell Scale Screening, and PRIME MD-PHQ2

## Substance Use Assessment in Primary Care

***Methodology:*** IEHP-Defined Quality Measure

***Measure Description:*** The percentage of members 18 years and older who were screened for substance use during the measurement year (2020).

| CODES TO IDENTIFY SUBSTANCE USE ASSESSMENT IN PRIMARY CARE: | | | |
|---|---|---|---|
| **Service** | **Code Type** | **Code** | **Code Description** |
| Substance Use Assessment in Primary Care | CPT | 99408 | Alcohol and/or Substance (other than tobacco) Abuse Structured Screening (e.g. Audit DAST) and Brief Intervention (SBI) Services 15 to 30 Minutes |
| Substance Use Assessment in Primary Care | CPT | 99409 | Alcohol and/or Substance (other than tobacco) Abuse Structured Screening (e.g. Audit DAST) and Brief Intervention (SBI) Services Greater than 30 Minutes |
| Substance Use Assessment in Primary Care | HCPCS | G0396 | Alcohol and/or Substance (other than tobacco) Abuse Structured Screening (e.g. Audit DAST) and Brief Intervention 15 to 30 Minutes |

| CODES TO IDENTIFY SUBSTANCE USE ASSESSMENT IN PRIMARY CARE: | | | |
|---|---|---|---|
| **Service** | **Code Type** | **Code** | **Code Description** |
| Substance Use Assessment in Primary Care | HCPCS | G0397 | Alcohol and/or Substance (other than tobacco) Abuse Structured Screening (e.g. Audit DAST) and Brief Intervention Greater than 30 Minutes |
| Substance Use Assessment in Primary Care | HCPCS | G0442 | Annual Alcohol Misuse Screening 15 Minutes |
| Substance Use Assessment in Primary Care | HCPCS | G0443 | Brief face-to-face behavioral counseling for alcohol misuse, 15 minutes |
| Substance Use Assessment in Primary Care | HCPCS | H0049 | Alcohol and/or Drug Assessment |
| Substance Use Assessment in Primary Care | HCPCS | H0050 | Alcohol and/or Drug Service Brief Intervention Per 15 Minutes |

***Denominator***: All Members aged 18 years and older during the measurement year (2020). Member counted only once in the denominator.

***Numerator:*** Members who were screened for substance use at least once during the measurement year (2020).

# Population: Women

## Breast Cancer Screening (BCS)

***Methodology:*** HEDIS®

***Measure Description:*** The percentage of women 50–74 years of age who had a mammogram to screen for breast cancer any time on or between October 1 two years prior to the measurement year (2018) and December 31 of the measurement year (2020).

- The eligible population in the measure meets all of the following criteria:
    1. Women 52-74 years as of December 31 of the measurement year (2020).
    2. Continuous enrollment from October 1 two years prior to the measurement year (2018) through December 31 of the measurement year (2020) with no more than one gap in enrollment of up to 45 days for each calendar year of continuous enrollment. No gaps in enrollment are allowed from October 1 two years prior to the measurement year (2018) through December 31 two years prior to the measurement year (2018).

# *Unhealthy Alcohol Use Screening and Follow-Up (ASF-E)**

***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).**

## SUMMARY OF CHANGES FOR HEDIS MY 2023

- Refer to the Technical Release Notes file in the Digital Measures Package for a comprehensive list of changes.
- Revised the "Other" criteria in the Nonclinical Components table under *Rules for Allowable Adjustments of HEDIS.*

| | |
|---|---|
| **Description** | The percentage of members 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.<br>• *Unhealthy Alcohol Use Screening*. The percentage of members who had a systematic screening for unhealthy alcohol use.<br>• *Follow-Up Care on Positive Screen*. The percentage of members receiving brief counseling or other follow-up care within 2 months of screening positive for unhealthy alcohol use. |
| **Measurement period** | January 1–December 31. |
| **Clinical recommendation statement** | 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) |
| **Citations** | U.S. Preventive Services Task Force. 2018. "Unhealthy Alcohol Use in Adolescents and Adults: Screening and Behavioral Counseling Interventions." JAMA 320(18):1899–1909. DOI:10.1001/jama.2018.16789. |
| **Characteristics** | |
| **Scoring** | Proportion. |
| **Type** | Process. |
| **Stratification** | • Unhealthy Alcohol Use Screening.<br>– Product line:<br>▪ Commercial.<br>▪ Medicaid.<br>▪ Medicare.<br>– Age (as of the start of the measurement period, for each product line):<br>▪ 18–44 years.<br>▪ 45–64 years.<br>▪ 65 years and older. |

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

- Follow-Up on Care Positive Screen.
  - Product line:
    - Commercial.
    - Medicaid.
    - Medicare.
  - Age (as of the start of the measurement period, for each product line):
    - 18–44 years.
    - 45–64 years.
    - 65 years and older.

</td></tr>
<tr><td>Risk adjustment</td><td>None.</td></tr>
<tr><td>Improvement notation</td><td>A higher rate indicates better performance.</td></tr>
<tr><td>Guidance</td><td>Allocation:<br>The member was enrolled with a medical benefit throughout the participation period.<br><br>When identifying members in hospice, the requirements described in General Guideline 15 for identification of hospice members using the monthly membership detail data files are not included in the measure calculation logic and need to be programmed manually.<br><br>Reporting:<br>The total is the sum of the age stratifications.<br><br>Product line stratifications are not included in the measure calculation logic and need to be programmed manually.</td></tr>
<tr><td colspan="2">Definitions</td></tr>
<tr><td>Participation</td><td>The identifiers and descriptors for each organization’s coverage used to define members’ eligibility for measure reporting. Allocation for reporting is based on eligibility during the participation period.</td></tr>
<tr><td>Participation period</td><td>The measurement period.</td></tr>
<tr><td>Unhealthy Alcohol Use Screening</td><td>A standard assessment instrument that has been normalized and validated for the adult patient population. Eligible screening instruments with thresholds for positive findings include:
<table>
<tr><th>Screening Instrument</th><th>Positive Finding</th></tr>
<tr><td>Alcohol Use Disorders Identification Test (AUDIT) screening instrument</td><td>Total score ≥8</td></tr>
<tr><td>Alcohol Use Disorders Identification Test Consumption (AUDIT-C) screening instrument</td><td>Total score ≥4 for men<br>Total score ≥3 for women</td></tr>
</table>
</td></tr>
</table>

<table>
<tr><td>Alcohol Counseling or Other Follow-Up Care</td><td>
<table>
<tr><th>Screening Instrument</th><th>Positive Finding</th></tr>
<tr><td>Single-question screen:<br>“How many times in the past year have you had 5 (for men) or 4 (for women and all adults older than 65 years) or more drinks in a day?”</td><td>Total score ≥1</td></tr>
</table>
Any of the following on or up to 60 days after the first positive screen:
<ul>
<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>
</td></tr>
<tr><td>Initial population</td><td>Initial population 1<br>Members 18 years and older at the start of the measurement period who also meet criteria for participation.<br><br>Initial population 2<br>Same as the initial population 1.</td></tr>
<tr><td>Exclusions</td><td>Exclusions 1
<ul>
<li>Members with alcohol use disorder that starts during the year prior to the measurement period.</li>
<li>Members with history of dementia any time during the member’s history through the end of the measurement period.</li>
<li>Members in hospice or using hospice services any time during the measurement period.</li>
</ul>
Exclusions 2<br>Same as exclusions 1.</td></tr>
<tr><td>Denominator</td><td>Denominator 1<br>The initial population, minus exclusions.<br><br>Denominator 2<br>All members in numerator 1 with a positive finding for unhealthy alcohol use screening between January 1 and November 1 of the measurement period.</td></tr>
<tr><td>Numerator</td><td>Numerator 1—Unhealthy Alcohol Use Screening<br>Members with a documented result for unhealthy alcohol use screening performed between January 1 and November 1 of the measurement period.<br><br>Numerator 2—Follow-Up Care on Positive Screen<br>Members receiving alcohol counseling or other follow-up care on or up to 60 days after the date of the first positive screen (61 days total).</td></tr>
</table>

**Data criteria (element level)**

***Value Sets:***

- **ASFE_HEDIS_MY2023-2.0.0**
  - Alcohol Counseling or Other Follow Up Care (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1437)
  - Alcohol Use Disorder (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1339)
  - Dementia (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1074)
- **NCQA_Hospice-2.0.0**
  - Hospice Encounter (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1761)
  - Hospice Intervention (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1762)

***Direct reference codes and codesystems:***

- **ASFE_HEDIS_MY2023-2.0.0**
  - codesystem "ICD-10-CM": 'http://hl7.org/fhir/sid/icd-10-cm'
  - codesystem "LOINC": 'http://loinc.org'
  - code "Alcohol abuse counseling and surveillance of alcoholic": 'Z71.41' from "ICD-10-CM" display 'Alcohol abuse counseling and surveillance of alcoholic'
  - code "How often have you had five or more drinks in one day during the past year [Reported]": '88037-7' from "LOINC" display 'How often have you had five or more drinks in one day during the past year [Reported]'
  - code "How often have you had four or more drinks in one day during the past year [Reported]": '75889-6' from "LOINC" display 'How often have you had four or more drinks in one day during the past year [Reported]'
  - code "Total score [AUDIT-C]": '75626-2' from "LOINC" display 'Total score [AUDIT-C]'
  - code "Total score [AUDIT]": '75624-7' from "LOINC" display 'Total score [AUDIT]'
- **NCQA_Terminology-2.0.0**
  - codesystem "ActCode": 'http://terminology.hl7.org/CodeSystem/v3-ActCode'
  - codesystem "ConditionClinicalStatusCodes": 'http://terminology.hl7.org/CodeSystem/condition-clinical'
  - code "active": 'active' from "ConditionClinicalStatusCodes"
  - code "managed care policy": 'MCPOL' from "ActCode"
  - code "retiree health program": 'RETIRE' from "ActCode"
  - code "subsidized health program": 'SUBSIDIZ' from "ActCode"

## Data Elements for Reporting

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

***Table ASF-E-1/2/3: Data Elements for Unhealthy Alcohol Use Screening and Follow-Up***

| Metric | Age | Data Element | Reporting Instructions |
|---|---|---|---|
| Screening | 18-44 | InitialPopulation | For each Metric and Stratification |
| FollowUp | 45-64 | ExclusionsByEHR | For each Metric and Stratification |
| | 65+ | ExclusionsByCaseManagement | For each Metric and Stratification |
| | Total | ExclusionsByHIERegistry | For each Metric and Stratification |
| | | ExclusionsByAdmin | For each Metric and Stratification |
| | | Exclusions | (Sum over SSoRs) |
| | | Denominator | For each Metric and Stratification |
| | | NumeratorByEHR | For each Metric and Stratification |
| | | NumeratorByCaseManagement | For each Metric and Stratification |
| | | NumeratorByHIERegistry | For each Metric and Stratification |
| | | NumeratorByAdmin | For each Metric and Stratification |
| | | Numerator | (Sum over SSoRs) |
| | | Rate | (Percent) |

## Rules for Allowable Adjustments of HEDIS

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

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

***Rules for Allowable Adjustments of Unhealthy Alcohol Use Screening and Follow-Up***

| NONCLINICAL COMPONENTS | | |
|---|---|---|
| **Eligible Population** | **Adjustments Allowed (Yes/No)** | **Notes** |
| Product lines | Yes | Organizations are not required to use product line criteria; product lines may be combined and all (or no) product line criteria may be used. |
| Ages | Yes, with limits | The age determination dates may be changed (e.g., select, "age as of June 30").<br>Changing the denominator age range is allowed if the limits are within the specified age range (18 years and older).<br>Organizations must consult UPSTSF guidelines when considering whether to expand the age ranges outside of the current thresholds. |
| Allocation | Yes | Organizations are not required to use enrollment criteria; adjustments are allowed. |
| Benefits | Yes | Using a benefit is not required; adjustments are allowed. |
| Other | Yes | Organizations may use additional eligible population criteria to focus on an area of interest defined by gender, race, ethnicity, socioeconomic or sociodemographic characteristics, geographic region or another characteristic. |
| **CLINICAL COMPONENTS** | | |
| **Eligible Population** | **Adjustments Allowed (Yes/No)** | **Notes** |
| Event/diagnosis | No | Value sets, direct reference codes and logic may not be changed for denominator 2. |
| **Denominator Exclusions** | **Adjustments Allowed (Yes/No)** | **Notes** |
| Exclusions | No | Apply exclusions according to specified direct reference codes. |
| Exclusion: Hospice | Yes | The hospice exclusion is not required. Refer to *Exclusions* in the *Guidelines for the Rules for Allowable Adjustments*. |
| **Numerator Criteria** | **Adjustments Allowed (Yes/No)** | **Notes** |
| • Unhealthy Alcohol Use Screening<br>• Counseling Or Other Follow-Up On Positive Screen | No | Value sets, direct reference codes and logic may not be changed. |

# Use of Imaging Studies for Low Back Pain (LBP)

## SUMMARY OF CHANGES TO HEDIS MY 2023

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

## Description

The percentage of members 18–75 years of age with 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.

