OHIC Measure Alignment Work Group
2023 Annual Review of the ACO Aligned Measure Set
Measure Specifications

Breast Cancer Screening (BCS-E)

SUMMARY OF CHANGES TO HEDIS MY 2023

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

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

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

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

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

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

Data criteria (element level)

Value Sets:

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

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

Direct reference codes and codesystems:

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

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

Data Elements for Reporting

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

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

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

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

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

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

Metric
BreastCancerScreening

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

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

Metric
BreastCancerScreening

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

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

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

Rules for Allowable Adjustments of HEDIS

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

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

Rules for Allowable Adjustments of Breast Cancer Screening—ECDS

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

CAHPS® Clinician & Group Survey with Patient-Centered Medical Home Items

Version: 3.0

Population: Adult

Language: English

Notes

- **Patient-Centered Medical Home (PCMH) items.** This version of the Clinician & Group Survey includes the 3.0 version of PCMH items. PCMH items have been incorporated into the core items; for easy identification, they are highlighted in yellow.
- **References to "this provider" rather than "this doctor:"** This survey uses "this provider" to refer to the individual specifically named in Question 1. A "provider" could be a doctor, nurse practitioner, physician assistant, or other individual who provides clinical care. Survey users may change "provider" to "doctor" throughout the questionnaire. For guidance, please see **Preparing a Questionnaire Using the CAHPS Clinician & Group Survey**.
- **Supplemental items:** Survey users may add questions to this survey. Please visit the CAHPS Web site to review supplemental items developed by the CAHPS Consortium and descriptions of major item sets.

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

File name: adult-eng-cg30-PCMH-2352a.docx
Last updated: October 30, 2020

Instructions for Front Cover

- Replace the cover of this document with your own front cover. Include a user-friendly title and your own logo.
- Include this text regarding the confidentiality of survey responses:

  Your Privacy is Protected. All information that would let someone identify you or your family will be kept private. {VENDOR NAME} will not share your personal information with anyone without your OK. Your responses to this survey are also completely **confidential**. You may notice a number on the cover of the survey. This number is used **only** to let us know if you returned your survey so we don't have to send you reminders.

  Your Participation is Voluntary. You may choose to answer this survey or not. If you choose not to, this will not affect the health care you get.

  What To Do When You're Done. Once you complete the survey, place it in the envelope that was provided, seal the envelope, and return the envelope to [INSERT VENDOR ADDRESS].

  If you want to know more about this study, please call XXX-XXX-XXXX.

Instructions for Format of Questionnaire

Proper formatting of a questionnaire improves response rates, the ease of completion, and the accuracy of responses. The CAHPS team's recommendations include the following:

- If feasible, insert blank pages as needed so that the survey instructions (see next page) and the first page of questions start on the right-hand side of the questionnaire booklet.
- Maximize readability by using two columns, serif fonts for the questions, and ample white space.
- Number the pages of your document, but remove the headers and footers inserted to help sponsors and vendors distinguish among questionnaire versions.

Additional guidance is available in **Preparing a Questionnaire Using the CAHPS Clinician & Group Survey**.

Survey Instructions

Answer each question by marking the box to the left of your answer.

You are sometimes told to skip over 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:

☒ Yes → **If Yes, go to #1 on page 1**
☐ No

Your Provider

1. 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 #29 on page 4**

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?

[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 #29 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 on page 2**

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. Did this provider's office give you information about what to do if you needed care during evenings, weekends, or holidays?

1 ☐ Yes
2 ☐ No

10. 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 #12**

11. 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

12. 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

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

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

14. 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

15. 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

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

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

17. 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 #19**

18. 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

19. 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

20. Specialists are doctors like surgeons, heart doctors, allergy doctors, skin doctors, and other doctors who specialize in one area of health care. In the last 6 months, did you see a specialist for a particular health problem?

[1] ☐ Yes
[2] ☐ No → **If No, go to #22**

21. In the last 6 months, how often did the provider named in Question 1 seem informed and up-to-date about the care you got from specialists?