## Calculation

The measure is reported as an inverted rate [1–(numerator/eligible population)]. A higher score indicates appropriate treatment of low back pain (i.e., the proportion for whom imaging studies did not occur).

## Definitions

| | |
|---|---|
| **Intake period** | January 1–December 3 of the measurement year. The intake period is used to identify the first eligible encounter with a principal diagnosis of low back pain. |
| **IESD** | 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. |
| **Negative diagnosis history** | A period of 180 days (6 months) prior to the IESD when the member had no claims/encounters with any diagnosis of low back pain. |

## Eligible Population

| | |
|---|---|
| **Product line** | Commercial, Medicaid, Medicare (report each product line separately). |
| **Ages** | 18 years as of January 1 of the measurement year to 75 years as of December 31 of the measurement year.<br><br>Report two age stratifications and a total rate:<br>• 18–64.<br>• 65–75.<br>• Total.<br><br>The total is the sum of the age stratifications. |

**Continuous enrollment** 180 days (6 months) prior to the IESD through 28 days after the IESD.

**Allowable gap** None.

**Anchor date** IESD.

**Benefit** Medical.

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

***Step 1*** Identify all members in the specified age range who had any of the following during the intake period:

- An outpatient visit (Outpatient Value Set), observation visit (Observation Value Set) or an ED visit (ED Value Set) with a principal diagnosis of uncomplicated low back pain (Uncomplicated Low Back Pain Value Set).
  - Do not include visits that result in an inpatient stay (Inpatient Stay Value Set).
- Osteopathic or chiropractic manipulative treatment (Osteopathic and Chiropractic Manipulative Treatment Value Set) with a principal diagnosis of uncomplicated low back pain (Uncomplicated Low Back Pain Value Set).
- Physical therapy visit (Physical Therapy Value Set) with a principal diagnosis of uncomplicated low back pain (Uncomplicated Low Back Pain Value Set).
- Telephone visit (Telephone Visits Value Set) with a principal diagnosis of uncomplicated low back pain (Uncomplicated Low Back Pain Value Set).
- E-visit or virtual check-in (Online Assessments Value Set) with a principal diagnosis of uncomplicated low back pain (Uncomplicated Low Back Pain Value Set).

***Step 2*** Determine the IESD. For each member identified in step 1, determine the earliest episode of low back pain. If the member had more than one encounter, include only the first encounter.

***Step 3*** Test for negative diagnosis history. Remove members with a diagnosis of uncomplicated low back pain (Uncomplicated Low Back Pain Value Set) during the 180 days (6 months) prior to the IESD.

***Step 4*** Calculate continuous enrollment. Members must be continuously enrolled for 180 days (6 months) prior to the IESD through 28 days after the IESD.

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

- *Cancer.* Cancer any time during the member's history through 28 days after the IESD. Any of the following meet criteria:
  - Malignant Neoplasms Value Set.
  - Other Neoplasms Value Set.
  - History of Malignant Neoplasm Value Set.
  - Other Malignant Neoplasm of Skin Value Set.
- *Recent trauma.* Trauma (Trauma Value Set) any time during the 3 months (90 days) prior to the IESD through 28 days after the IESD.

- *Intravenous drug abuse.* IV drug abuse (IV Drug Abuse Value Set) any time during the 12 months (1 year) prior to the IESD through 28 days after the IESD.
- *Neurologic impairment*. Neurologic impairment (Neurologic Impairment Value Set) any time during the 12 months (1 year) prior to the IESD through 28 days after the IESD.
- *HIV.* HIV (HIV Value Set) any time during the member's history through 28 days after the IESD.
- *Spinal infection.* Spinal infection (Spinal Infection Value Set) any time during the 12 months (1 year) prior to the IESD through 28 days after the IESD.
- *Major organ transplant.* Major organ transplant (Organ Transplant Other Than Kidney Value Set; Kidney Transplant Value Set; History of Kidney Transplant Value Set) any time in the member's history through 28 days after the IESD.
- *Prolonged use of corticosteroids.* 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.

  To identify consecutive treatment days, identify calendar days covered by at least one dispensed corticosteroid (Corticosteroid Medications List). For overlapping prescriptions and multiple prescriptions on the same day assume the member started taking the second prescription after exhausting the first prescription. For example, if a member had a 30-days prescription dispensed on June 1 and a 30-days prescription dispensed on June 26, there are 60 covered calendar days (June 1–July 30).

  Count only medications dispensed during the 12 months (1 year) prior to and including the IESD. When identifying consecutive treatment days, do not count days supply that extend beyond the IESD. For example, if a member had a 90-days prescription dispensed on the IESD, there is one covered calendar day (the IESD).

  No gaps are allowed.

***Corticosteroid Medications***

| Description | Prescription | |
|---|---|---|
| Corticosteroid | • Hydrocortisone | • Methylprednisolone |
| | • Cortisone | • Triamcinolone |
| | • Prednisone | • Dexamethasone |
| | • Prednisolone | • Betamethasone/Betamethasone acetate |

- *Osteoporosis*. Osteoporosis therapy (Osteoporosis Medication Therapy Value Set, Long-Acting Osteoporosis Medications Value Set) or a dispensed prescription to treat osteoporosis (Osteoporosis Medications List) any time during the member's history through 28 days after the IESD.

***Osteoporosis Medications***

| Description | Prescription | |
|---|---|---|
| Bisphosphonates | • Alendronate<br>• Alendronate-cholecalciferol<br>• Ibandronate | • Risedronate<br>• Zoledronic acid |
| Other agents | • Abaloparatide<br>• Denosumab<br>• Raloxifene | • Romosozumab<br>• Teriparatide |

- *Fragility fracture.* Fragility fracture (Fragility Fractures Value Set) any time during the 3 months (90 days) prior to the IESD through 28 days after the IESD.
- *Lumbar surgery.* Lumbar surgery (Lumbar Surgery Value Set) any time during the member's history through 28 days after the IESD.
- *Spondylopathy.* Spondylopathy (Spondylopathy Value Set) any time during the member's history through 28 days after the IESD.
- *Palliative care*. Members receiving palliative care (Palliative Care Assessment Value Set; Palliative Care Encounter Value Set; Palliative Care Intervention Value Set; ICD-10-CM code Z51.5) any time during the measurement year.
- Members in hospice or using hospice services any time during the measurement year. Refer to *General Guideline 15: Members in Hospice.*
- Members who died any time during the measurement year. Refer to *General Guideline 16: Deceased Members.*

**Exclusions** Exclude members who meet any of the following criteria:

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

- Members 66 years of age and older as of December 31 of the measurement year (all product lines) with frailty ***and*** advanced illness. Members must meet ***BOTH*** of the following frailty and advanced illness criteria to be excluded:
  1. At least two indications of frailty (Frailty Device Value Set; Frailty Diagnosis Value Set; Frailty Encounter Value Set; Frailty Symptom Value Set) with different dates of service during the measurement year.
  2. Any of the following during the measurement year or the year prior to the measurement year (count services that occur over both years):
     - At least two outpatient visits (Outpatient Value Set), observation visits (Observation Value Set), ED visits (ED Value Set), telephone visits (Telephone Visits Value Set), e-visits or virtual check-ins (Online Assessments Value Set), nonacute inpatient encounters (Nonacute Inpatient Value Set) or nonacute inpatient discharges (instructions below; the diagnosis must be on the discharge claim) on different dates of service, with an advanced illness diagnosis (Advanced Illness Value Set). Visit type need not be the same for the two visits. To identify a nonacute inpatient discharge:

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

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

– A dispensed dementia medication (Dementia Medication List).

***Dementia Medications***

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

## Administrative Specification

**Denominator** The eligible population.

**Numerator** An imaging study (Imaging Study Value Set) with a diagnosis of uncomplicated low back pain (Uncomplicated Low Back Pain Value Set) on the IESD or in the 28 days following the IESD.

### *Note*

- *Although denied claims are not included when assessing the numerator, all claims (paid, suspended, pending and denied) must be included when identifying the eligible population.*
- *Do not include supplemental data when identifying the eligible population or assessing the numerator. Supplemental data can be used for only required exclusions for this measure.*

## Data Elements for Reporting

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

***Table LBP-1/2/3: Data Elements for Use of Imaging Studies for Low Back Pain***

| Metric | Age | Data Element | Reporting Instructions |
|---|---|---|---|
| LowBackPainImaging | 18-64 | EligiblePopulation | For each Stratification |
| | 65-75 | ExclusionAdminRequired | For each Stratification |
| | Total | NumeratorByAdmin | For each Stratification |
| | | Rate | (Percent) |

## Rules for Allowable Adjustments of HEDIS

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

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

***Rules for Allowable Adjustments of Use of Imaging Studies for Low Back Pain***

| NONCLINICAL COMPONENTS | | |
|---|---|---|
| **Eligible Population** | **Adjustments Allowed (Yes/No)** | **Notes** |
| Product lines | Yes | Organizations are not required to use product line criteria; product lines may be combined, and all (or no) product line criteria may be used. |
| Ages | Yes, with limits | The age determination dates may be changed (e.g., select, "age as of June 30").<br>Changing the denominator age range is allowed if the limits are within the specified age range (18–50 years).<br>The denominator age may not be expanded. |
| Continuous enrollment, allowable gap, anchor date | Yes | Organizations are not required to use enrollment criteria; adjustments are allowed.<br>***Note:*** *Changes to* these *criteria can affect how* the *event/diagnosis will be calculated using* the *intake period, IESD, negative diagnosis history.* |
| Benefits | Yes | Organizations are not required to use a benefit; adjustments are allowed. |
| Other | Yes | Organizations may use additional eligible population criteria to focus on an area of interest defined by gender, race, ethnicity, socioeconomic or sociodemographic characteristics, geographic region or another characteristic. |
| **CLINICAL COMPONENTS** | | |
| **Eligible Population** | **Adjustments Allowed (Yes/No)** | **Notes** |
| Event/diagnosis | No | Only events that contain (or map to) codes in the value sets may be used to identify visits, treatment, therapy or e-visits or virtual check-ins. The value sets and logic may not be changed. |
| **Denominator Exclusions** | **Adjustments Allowed (Yes/No)** | **Notes** |
| Required exclusions | Yes, with limits | Apply required exclusions according to specified medication lists and value sets.<br>The hospice, deceased member and palliative care exclusions are not required. Refer to *Exclusions* in the *Guidelines for the Rules for Allowable Adjustments*. |
| **Numerator Criteria** | **Adjustments Allowed (Yes/No)** | **Notes** |
| Imaging Study | Yes, with limits | Value sets and logic may not be changed.<br>Organizations may include denied claims to calculate the numerator. |

# *Utilization of the PHQ-9 to Monitor Depression Symptoms for Adolescents and Adults (DMS-E)**

***Adapted with financial support from the Agency for Healthcare Research and Quality (AHRQ) and the Centers for Medicare & Medicaid Services (CMS) under the CHIPRA Pediatric Quality Measures Program Centers of Excellence grant number U18HS020503, and with permission from the measure developer, Minnesota Community Measurement.**

## SUMMARY OF CHANGES TO HEDIS MY 2023

- Refer to the Technical Release Notes file in the Digital Measures Package for a comprehensive list of changes.
- Revised the "Other" criteria in the Nonclinical Components table under *Rules for Allowable Adjustments of HEDIS.*

| | |
|---|---|
| **Description** | The percentage of members 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. |
| **Measurement period** | January 1–December 31. |
| **Clinical recommendation statement** | 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).<br><br>The PHQ-9 tool assesses the nine DSM, Fourth Edition, Text Revision (DSM-IV-TR) 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). |
| **Citations** | Cheung, A.H., R.A. Zuckerbrot, P.S. Jensen, D. Laraque, R.E.K. Stein, GLAD-PC Steering Group. 2018. "Guidelines for Adolescent Depression in Primary Care (GLAD-PC): II. Treatment and Ongoing management." Pediatrics 141(3):e20174082.<br><br>Kroenke, K, R.L. Spitzer, J.B.W. Williams. 2001. The PHQ-9: Validity of a brief depression severity measure. Journal of General Internal Medicine 16(9): 606-13.<br><br>Trangle, M., Gursky, J., Haight, R., Hardwig, J., Hinnenkamp, T., Kessler, D., Mack, N., Myszkowski, M. Institute for Clinical Systems Improvement. Adult Depression in Primary Care. Updated March 2016. |

| **Characteristics** | |
|---|---|
| **Scoring** | Proportion. |
| **Type** | Process. |
| **Stratification** | • Utilization of PHQ-9 Period 1.<br>– Product line:<br>▪ Commercial.<br>▪ Medicaid.<br>▪ Medicare.<br>– Age (as of the start of the measurement period, for each product line):<br>▪ 12–17 years (for commercial and Medicaid only).<br>▪ 18–44 years.<br>▪ 45–64 years.<br>▪ 65 years and older.<br>• Utilization of PHQ-9 Period 2.<br>– Product line:<br>▪ Commercial.<br>▪ Medicaid.<br>▪ Medicare.<br>– Age (as of the start of the measurement period, for each product line):<br>▪ 12–17 years (for commercial and Medicaid only).<br>▪ 18–44 years.<br>▪ 45–64 years.<br>▪ 65 years and older.<br>• Utilization of PHQ-9 Period 3.<br>– Product line:<br>▪ Commercial.<br>▪ Medicaid.<br>▪ Medicare.<br>– Age (as of the start of the measurement period, for each product line):<br>▪ 12–17 years (for commercial and Medicaid only).<br>▪ 18–44 years.<br>▪ 45–64 years.<br>▪ 65 years and older. |
| **Risk adjustment** | None. |
| **Improvement notation** | A higher rate indicates better performance. |

| | |
|---|---|
| **Guidance** | **Allocation:**<br>The member was enrolled with a medical benefit throughout the participation period.<br><br>When identifying members in hospice, the requirements described in *General Guideline 15* for identification of hospice members using the monthly membership detail data files are not included in the measure calculation logic and need to be programmed manually.<br><br>**Requirements:**<br>• Members 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.<br>• The measure allows the use of two PHQ-9 assessments. Selection of the appropriate assessment should be based on the member's age:<br>– *PHQ-9:* 12 years of age and older.<br>– *PHQ-9 Modified for Teens:* 12–17 years of age.<br>• The PHQ-9 assessment does not need to occur during a face-to-face encounter; it may be completed over the telephone or through a web-based portal.<br><br>**Reporting:**<br>The total is the sum of the age stratifications.<br><br>Product line stratifications are not included in the measure calculation logic and need to be programmed manually.<br><br>NCQA calculates the performance rate by dividing the sum of the numerators across the three assessment periods by the sum of the denominators across the three assessment periods. |
| **Definitions** | |
| **Participation** | The identifiers and descriptors for each organization's coverage used to define members' eligibility for measure reporting. Allocation for reporting is based on eligibility during the participation period. |
| **Participation period** | The measurement period. |
| **Assessment period** | The measurement period is divided into three assessment periods with specific dates of service:<br>• *Assessment period 1*: January 1–April 30.<br>• *Assessment period 2*: May 1–August 31.<br>• *Assessment period 3*: September 1–December 31. |
| **Interactive outpatient encounter** | 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. |

| | |
|---|---|
| **Initial population** | **Initial population 1**<br>Members 12 years and older at the start of the measurement period who also meet the criteria for participation, with at least one interactive outpatient encounter that starts during assessment period 1, with a diagnosis of major depression or dysthymia.<br><br>**Initial population 2**<br>Members 12 years and older at the start of the measurement period who also meet the criteria for participation, with at least one interactive outpatient encounter that starts during assessment period 2, with a diagnosis of major depression or dysthymia.<br><br>**Initial population 3**<br>Members 12 years and older at the start of the measurement period who also meet the criteria for participation, with at least one interactive outpatient encounter that starts during assessment period 3, with a diagnosis of major depression or dysthymia. |
| **Exclusions** | **Exclusions 1**<br>Members with any of the following any time during the member's history through the end of the measurement period:<br>• Bipolar disorder.<br>• Personality disorder.<br>• Psychotic disorder.<br>• Pervasive developmental disorder.<br>***OR***<br>• Members in hospice or using hospice services any time during the measurement period.<br><br>**Exclusions 2**<br>Same as exclusions 1.<br><br>**Exclusions 3**<br>Same as exclusions 1. |
| **Denominator** | **Denominator 1**<br>The initial population 1, minus exclusions.<br><br>**Denominator 2**<br>The initial population 2, minus exclusions.<br><br>**Denominator 3**<br>The initial population 3, minus exclusions. |
| **Numerator** | **Numerator 1—Utilization of PHQ-9 Period 1**<br>A PHQ-9 score in the member’s record during assessment period 1.<br><br>**Numerator 2—Utilization of PHQ-9 Period 2**<br>A PHQ-9 score in the member’s record during assessment period 2.<br><br>**Numerator 3—Utilization of PHQ-9 Period 3**<br>A PHQ-9 score in the member’s record during assessment period 3. |

**Data criteria (element level)**

***Value Sets:***

- **DMSE_HEDIS_MY2023-2.0.0**
  - Bipolar Disorder (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1044)
  - Interactive Outpatient Encounter (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1347)
  - Major Depression or Dysthymia (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1351)
  - Other Bipolar Disorder (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1399)
  - Personality Disorder (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1355)
  - Pervasive Developmental Disorder (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1356)
  - Psychotic Disorders (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1352)
- **NCQA_Hospice-2.0.0**
  - Hospice Encounter (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1761)
  - Hospice Intervention (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1762)

***Direct reference codes and codesystems:***

- **DMSE_HEDIS_MY2023-2.0.0**
  - codesystem "LOINC": 'http://loinc.org'
  - code "Patient Health Questionnaire 9 item (PHQ-9) total score [Reported]": '44261-6' from "LOINC" display 'Patient Health Questionnaire 9 item (PHQ-9) total score [Reported]'
  - code "Patient Health Questionnaire-9: Modified for Teens total score [Reported.PHQ.Teen]": '89204-2' from "LOINC" display 'Patient Health Questionnaire-9: Modified for Teens total score [Reported.PHQ.Teen]'
- **NCQA_Terminology-2.0.0**
  - codesystem "ActCode": 'http://terminology.hl7.org/CodeSystem/v3-ActCode'
  - codesystem "ConditionClinicalStatusCodes": 'http://terminology.hl7.org/CodeSystem/condition-clinical'
  - code "active": 'active' from "ConditionClinicalStatusCodes"
  - code "managed care policy": 'MCPOL' from "ActCode"
  - code "retiree health program": 'RETIRE' from "ActCode"
  - code "subsidized health program": 'SUBSIDIZ' from "ActCode"

## Data Elements for Reporting

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

***Table DMS-E-1/2: Data Elements for Utilization of the PHQ-9 to Monitor Depression Symptoms for Adolescents and Adults***

| Metric | TimePeriod | Age | Data Element | Reporting Instructions |
|---|---|---|---|---|
| PHQ9Utilization | 1 | 12-17 | InitialPopulationByEHR | For each Stratification |
| | 2 | 18-44 | InitialPopulationByCaseManagement | For each Stratification |
| | 3 | 45-64 | InitialPopulationByHIERegistry | For each Stratification |
| | Total | 65+ | InitialPopulationByAdmin | For each Stratification |
| | | Total | InitialPopulation | (Sum over SSoRs) |
| | | | ExclusionsByEHR | For each Stratification |
| | | | ExclusionsByCaseManagement | For each Stratification |
| | | | ExclusionsByHIERegistry | For each Stratification |
| | | | ExclusionsByAdmin | For each Stratification |
| | | | Exclusions | (Sum over SSoRs) |
| | | | Denominator | For each Stratification |
| | | | NumeratorByEHR | For each Stratification |
| | | | NumeratorByCaseManagement | For each Stratification |
| | | | NumeratorByHIERegistry | For each Stratification |
| | | | NumeratorByAdmin | For each Stratification |
| | | | Numerator | (Sum over SSoRs) |
| | | | Rate | (Percent) |

***Table DMS-E-3: Data Elements for Utilization of the PHQ-9 to Monitor Depression Symptoms for Adolescents and Adults***

| Metric | TimePeriod | Age | Data Element | Reporting Instructions |
|---|---|---|---|---|
| PHQ9Utilization | 1 | 18-44 | InitialPopulationByEHR | For each Stratification |
| | 2 | 45-64 | InitialPopulationByCaseManagement | For each Stratification |
| | 3 | 65+ | InitialPopulationByHIERegistry | For each Stratification |
| | Total | Total | InitialPopulationByAdmin | For each Stratification |
| | | | InitialPopulation | (Sum over SSoRs) |
| | | | ExclusionsByEHR | For each Stratification |
| | | | ExclusionsByCaseManagement | For each Stratification |
| | | | ExclusionsByHIERegistry | For each Stratification |
| | | | ExclusionsByAdmin | For each Stratification |
| | | | Exclusions | (Sum over SSoRs) |
| | | | Denominator | For each Stratification |
| | | | NumeratorByEHR | For each Stratification |
| | | | NumeratorByCaseManagement | For each Stratification |
| | | | NumeratorByHIERegistry | For each Stratification |
| | | | NumeratorByAdmin | For each Stratification |
| | | | Numerator | (Sum over SSoRs) |
| | | | Rate | (Percent) |

## Rules for Allowable Adjustments of HEDIS

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

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

***Rules for Allowable Adjustments of Utilization of the PHQ-9 to Monitor Depression Symptoms for Adolescents and Adults***

| NONCLINICAL COMPONENTS | | |
|---|---|---|
| **Eligible Population** | **Adjustments Allowed (Yes/No)** | **Notes** |
| Product lines | Yes | Organizations are not required to use product line criteria; product lines may be combined and all (or no) product line criteria may be used. |
| Ages | Yes, with limits | The age determination dates may be changed (e.g., select, "age as of June 30").<br>Changing the denominator age range is allowed if the limits are within the specified age range (12 years and older).<br>Expanding the denominator age range to 11 years and older is allowed. |
| Allocation | Yes | Organizations are not required to use enrollment criteria; adjustments are allowed. |
| Benefits | Yes | Organizations are not required to use a benefit; adjustments are allowed. |
| Other | Yes | Organizations may use additional eligible population criteria to focus on an area of interest defined by gender, race, ethnicity, socioeconomic or sociodemographic characteristics, geographic region, or another characteristic. |
| **CLINICAL COMPONENTS** | | |
| **Eligible Population** | **Adjustments Allowed (Yes/No)** | **Notes** |
| Event/diagnosis | No | Only events or diagnoses that contain (or map to) codes in the value sets may be used to identify visits with a diagnosis. Value sets and logic may not be changed. |
| **Denominator Exclusions** | **Adjustments Allowed (Yes/No)** | **Notes** |
| Exclusions | No | Apply exclusions according to specified value sets. |
| Exclusion: Hospice | Yes | The hospice exclusion is not required. Refer to *Exclusions* in the *Guidelines for the Rules for Allowable Adjustments*. |
| **Numerator Criteria** | **Adjustments Allowed (Yes/No)** | **Notes** |
| PHQ-9 Score | No | Value sets, direct reference codes and logic may not be changed. |

****NQF-ENDORSED VOLUNTARY CONSENSUS STANDARDS FOR HOSPITAL CARE****

# Measure Information Form

**Measure Set:** Perinatal Care (PC)

**Set Measure ID:** PC-01

**Performance Measure Name:** Elective Delivery

**Description:** Patients with elective vaginal deliveries or elective cesarean births at >= 37 and < 39 weeks of gestation completed

**Rationale:** For almost 3 decades, the American College of Obstetricians and Gynecologists (ACOG) and the American Academy of Pediatrics (AAP) have had in place a standard requiring 39 completed weeks gestation prior to ELECTIVE delivery, either vaginal or operative (ACOG, 1996). A survey conducted in 2007 of almost 20,000 births in HCA hospitals throughout the U.S. carried out in conjunction with the March of Dimes at the request of ACOG revealed that almost 1/3 of all babies delivered in the United States are electively delivered with 5% of all deliveries in the U.S. delivered in a manner violating ACOG/AAP guidelines. Most of these are for convenience, and result in significant short term neonatal morbidity (neonatal intensive care unit admission rates of 13- 21%) (Clark et al., 2009).

According to Glantz (2005), compared to spontaneous labor, elective inductions result in more cesarean births and longer maternal length of stay. The American Academy of Family Physicians (2000) also notes that elective induction doubles the cesarean delivery rate. Repeat elective cesarean births before 39 weeks gestation also result in higher rates of adverse respiratory outcomes, mechanical ventilation, sepsis and hypoglycemia for the newborns (Tita et al., 2009).

**Type Of Measure:** Process

**Improvement Noted As:** Decrease in the rate

**Numerator Statement:** Patients with elective deliveries

> **Included Populations:** *ICD-10-PCS Principal Procedure Code or ICD-10-PCS Other Procedure Codes* for one or more of the following:
>
> - Medical induction of labor as defined in Appendix A, Table 11.05 while not in *Labor* prior to the procedure
> - Cesarean birth as defined in Appendix A, Table 11.06 and all of the following:
>   - not in *Labor*
>   - no history of a *Prior Uterine Surgery*
>
> **Excluded Populations:** None
>
> **Data Elements:**

- *ICD-10-PCS Other Procedure Codes*
- *ICD-10-PCS Principal Procedure Code*
- *Labor*
- *Prior Uterine Surgery*

**Denominator Statement:** Patients delivering newborns with >= 37 and < 39 weeks of gestation completed

**Included Populations:**

- *ICD-10-PCS Principal Procedure Code or ICD-10-PCS Other Procedure Codes* for delivery as defined in Appendix A, Table 11.01.1

- *ICD-10-CM Principal Diagnosis Code or ICD-10-CM Other Diagnosis Codes* for planned cesarean birth in labor as defined in Appendix A, Table 11.06.1

**Excluded Populations:**

- *ICD-10-CM Principal Diagnosis Code or ICD-10-CM Other Diagnosis Codes* for conditions possibly justifying elective delivery prior to 39 weeks gestation as defined in Appendix A, Table 11.07
- History of prior stillbirth
- Less than 8 years of age
- Greater than or equal to 65 years of age
- Length of stay > 120 days
- *Gestational Age* < 37 or >= 39 weeks or UTD

**Data Elements:**

- *Admission Date*
- *Birthdate*
- *Discharge Date*
- *Gestational Age*
- *History of Stillbirth*
- *ICD-10-CM Other Diagnosis Codes*
- *ICD-10-CM Principal Diagnosis Code*

**Risk Adjustment:** No.

**Data Collection Approach:** Retrospective data sources for required data elements include administrative data and medical records.

**Data Accuracy:** Variation may exist in the assignment of ICD-10 codes; therefore, coding practices may require evaluation to ensure consistency.

**Measure Analysis Suggestions:** In order to identify areas for improvement, hospitals may want to review results based on specific ICD-10 codes or patient populations. Data could be analyzed further to determine specific patterns or trends to help reduce elective deliveries.

**Sampling:** Yes. For additional information see the Sampling Section.

**Data Reported As:** Aggregate rate generated from count data reported as a proportion.

**Selected References:**


- American Academy of Family Physicians. (2000). Tips from Other Journals: Elective induction doubles cesarean delivery rate, 61, 4.Retrieved December 29, 2008 at: http://www.aafp.org/afp/20000215/tips/39.html.
- American College of Obstetricians and Gynecologists. (November 1996). ACOG Educational Bulletin.
- Borders, E.B., Birsner, M.L., Gyanmfi-Bannerbaum, C. (2019). Avoidance of nonmedically indicated early-term deliveries and associated neonatal morbidities. American College of Obstetricians and Gynecologists Committee Opinion, 133:2, e156-163.
- Clark, S., Miller, D., Belfort, M., Dildy, G., Frye, D., & Meyers, J. (2009). Neonatal and maternal outcomes associated with elective delivery. [Electronic Version]. *Am J Obstet Gynecol*. 200:156.e1-156.e4.
- Glantz, J. (Apr.2005). Elective induction vs. spontaneous labor associations and outcomes. [Electronic Version]. *J Reprod Med*. 50(4):235-40.
- Tita, A., Landon, M., Spong, C., Lai, Y., Leveno, K., Varner, M, et al. (2009). Timing of elective repeat cesarean delivery at term and neonatal outcomes. [Electronic Version]. *NEJM*. 360:2, 111-120.

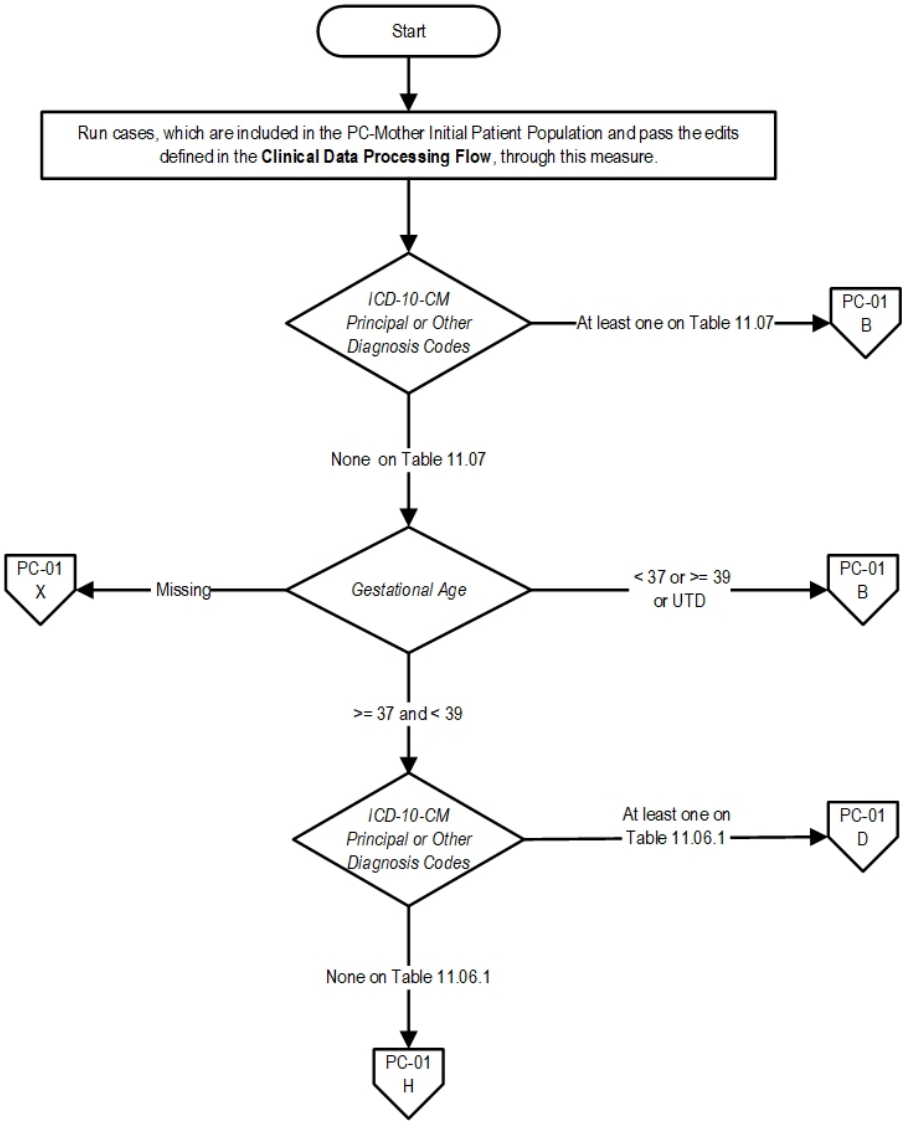

**Original Performance Measure Source / Developer:**
Hospital Corporation of America-Women's and Children's Clinical Services

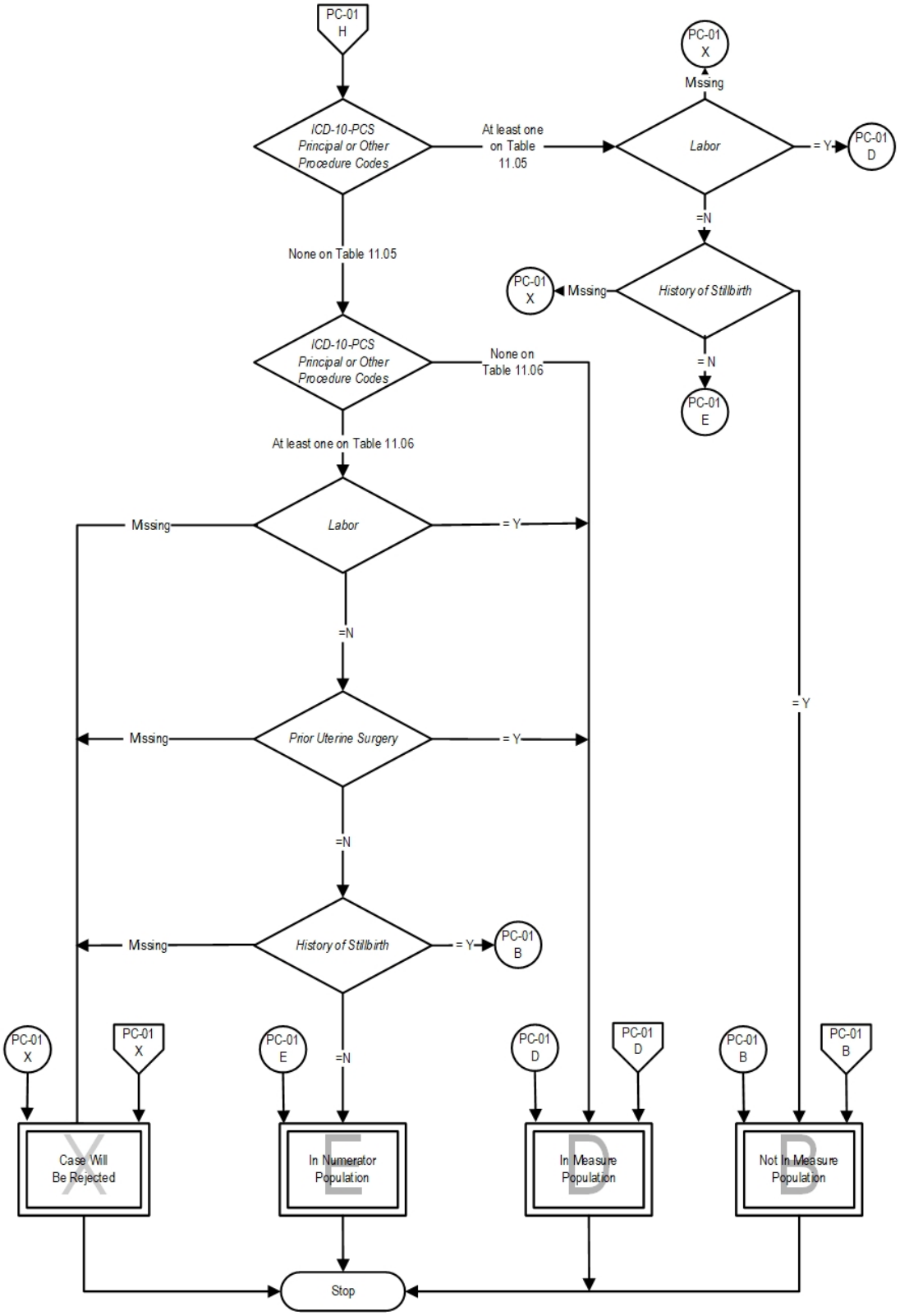
**Measure Algorithm:**

## PC-01: Elective Delivery

**Numerator:** Patients with elective deliveries

**Denominator:** Patients delivering newborns with >= 37 and < 39 weeks of gestation completed





# Fluoride Varnish

Rhode Island Department of Health

## A. DESCRIPTION

The percentage of children who received a fluoride varnish application in primary care in the 12 months preceding their first, second, or third birthday.

Guidance for Reporting:

- This measure includes three age-specific indicators assessing whether children are screened by their first, second or third birthdays. Four rates, one for each age group and a combined rate, are to be calculated and reported.

## B. ELIGIBLE POPULATION

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

## C. DATA SOURCE

### C.1 – Administrative Specifications

Denominator

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

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

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

Denominator 4: All children in the eligible population who turned 1, 2, or 3 during the measurement year, i.e., the sum of denominators 1, 2, and 3.

Numerators

The numerators identify children who received a fluoride varnish application by a medical practice. National recommendations call for application among young children. The measure is based on three, age-specific indicators.

Numerator 1: Children in Denominator 1 who had a claim with CPT code 99188 or CDT code D1206 billed by a medical practice by their first birthday.

Numerator 2: Children in Denominator 2 who had a claim with CPT code 99188 or CDT code D1206 billed by a medical practice after their first and before or on their second birthdays.

Numerator 3: Children in Denominator 3 who had a claim with CPT code 99188 or CDT code D1206 billed by a medical practice after their second and before or on their third birthdays.

Numerator 4: Children in the entire eligible population who had claim with CPT code 99188 or CDT code D1206 billed by a medical practice in the 12 months preceding their 1st, 2nd, or 3rd birthday (the sum of numerators 1, 2 and 3).

Claims data: CPT code 99188 (application of topical fluoride varnish by a physician or other qualified health care professional) or CDT code D1206 (topical application of fluoride varnish) when billed by a medical practice.

C.2 – Medical Record Specifications

Denominator

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

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

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

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

Denominator 4: The entire sample of 411 children.

Numerators

Numerator 1: Children in Denominator 1 who had received a fluoride varnish application that was documented by their first birthday

Numerator 2: Children in Denominator 2 who had received a fluoride varnish application that was documented after their first and before or on their second birthday

Numerator 3: Children in Denominator 3 who received a fluoride varnish application that was documented after their second and before or on their third birthday

Numerator 4: Children in Denominator 4 who had received a fluoride varnish application that was documented in the 12 months preceding their first, second or third birthday (the sum of numerators 1, 2 and 3).

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

- A note indicating the date on which the test was performed, and
- Evidence of a fluoride varnish application

D. EXCLUSIONS

None.

E. CALCULATION ALGORITHM

Step 1:

Determine the denominators.

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

Step 2:

Determine the numerators.

For each age cohort, and for the total, identify children who had received a fluoride varnish application by their birthday as found through claims data or documented in the medical chart.

Claims Data:

Children for whom a claim of 99188 or D1206 billed by a medical practice was submitted for services in the 12 months preceding their birthday.

Medical Record:

Children who had documentation in the medical record of receiving a fluoride varnish application, validated tool in the 12 months preceding their birthday.

Documentation must include the date of screening and evidence that the fluoride varnish application was completed.

Step 3:

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

Step 4: Create the overall measure of screening based on the age-specific numerators and denominators.

Total Numerator: Numerator 1 + Numerator 2 + Numerator 3

Total Denominator: Denominator 1 + Denominator 2 + Denominator 3

Sampling Methodology

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

## F. OPTIONAL AGE-SPECIFIC OVERSAMPLING FOR THE DENOMINATOR

A sample of 411 will provide sufficient statistical power for states reporting a state-wide developmental screening rate for children ages 1 to 3. With the smaller age-specific samples, the confidence intervals around the age-specific rates will be larger. Because states will want to use this measure to improve screening rates, age-specific rates may help states to target their efforts. Some states may wish to augment the sample in order to monitor screening rates for a particular age group; compare screening rates for a particular age group with that in other states; or look within an age group at subgroups, defined by race/ethnicity, geographic region, or language. For these applications, the age-specific sample of 137 maybe insufficient, and the state may need a larger sample to obtain statistically meaningful results. The size of the sample required depends on the use of the data, so consultation with a statistician is recommended. The following instructions guide the development of an oversample.

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

# Patient Engagement with an AE Primary Care Provider Measure Specifications

**Rhode Island Executive Office of Health and Human Services**
**As of May 23, 2022**

**SUMMARY OF CHANGES FOR 2023 (PERFORMANCE YEAR 6)**

- New measure for 2023.

## Description

The percentage of attributed patients who have engaged with an AE primary care provider.

*Note: EOHHS recognizes that patient engagement with an AE may extend beyond what is captured by this measure (e.g., visits with a care manager, care coordinator, integrated behavioral health specialist, etc.). The intent of this measure, however, is to focus exclusively on visits with an AE primary care provider.*

## Eligible Population

| | |
|---|---|
| **Product lines** | Medicaid |
| **Stratification** | Ages as of December 31 of the measurement year. Report three age-stratified rates and a total rate.<br>• 1-17 years<br>• 18-39 years<br>• 40+ years<br>The total is the sum of the stratifications. |
| **Ages** | All ages |
| **Continuous enrollment** | The measurement period, as defined using the lookback period |
| **Allowable gap** | No more than one gap in enrollment of up to 45 days during each year of continuous enrollment with an MCO. To determine continuous enrollment for a Medicaid beneficiary for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage (i.e., a member whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).[1,2,3] |
| **Anchor date** | In the AE on December 31 of the measurement year. |

[1] NCQA added the Medicaid language after receiving high volumes of questions from Medicaid organizations stating they were unable to determine gaps based on days and could only assess on a monthly basis. The intent of the language is to clarify that, if the organization could only assess enrollment on a monthly basis (e.g., for select populations in RI identified in footnote 2), then a 2-month gap exceeds 45 days and is not allowed.
[2] RIte Care enrollment is verified daily whereas other populations, including expansion adults and adults with disabilities, are verified monthly.
[3] Members 18-39 years can have two allowable gaps and still be included in the denominator as the lookback period for this population is 24 months and not 12 months.

| | |
|---|---|
| **Lookback period** | 24 months for members 18-39<br>12 months for members 1-17 and 40+ |
| **Benefit** | Medical |
| **Event/diagnosis** | Attribution or re-attribution to the AE for 11 of 12 months of the measurement year. |
| **Exclusions** | • Members who were not enrolled for the full measurement year, with the exception of the allowable gap.<br>• Members in hospice care (see "Exclusions" tab in Excel spreadsheet for eligible codes) |

## Administrative Specifications

| | |
|---|---|
| **Denominator** | The eligible population |
| **Numerator 1** | One or more ambulatory, preventive or outpatient visits with an AE primary care provider as of December 31 of the measurement year during the last twelve months for attributed members under age 18.<br><br>See "Numerator 1 2 and 3" tab in the Excel spreadsheet for eligible codes. |
| **Numerator 2** | One or more ambulatory, preventive or outpatient visits with an AE primary care provider as of December 31 of the measurement year during the last 24 months for attributed members ages 18 to 39.<br><br>See "Numerator 1 2 and 3" tab in the Excel spreadsheet for eligible codes. |
| **Numerator 3** | One or more ambulatory, preventive or outpatient visits with an AE primary care provider as of December 31 of the measurement year during the last 12 months for attributed members ages 40 and over.<br><br>See "Numerator 1 2 and 3" tab in the Excel spreadsheet for eligible codes. |
| **Exclusions** | None |

## Excel Spreadsheet with Eligible Codes

Patient
Engagement Measu

# Patient Safety Indicator 90 (PSI 90)
# Patient Safety and Adverse Events Composite
# July 2021
# Hospital-Level Indicator
# Type of Score: Ratio

**Prepared by:**

Agency for Healthcare Research and Quality

U.S. Department of Health and Human Services

www.qualityindicators.ahrq.gov

## DESCRIPTION

The weighted average of the observed-to-expected ratios for the following component indicators:

- PSI 03 Pressure Ulcer Rate
- PSI 06 Iatrogenic Pneumothorax Rate
- PSI 08 In-Hospital Fall With Hip Fracture Rate
- PSI 09 Postoperative Hemorrhage or Hematoma Rate
- PSI 10 Postoperative Acute Kidney Injury Requiring Dialysis Rate
- PSI 11 Postoperative Respiratory Failure Rate
- PSI 12 Perioperative Pulmonary Embolism (PE) or Deep Vein Thrombosis (DVT) Rate
- PSI 13 Postoperative Sepsis Rate
- PSI 14 Postoperative Wound Dehiscence Rate
- PSI 15 Abdominopelvic Accidental Puncture or Laceration Rate

PSI 90 combines the smoothed (empirical Bayes shrinkage) indirectly standardized morbidity ratios (observed/expected ratios) from selected AHRQ Patient Safety Indicators (PSIs). The weights of the individual component indicators are based on two concepts: the volume of the adverse event and the harm associated with the adverse event. The volume weights were calculated based on the number of safety-related events for the component indicators in the all-payer reference population. The harm weights were calculated by multiplying empirical estimates of the probability of excess harms associated with each patient safety event by the corresponding utility weights (1–disutility). Disutility is the measure of the severity of the adverse events associated with each of the harms (i.e., outcome severity, or least preferred states from the patient perspective). The harm weights were calculated using linked claims data for two years of Medicare Fee for Service beneficiaries.

**Table 1. Composite Weights for PSI 90 v2021**

| INDICATOR | HARM WEIGHT | VOLUME WEIGHT | COMPONENT WEIGHT |
|---|---|---|---|
| PSI 3 Pressure Ulcer Rate | 0.3080 | 0.1048 | 0.1641 |
| PSI 6 Iatrogenic Pneumothorax Rate | 0.1381 | 0.0457 | 0.0321 |
| PSI 8 In Hospital Fall With Hip Fracture Rate | 0.1440 | 0.0194 | 0.0142 |
| PSI 9 Postoperative Hemorrhage or Hematoma Rate | 0.0570 | 0.1526 | 0.0442 |
| PSI 10 Postoperative Acute Kidney Injury Requiring Dialysis Rate | 0.3584 | 0.0310 | 0.0564 |
| PSI 11 Postoperative Respiratory Failure Rate | 0.2219 | 0.2125 | 0.2397 |
| PSI 12 Perioperative Pulmonary Embolism or Deep Vein Thrombosis Rate | 0.1557 | 0.2318 | 0.1835 |
| PSI 13 Postoperative Sepsis Rate | 0.3102 | 0.1384 | 0.2182 |
| PSI 14 Postoperative Wound Dehiscence Rate | 0.1441 | 0.0170 | 0.0125 |
| PSI 15 Abdominopelvic Accidental Puncture or Laceration Rate | 0.1474 | 0.0468 | 0.0351 |

Source: 2018 State Inpatient Databases, Healthcare Cost and Utilization Program, Agency for Healthcare Research and Quality. 2013-2014 Medicare Fee-for-Service claims data.

For more information, see Quality Indicator Empirical Methods and Composite User Guide.

# Prenatal and Postpartum Care (PPC)

## SUMMARY OF CHANGES TO HEDIS MY 2023

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

## Description

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

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

## Definitions

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

## Eligible Population

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

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

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

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

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

**Age** None specified.

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

**Allowable gap** None.

**Anchor date** Date of delivery.

**Benefit** Medical.

**Event/diagnosis** Delivered a live birth on or between October 8 of the year prior to the measurement year and October 7 of the measurement year. Include members who delivered in any setting.

Multiple births. Members who had two separate deliveries (different dates of service) between October 8 of the year prior to the measurement year and October 7 of the measurement year count twice. Members who had multiple live births during one pregnancy count once.

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

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

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

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

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

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

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

## Administrative Specification

**Denominator** The eligible population.

**Numerator**

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

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

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

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

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

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

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

- A bundled service (Prenatal Bundled Services Value Set) where the organization can identify the date when prenatal care was initiated (because bundled service codes are used on the date of delivery, these codes may be used only if the claim form indicates when prenatal care was initiated).
- A visit for prenatal care (Stand Alone Prenatal Visits Value Set).
- A prenatal visit (Prenatal Visits Value Set; Telephone Visits Value Set; Online Assessments Value Set) ***with*** a pregnancy-related diagnosis code (Pregnancy Diagnosis Value Set).

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

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

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

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

## Hybrid Specification

**Denominator**

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

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

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

**Numerator**

***Timeliness of Prenatal Care***

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

**Administrative**

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

**Medical record**

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

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

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

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

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

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

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

### *Note*

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

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

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

## Data Elements for Reporting

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

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

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

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

| Metric |
|---|
| TimelinessPrenatalCare |
| PostpartumCare |

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

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

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

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

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

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

## Rules for Allowable Adjustments of HEDIS

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

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

***Rules for Allowable Adjustments of Prenatal and Postpartum Care***

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

# Severe Sepsis and Septic Shock: Management Bundle (Composite Measure)

| | |
|---|---|
| **NQF Endorsement Status** | Endorsed |
| **NQF ID** | 0500 |
| **Measure Type** | Composite |
| **Measure Content Last Updated** | 2021-02-01 |
| **Info As Of** | Not Available |

## Properties

| | |
|---|---|
| **Description** | This measure focuses on adults 18 years and older with a diagnosis of severe sepsis or septic shock. Consistent with Surviving Sepsis Campaign guidelines, the measure contains several elements, including measurement of lactate, obtaining blood cultures, administering broad spectrum antibiotics, fluid resuscitation, vasopressor administration, reassessment of volume status and tissue perfusion, and repeat lactate measurement. As reflected in the data elements and their definitions, these elements should be performed in the early management of severe sepsis and septic shock. |
| **Numerator** | The number of patients in the denominator who received ALL of the following components (if applicable) for the early management of severe sepsis and septic shock: initial lactate levels, blood cultures, antibiotics, fluid resuscitation, repeat lactate level, vasopressors, and volume status and tissue perfusion reassessment. |
| **Denominator** | Inpatients age 18 and over with an ICD-10-CM Principal or Other Diagnosis Code of Sepsis, Severe Sepsis, or Septic Shock. |
| **Denominator Exclusions** | The following patients are excluded from the denominator:<br>Severe sepsis is not present<br>Patients Transferred in from another acute care facility<br>Patients receiving IV antibiotics for more than 24 hours prior to presentation of severe sepsis.<br>Patients with a Directive for Comfort Care or Palliative Care within 3 hours of presentation of severe sepsis<br>Patients with an Administrative Contraindication to Care within 6 |

# Severe Sepsis and Septic Shock: Management Bundle (Composite Measure)

hours of presentation of severe sepsis

Patients with an Administrative Contraindication to Care within 6 hours of presentation of septic shock

Patients with a Directive for Comfort Care or Palliative Care within 6 hours of presentation of septic shock

Patients with septic shock who are discharged within 6 hours of presentation

Patients with severe sepsis who are discharged within 6 hours of presentation

Patients with a Length of Stay >120 days

Patients included in a Clinical Trial

**Rationale**

The evidence cited for all components of this measure is directly related to decreases in organ failure, overall reductions in hospital mortality, length of stay, and costs of care.

A principle of sepsis care is that clinicians must rapidly treat patients with an unknown causative organism and unknown antibiotic susceptibility. Since patients with severe sepsis have little margin for error regarding antimicrobial therapy, initial treatment should be broad spectrum to cover all likely pathogens. As soon as the causative organism is identified, based on subsequent culture and susceptibility testing, de-escalation is encouraged by selecting the most appropriate antimicrobial therapy to cover the identified pathogen, safely and cost effectively (Dellinger, 2012).

Multicenter efforts to promote bundles of care for severe sepsis and septic shock were associated with improved guideline compliance and lower hospital mortality (Ferrer, 2008 and Rhodes, 2015). Even with compliance rates of less than 30%, absolute reductions in mortality of 4-6% have been noted (Levy, 2010 and Ferrer, 2008). Absolute reductions in mortality of over 20% have been seen with compliance rates of 52% (Levy, 2010). Coba et al. has shown that when all bundle elements are completed and compared to patients who do not have bundle completion, the mortality difference is 14% (2011). Thus, there is a direct association between bundle compliance and improved mortality. Without a continuous quality initiative (CQI), even these compliance rates will not improve and will decrease over time (Ferrer, 2008). Multiple studies have shown that, for patients with severe sepsis, standardized order sets, enhanced

# Severe Sepsis and Septic Shock: Management Bundle (Composite Measure)

| | |
|---|---|
| | bedside monitor display, telemedicine, and comprehensive CQI feedback is feasible, modifies clinician behavior, and is associated with decreased hospital mortality (Thiel, 2009; Micek, 2006; Winterbottom, 2011; Schramm, 2011; Nguyen, 2007; Loyola, 2011). |
| **Evidence** | Not Available |

## Developer/Steward

| | |
|---|---|
| **Steward** | Centers for Medicare & Medicaid Services (CMS) |
| **Contact** | MMSSupport@Battelle.org |
| **Measure Developer** | Not specified |
| **Development Stage** | Fully Developed |

## Characteristics

| | |
|---|---|
| **Measure Type** | Composite |
| **Meaningful Measure Area** | Preventable Healthcare Harm |
| **Healthcare Priority** | Make Care Safer by Reducing Harm Caused in the Delivery of Care |
| **eCQM Spec Available** | No |
| **NQF Endorsement Status** | Endorsed |
| **NQF ID** | 0500 |
| **Last NQF Update** | 2017-07-13 |
| **Target Population Age** | 18+ |
| **Target Population Age (High)** | Not Available |
| **Target Population Age (Low)** | 18 |

# Severe Sepsis and Septic Shock: Management Bundle (Composite Measure)

| | |
|---|---|
| **Reporting Level** | Facility |
| **Conditions** | Infection |
| **Subconditions** | Sepsis |
| **Care Settings** | Hospital Inpatient; Hospital/Acute Care Facility |

## Groups

| | |
|---|---|
| **Core Measure Set** | Not Available |

| Measure Group | Group Identifier |
|---|---|
| SEP | |
| SEP | 1 |
| SEP | 01 |

## Measure Links

## Measure Program: Hospital Compare

| | |
|---|---|
| **Info As Of** | Not Available |
| **Program / Model Notes** | |
| **Data Sources** | Not Specified |
| **Purposes** | Not Available |
| **Quality Domain** | Patient Safety |
| **Reporting Frequency** | Not Available |

# Severe Sepsis and Septic Shock: Management Bundle (Composite Measure)

| | |
|---|---|
| **Impacts Payment** | Not Available |
| **Reporting Status** | Inactive |
| **Data Reporting Begin Date** | 2016-10-01 |
| **Data Reporting End Date** | 2017-10-01 |

## Measure Program Links

https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HospitalQualityInits/HospitalCompare

## Milestones

### Milestone: Implemented

| | |
|---|---|
| **Effective Date** | 2016-10-01 |
| **Comments** | Not Available |
| **Milestone Links** | http://www.gpo.gov/fdsys/pkg/FR-2014-08-22/pdf/2014-18545.pdf |

### Milestone: Finalized

| | |
|---|---|
| **Effective Date** | 2014-08-22 |
| **Comments** | Not Available |
| **Milestone Links** | http://www.gpo.gov/fdsys/pkg/FR-2015-08-17/pdf/2015-19049.pdf |

### Milestone: Reference

| | |
|---|---|
| **Effective Date** | 1900-01-01 |
| **Comments** | Not Available |
| **Milestone Links** | https://www.medicare.gov/hospitalcompare/search.html<br><br>http://www.qualitynet.org/dcs/ContentServer? |

# Severe Sepsis and Septic Shock: Management Bundle (Composite Measure)

c=Page&pagename=QnetPublic%2FPage%2FQnetTier4&cid=1228775436944

## Measure Program: Hospital Inpatient Quality Reporting

| | |
|---|---|
| **Info As Of** | Not Available |
| **Program / Model Notes** | |
| **Data Sources** | Not Available |
| **Purposes** | Not Available |
| **Quality Domain** | Patient Safety |
| **Reporting Frequency** | Not Available |
| **Impacts Payment** | No |
| **Reporting Status** | Active |
| **Data Reporting Begin Date** | 2016-01-01 |
| **Data Reporting End Date** | Not Available |

## Measure Program Links

https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HospitalQualityInits/HospitalRHQDAPU.html

## Milestones

### Milestone: Implemented

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| **Effective Date** | 2016-10-01 |
| **Comments** | Not Available |

### Milestone: Finalized

# Severe Sepsis and Septic Shock: Management Bundle (Composite Measure)

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| **Effective Date** | 2014-08-22 |
| **Comments** | Not Available |

# Measure #2: Transition Record with Specified Elements Received by Discharged Patients

**(Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)**

**(facility-level measure; included in bundled measure set: Measures 1, 2, & 3)**

*Care Transitions*

## Measure Description

Percentage of patients, regardless of age, discharged from an inpatient facility (eg, hospital inpatient or observation, skilled nursing facility, or rehabilitation facility) to home or any other site of care, or their caregiver(s), who received a transition record (and with whom a review of all included information was documented) at the time of discharge including, at a minimum, *all* of the specified elements

## Measure Components

**Numerator Statement**

- **See "Additional Information" for clarification of numerator elements and the bundling of measures 1, 2, & 3**

Patients or their caregiver(s) who received a transition record[a] (and with whom a review of all included information was documented) at the time of discharge including, at a minimum, *all* of the following elements:

Inpatient Care

- Reason for inpatient admission, AND
- Major procedures and tests performed during inpatient stay and summary of results, AND
- Principal diagnosis at discharge

Post-Discharge/ Patient Self-Management

- Current medication list,[b] AND
- Studies pending at discharge (eg, laboratory, radiological) , AND
- Patient instructions

Advance Care Plan

- Advance directives[c] or surrogate decision maker documented **OR** Documented reason for not providing advance care plan[d]

Contact Information/ Plan for Follow-up Care[e]

- 24-hour/7-day contact information including physician for emergencies related to inpatient stay, AND
- Contact information for obtaining results of studies pending at discharge, AND
- Plan for follow-up care,[f] AND
- Primary physician, other health care professional, or site designated for follow-up care[g]

Numerator Element Definitions*:*

a. Transition record: a core, standardized set of data elements related to patient's diagnosis, treatment, and care plan that is discussed with and provided to patient in printed or electronic format at each transition of care, and transmitted to the facility/physician/other health care professional providing follow-up care. Electronic format may be provided only if acceptable to patient.
b. Current medication list: all medications to be taken by patient after discharge, including all continued and new medications
c. Advance directives: eg, written statement of patient wishes regarding future use of life-

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| | sustaining medical treatment<br>d. Documented reason for not providing advance care plan: documentation that advance care plan was discussed but patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan, OR documentation as appropriate that the patient's cultural and/or spiritual beliefs preclude a discussion of advance care planning as it would be viewed as harmful to the patient's beliefs and thus harmful to the physician-patient relationship<br>e. Contact information/ plan for follow-up care: For patients discharged to an inpatient facility, the transition record may indicate that these four elements are to be discussed between the discharging and the "receiving" facilities.<br>f. Plan for follow-up care: may include any post-discharge therapy needed (eg, oxygen therapy, physical therapy, occupational therapy), any durable medical equipment needed, family/psychosocial resources available for patient support, etc.<br>g. Primary physician or other health care professional designated for follow-up care: may be designated primary care physician (PCP), medical specialist, or other physician or health care professional |
| **Denominator Statement** | All patients, regardless of age, discharged from an inpatient facility (eg, hospital inpatient or observation, skilled nursing facility, or rehabilitation facility) to home/self care or any other site of care |
| **Denominator Exclusions** | Patients who died<br>Patients who left against medical advice (AMA) or discontinued care |
| **Supporting Guideline & Other References** | The following evidence statements are quoted verbatim from the referenced clinical guidelines.<br><br>***Transition record***<br>All transitions must include a transition record. There is a minimal set of data elements that should always be part of the transition record:<br>– Principal diagnosis and problem list<br>– Medication list (reconciliation) including OTC/ herbals, allergies and drug interactions<br>– Clearly identifies the medical home/transferring coordinating physician/institution and their contact information<br>– Patient's cognitive status<br>– Test results/pending results<br>(TOCCC, 2008) [21]<br><br>Patients and/or their family/caregivers must receive, understand and be encouraged to participate in the development of their transition record which should take into consideration the patient's health literacy, insurance status and be culturally sensitive. (TOCCC, 2008)<br><br>**Standard PC.04.02.01**<br>When a [patient] is discharged or transferred, the [organization] gives information about the care, treatment, and services provided to the [patient] to other service providers who will provide the [patient] with care, treatment, or services.<br><br>• At the time of the patient's discharge or transfer, the hospital informs other service providers who will provide care, treatment, or services to the patient about the following:<br>- The reason for the patient's discharge or transfer<br>- The patient's physical and psychosocial status<br>- A summary of care, treatment, and services it provided to the patient<br>- The patient's progress toward goals<br>- A list of community resources or referrals made or provided to the patient<br>(See also PC.02.02.01, EP 1) (Joint Commission, 2009)[23] |

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| | **Standard PC.04.01.05**<br>Before the [organization] discharges or transfers a [patient], it informs and educates the [patient] about his or her follow-up care, treatment, and services.<br><br>1. When the hospital determines the patient's discharge or transfer needs, it promptly shares this information with the patient.<br><br>2. Before the patient is discharged, the hospital informs the patient of the kinds of continuing care, treatment, and services he or she will need.<br><br>3. When the patient is discharged or transferred, the hospital provides the patient with information about why he or she is being discharged or transferred.<br><br>5. Before the patient is transferred, the hospital provides the patient with information about any alternatives to the transfer.<br><br>7. The hospital educates the patient about how to obtain any continuing care, treatment, and services that he or she will need.<br><br>8. The hospital provides written discharge instructions in a manner that the patient and/or the patient's family or caregiver can understand. (See also RI.01.01.03, EP 1) (Joint Commission, 2009) [23] |

## Measure Importance

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| **Relationship to desired outcome** | Providing detailed discharge information enhances patients' preparation to self-manage post-discharge care and comply with treatment plans. Additionally, randomized trials have shown that many hospital readmissions can be prevented by patient education, predischarge assessment, and domiciliary aftercare.[20] One recent study found that patients participating in a hospital program providing detailed, personalized instructions at discharge, including a review of medication routines and assistance with arranging follow-up appointments, had 30% fewer subsequent emergency visits and hospital readmissions than patients who received usual care at discharge.[5] |
| **Opportunity for Improvement** | A prospective, cross-sectional study of discharged patients found that approximately 40% have pending test results at the time of discharge and that 10% of these require some action; yet outpatient physicians and patients are unaware of these results.[11] A more recent literature summary found that discharge summaries often lacked information important for follow-up care, including diagnostic test results (missing in 33-63% of summaries), treatment or hospital course (7-22%), discharge medications (2-40%), test results pending at discharge (65%), and follow-up plans (2-43%).[17] |
| **IOM Domains of Health Care Quality Addressed** [25] | • Safe<br>• Patient-centered<br>• Efficient<br>• Equitable |
| **Exclusion Justification** | Exclusions arise when patients who are included in the initial patient or eligible population for a measure do not meet the denominator criteria specific to the intervention required by the numerator. Exclusions are absolute and apply to all patients and therefore are not part of clinical judgment within a measure. Patients who expired and patients who left against medical advice (AMA) are categorized by inpatient facilities as having been "discharged" (with specific discharge status codes) and must therefore be excluded from the denominators for these measures. The Care Transitions Work Group acknowledges that it may be feasible to provide patients who leave AMA with a medication list and transition record (and to transmit this information to the facility/physician providing follow-up care), but not necessarily with the level of detail specified in |

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| | these measures. |
| **Harmonization with Existing Measures** | Harmonization with existing measures was not applicable to this measure. |

## Measure Designation

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| **Measure purpose** | • Quality Improvement<br>• Accountability |
| **Type of measure** | • Process |
| **Level of Measurement** | • Facility |
| **Care setting** | • Discharge from an inpatient facility (eg, hospital inpatient or observation, skilled nursing facility, or rehabilitation facility) |
| **Data source** | • Administrative data<br>• Medical record<br>• Electronic health record system<br>• Retrospective data collection flowsheet |

## Technical Specifications: Administrative Data

Administrative claims data collection requires users to identify the eligible population (denominator) and numerator using medical record abstraction (electronic or paper). Users report a rate based on all patients in a given practice for whom data are available and who meet the eligible population/denominator criteria.
The specifications listed below are those needed for performance calculation.
Note: Facilities are responsible for determining the appropriate use of codes.

| | **Facility-Level Specifications** |
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| **Denominator (Eligible Population)** | Identify patients discharged from inpatient facility using the following:<br>UB-04 (Form Locator 04 - Type of Bill):<br>• 0111 (Hospital Inpatient (Including Medicare Part A), Admit through Discharge Claim)<br>• 0114 (Hospital Inpatient (Including Medicare Part A), Interim - Last Claim)<br>• 0121 (Hospital Inpatient (Medicare Part B only), Admit through Discharge Claim)<br>• 0124 (Hospital Inpatient (Medicare Part B only), Interim - Last Claim)<br>• 0181 (Hospital - Swing Beds, Admit through Discharge Claim)<br>• 0184 (Hospital - Swing Beds, Interim - Last Claim)<br>• 0211 (Skilled Nursing-Inpatient (Including Medicare Part A), Admit through Discharge Claim)<br>• 0214 (Skilled Nursing-Inpatient (Including Medicare Part A), Interim - Last Claim)<br>• 0221 (Skilled Nursing-Inpatient (Medicare Part B only), Admit through Discharge Claim)<br>• 0224 (Skilled Nursing- Inpatient (Medicare Part B only), Interim - Last Claim)<br>• 0281 (Skilled Nursing-Swing Beds, Admit through Discharge Claim)<br>• 0284 (Skilled Nursing-Swing Beds, Interim - Last Claim)<br>AND<br>Discharge Status (Form Locator 17)<br>• 01 (Discharged to home or self care (routine discharge)<br>• 02 (Discharged/transferred to a short term general hospital for inpatient care)<br>• 03 (Discharged/transferred to skilled nursing facility (SNF) with Medicare certification in anticipation of skilled care)<br>• 04 (Discharged/transferred to a facility that provides custodial or supportive care)<br>• 05 (Discharged/transferred to a designated cancer center or children's hospital)<br>• 06 (Discharged/transferred to home under care of an organized home health |

service organization in anticipation of covered skilled care)
- 21 (Discharged/transferred to court/law enforcement)
- 43 (Discharged/transferred to a federal health care facility)
- 50 (Hospice – home)
- 51 (Hospice - medical facility (certified) providing hospice level of care)
- 61 (Discharged/transferred to hospital-based Medicare approved swing bed)
- 62 (Discharged/transferred to an inpatient rehabilitation facility (IRF) including rehabilitation distinct part units of a hospital)
- 63 (Discharged/transferred to a Medicare certified long term care hospital (LTCH))
- 64 (Discharged/transferred to a nursing facility certified under Medicaid but not certified under Medicare)
- 65 (Discharged/transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital)
- 66 (Discharged/transferred to a Critical Access Hospital (CAH))
- 69 (Discharged/transferred to a designated disaster alternative care site)
- 70 (Discharged/transferred to another type of health care institution not defined elsewhere in this code list)
- 81 (Discharged to home or self care with a planned acute care hospital inpatient readmission)
- 82 (Discharged/transferred to a short term general hospital for inpatient care with a planned acute care hospital inpatient readmission)
- 83 (Discharged/transferred to a skilled nursing facility (SNF) with Medicare certification with a planned acute care hospital inpatient readmission)
- 84 (Discharged/transferred to a facility that provides custodial or supportive care with a planned acute care hospital inpatient readmission)
- 85 (Discharged/transferred to a designated cancer center or children's hospital with a planned acute care hospital inpatient readmission)
- 86 (Discharged/transferred to home under care of organized home health service organization with a planned acute care hospital inpatient readmission)
- 87 (Discharged/transferred to court/law enforcement with a planned acute care hospital inpatient readmission)
- 88 (Discharged/transferred to a federal health care facility with a planned acute care hospital inpatient readmission
- 89 (Discharged/transferred to a hospital-based Medicare approved swing bed with a planned acute care hospital inpatient readmission)
- 90 (Discharged/transferred to an inpatient rehabilitation facility (IRF) including rehabilitation distinct part units of a hospital with a planned acute care hospital inpatient readmission)
- 91 (Discharged/transferred to a Medicare certified long term care hospital (LTCH) with a planned acute care hospital inpatient readmission)
- 92 (Discharged/transferred to nursing facility certified under Medicaid but not certified under Medicare with a planned acute care hospital inpatient readmission)
- 93 (Discharged/transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital with a planned acute care hospital inpatient readmission)
- 94 (Discharged/transferred to a critical access hospital (CAH) with a planned acute care hospital inpatient readmission)
- 95 (Discharged/transferred to another type of health care institution not defined elsewhere in this code list with a planned acute care hospital inpatient readmission)

OR

UB-04 (Form Locator 04 - Type of Bill):

- 0131 (Hospital Outpatient, Admit through Discharge Claim)
- 0134 (Hospital Outpatient, Interim - Last Claim)

AND
UB-04 (Form Locator 42 - Revenue Code):

- 0762 (Hospital Observation)
- 0490 (Ambulatory Surgery)
- 0499 (Other Ambulatory Surgery)

AND
Discharge Status (Form Locator 17)

- 01 (Discharged to home or self care (routine discharge)
- 02 (Discharged/transferred to a short term general hospital for inpatient care)
- 03 (Discharged/transferred to skilled nursing facility (SNF) with Medicare certification in anticipation of skilled care)
- 04 (Discharged/transferred to a facility that provides custodial or supportive care)
- 05 (Discharged/transferred to a designated cancer center or children's hospital
- 06 (Discharged/transferred to home under care of an organized home health service organization in anticipation of covered skilled care)
- 21 (Discharged/transferred to court/law enforcement)
- 43 (Discharged/transferred to a federal health care facility)
- 50 (Hospice – home)
- 51 (Hospice - medical facility (certified) providing hospice level of care)
- 61 (Discharged/transferred to hospital-based Medicare approved swing bed)
- 62 (Discharged/transferred to an inpatient rehabilitation facility (IRF) including rehabilitation distinct part units of a hospital)
- 63 (Discharged/transferred to a Medicare certified long term care hospital (LTCH))
- 64 (Discharged/transferred to a nursing facility certified under Medicaid but not certified under Medicare)
- 65 (Discharged/transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital)
- 66 (Discharged/transferred to a Critical Access Hospital (CAH))
- 69 (Discharged/transferred to a designated disaster alternative care site)
- 70 (Discharged/transferred to another type of health care institution not defined elsewhere in this code list)
- 81 (Discharged to home or self-care with a planned acute care hospital inpatient readmission)
- 82 (Discharged/transferred to a short term general hospital for inpatient care with a planned acute care hospital inpatient readmission)
- 83 (Discharged/transferred to a skilled nursing facility (SNF) with Medicare certification with a planned acute care hospital inpatient readmission)
- 84 (Discharged/transferred to a facility that provides custodial or supportive care with a planned acute care hospital inpatient readmission)
- 85 (Discharged/transferred to a designated cancer center or children's hospital with a planned acute care hospital inpatient readmission)
- 86 (Discharged/transferred to home under care of organized home health service organization with a planned acute care hospital inpatient readmission)
- 87 (Discharged/transferred to court/law enforcement with a planned acute care hospital inpatient readmission)
- 88 (Discharged/transferred to a federal health care facility with a planned acute care hospital inpatient readmission
- 89 (Discharged/transferred to a hospital-based Medicare approved swing bed

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| | with a planned acute care hospital inpatient readmission)<br>• 90 (Discharged/transferred to an inpatient rehabilitation facility (IRF) including rehabilitation distinct part units of a hospital with a planned acute care hospital inpatient readmission)<br>• 91 (Discharged/transferred to a Medicare certified long term care hospital (LTCH) with a planned acute care hospital inpatient readmission)<br>• 92 (Discharged/transferred to nursing facility certified under Medicaid but not certified under Medicare with a planned acute care hospital inpatient readmission)<br>• 93 (Discharged/transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital with a planned acute care hospital inpatient readmission)<br>• 94 (Discharged/transferred to a critical access hospital (CAH) with a planned acute care hospital inpatient readmission)<br>• 95 (Discharged/transferred to another type of health care institution not defined elsewhere in this code list with a planned acute care hospital inpatient readmission) |
| **Numerator** | **Numerator Elements to be identified through medical record abstraction:**<br><br>See Sample Data Collection Tool below. |
| **Denominator Exclusions** | UB-04 (Form Locator 17 - Discharge Status):<br>• 07 (Left against medical advice or discontinued care)<br>• 20 (Expired)<br>• 40 (Expired at home)<br>• 41 (Expired in a medical facility (e.g. hospital, SNF, ICF, or free standing hospice))<br>• 42 (Expired-place unknown) |

## Technical Specifications: Electronic Health Record System

The PCPI seeks to facilitate the integration of its measures into electronic health record (EHR) systems, registries, and applications used by physicians and other health care professionals that improve health care quality and prevent medical errors. In particular, it is valuable to have data for measurement and improvement available at the point of care and for practice-wide or facility-wide analysis as well as for external reporting.

The Care Transitions measures do not lend themselves to a "traditional specification" for EHR reporting, where data elements, logic and clinical coding are identified to calculate the measure, due to the fact the fact that every facility may have a different template for a transition record and the information required for this measure is based on individualized patient information unique to one episode of care (ie, inpatient stay). We have provided guidance on how a facility should query the electronic health record for the information required for this measure.

As the quality measures arena moves forward with EHR reporting, the Care Transitions measures will be aligned with the ONC Health IT Standards Committee (HITSC) recommendations that certain vocabulary standards be used for quality measure reporting, in accordance with the Quality Data Model (https://ecqi.healthit.gov/qdm).

Producing the Transition Record with Specified Elements

Facilities that have implemented an EHR should utilize their system to produce a standardized template that providers will complete to generate the Transition Record. A standardized template will ensure that all data elements specified in the performance measure are included each time a Transition Record is prepared. Each facility has the autonomy to customize the format of the Transition Record, based on clinical workflow, policies and procedures, and the patient population treated at the individual institution

Transmitting the Transition Record with Specified Elements

This performance measure does not require that the Transition Record be transmitted to the next provider(s) of care. However, if the Transition Record is transmitted to the next provider(s) of care, it should be done so in accordance with established approved standards for interoperability. The ONC Health IT Standards Committee (HITSC) has recommended that certain vocabulary standards are used for quality measure reporting, in accordance with the Quality Data Model. In addition, the use of recognized interoperability standards for the transmission of the Transition Record information will ensure that the information can be received into the destination EHR.

Systematic External Reporting of the Transition Record

In order to report, at the facility level, which of the discharged patients have received a Transition Record, a discrete data field and code indicating the patient received a Transition Record at discharge may be needed in the EHR.

## Technical Specifications: Retrospective Data Collection Flowsheet

This form is intended to be used for patients who were discharged from the inpatient setting, does not include patients that left against medical advice (AMA) or patients that expired during their inpatient visit.

**Transition Record with Specified Elements Received by Discharged Patients**
*and*
**Timely Transmission of Transition Record**
**(Inpatient Discharges to Home/Self Care or Any Other Site of Care)**

**Patient Name:**

**Medical Record Number or other patient identifier:**

**Date of Discharge:**

**Numerator:**

| | | Yes | No | Instructions |
|---|---|---|---|---|
| **Transition Record with all of the specified elements** | **Did patient receive a Transition Record at discharge?** *(Underlined terms are defined below)* | | | If yes, answer questions below to determine that all appropriate elements were included in the Transition Record. |
| | **Are the following elements included in Transition Record?** | **Yes** | **No** | If a given element does not apply to patient, transition record should state the same (eg, no pending studies at discharge) |
| **Inpatient Care** | Reason for inpatient admission | | | |
| | Major procedures and tests, including summary of results | | | |
| | Principal diagnosis at discharge | | | |
| **Post-Discharge/ Patient Self-Management** | Current Medication List | | | |
| | Studies Pending at Discharge (or documentation that no studies are pending) | | | |
| | Patient Instructions | | | |
| **Advance Care Plan** | Advance directives or surrogate decision maker documented OR Documented reason for not providing advance care plan | | | |
| **Contact Information/ Plan for Follow-Up Care** | 24-hour/7-day contact information including physician for emergencies related to inpatient stay | | | |
| | Contact information for obtaining results of studies pending at discharge | | | |
| | Plan for follow-up care | | | |
| | Primary physician, other health care professional, or site designated for follow-up care | | | |

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| **Transition Record with all of the specified elements** | **Are ALL specified elements included in the transition record?** | | | *Review responses above to determine if all elements were included in transition record* |

| | | | |
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| **Discharge Information** | Date and time patient was discharged from facility | | |
| | Date and time Transition Record was transmitted to receiving facility, or physician, or other health care professional | | |
| | Was Transition Record transmitted within 24 hours of discharge? | **Yes** | **No** |
| | | | |

**Definition of Terms:**

| | |
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| **Transition record** | A core, standardized set of data elements related to patient's diagnosis, treatment, and care plan that is discussed with and provided to patient in a printed or electronic format at each transition of care, and transmitted to the facility/physician/other health care professional providing follow-up care. The Transition record may be provided only in electronic format if acceptable to patient. |
| **Current medication list** | All medications to be taken by patient after discharge, including all continued and new medications |
| **Advance directives** | eg, written statement of patient wishes regarding future use of life-sustaining medical treatment |
| **Documented reason for not providing advance care plan** | Documentation that advance care plan was discussed but patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan, OR documentation as appropriate that the patient's cultural and/or spiritual beliefs preclude a discussion of advance care planning as it would be viewed as harmful to the patient's beliefs and thus harmful to the physician-patient relationship |
| **Contact information/ plan for follow-up care** | For patients discharged to an inpatient facility, the transition record may indicate that these four elements are to be discussed between the discharging and the "receiving" facilities. |
| **Plan for follow-up care** | May include any post-discharge therapy needed (eg, oxygen therapy, physical therapy, occupational therapy), any durable medical equipment needed, family/psychosocial resources available for patient support, etc. |
| **Primary physician or other health care professional designated for follow-up care** | May be designated primary care physician (PCP), medical specialist, or other physician or health care professional |
| **Transmitted** | Transition record may be transmitted to the facility or physician or other health care professional designated for follow-up care via fax, secure e-mail, or mutual access to an electronic health record (EHR). |

## Additional Information

By requiring the completion and prompt transmission of a detailed "transition record" for discharged patients, these measures are promoting a significant enhancement to the customary use of the "discharge summary," the traditional means of information transfer for which existing standards require completion within 30 days. Numerous studies have documented the prevalence of communication gaps and discontinuities in care for patients after discharge,[9-11] and the significant effect of these lapses on hospital readmissions and other indicators of the quality of transitional care.[17-20] Current information and communication technology can facilitate the routine completion and transmission of a transition record within 24 hours of discharge, which could greatly reduce communication gaps and may have a positive downstream effect on patient outcomes.

Consistent with the cited Joint Commission standards, the information in the transition record should be provided in a manner that can be understood by patients or their caregivers. Patient/caregiver understanding of this information may be assessed by various methods, including "teach-back."

Measures 1, 2, & 3 address closely related, interdependent aspects of the transition in care for patients discharged from an inpatient facility and are therefore proposed as a bundled set of measures. The intent of this proposal is that the measures always be used together when assessing performance; no one of these measures should be selected for use independently. The bundling of the measures is *not* intended to suggest the use of any particular scoring methodology (ie, a composite score), nor does it imply either equality or difference in the relative "weights" of the three measures. A performance score for each of the three measures should be reported individually.

This rationale and methodology for a measure bundle are consistent with the definitions for "bundle" and "composite" provided by the Institute for Healthcare Improvement (IHI):

> Bundle – a series of interventions related to a specific condition that, when implemented together, will achieve significantly better outcomes than when implemented individually.
>
> Composite measure – a combination of two or more individual measures into a single measure that results in a single score. (www.ihi.org)