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

Please answer these questions about the provider named in Question 1 of this survey.

22. In the last 6 months, did someone from this providers' office talk with you about specific goals for your health?

[1] ☐ Yes
[2] ☐ No

23. In the last 6 months, did someone from this providers' office as you if there are things that make it hard for you to take care of your health?

[1] ☐ Yes
[2] ☐ No

24. In the last 6 months, did you and someone from this provider's office talk about things in your life that worry you or cause you stress?

[1] ☐ Yes
[2] ☐ No

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

[1] ☐ Yes
[2] ☐ No → **If No, go to #27 on page 4**

26. 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

27. 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

28. 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

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

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

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

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

31. 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

32. Are you male or female?

1 ☐ Male
2 ☐ Female

33. 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

34. Are you of Hispanic or Latino origin or descent?

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

35. 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

36. Did someone help you complete this survey?

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

37. 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.

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

CAHPS Clinician & Group Survey

Version: Adult Visit Survey 4.0 (beta)

Language: English

Notes

- **Purpose of Visit Survey 4.0 (beta):** This new version of the Clinician & Group Survey asks patients about their experiences with care at their most recent visit with an ambulatory care provider. The CAHPS team developed this version to support users in asking about all synchronous visits, including interactions in person, by phone, or by video.
- **Beta designation:** The "beta" designation means that the instrument has not yet been field tested by the CAHPS Consortium or approved as a CAHPS survey.
- **Front cover**: Users should replace the cover of this document with their own front cover, with a user-friendly title and their own logo.

Learn more about this survey at https://www.ahrq.gov/cahps/surveys-guidance/cg/index.html. For assistance with this survey, please contact the CAHPS Help Line at 800-492-9261 or cahps1@westat.com.

cahps®
File name: adult-eng-cg40-3351a.docx
Last updated: October 30, 2020

Your Provider

1. Visits with a health care provider can be **in person, by phone, or by video.** Our records show that you had a recent visit with the provider named below.

Name of provider label goes here

Is that right?

[1] ☐ Yes
[2] ☐ No → **If No, go to #25 on page 3**

Please think of this provider as you answer the survey.

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

[1] ☐ Yes
[2] ☐ No

3. How long has it been since your most recent in-person, phone, or video visit with this provider?

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

These questions ask about your most recent visit with this provider.

4. Was your most recent visit with this provider **in person?**

[1] ☐ Yes → **If Yes, go to #11 on page 2**
[2] ☐ No

5. Was your most recent visit with this provider a **video visit?**

[1] ☐ Yes
[2] ☐ No → **If No, go to #9**

6. Did you need instructions from this provider's office about how to use video for this visit?

[1] ☐ Yes
[2] ☐ No → **If No, go to #8**

7. Did this provider's office give you all the instructions you needed to use video for this visit?

[1] ☐ Yes, definitely
[2] ☐ Yes, somewhat
[3] ☐ No

8. During your most recent visit, was the video easy to use?

[1] ☐ Yes, definitely → **Go to #10**
[2] ☐ Yes, somewhat → **Go to #10**
[3] ☐ No → **Go to #10**

9. Was your most recent visit with this provider by **phone**?

[1] ☐ Yes
[2] ☐ No → **If No, go to #11 on page 2**

10. During your most recent visit, were you and this provider able to hear each other clearly?

[1] ☐ Yes, definitely
[2] ☐ Yes, somewhat
[3] ☐ No

11. Was your most recent visit for an illness, injury, or condition that **needed care right away**?

[1] ☐ Yes
[2] ☐ No → **If No, go to #13**

12. Was that recent visit as soon as you needed?

[1] ☐ Yes, definitely
[2] ☐ Yes, somewhat
[3] ☐ No

13. Did your most recent visit start on time?

[1] ☐ Yes, definitely
[2] ☐ Yes, somewhat
[3] ☐ No

14. During your most recent visit, did this provider explain things in a way that was easy to understand?

[1] ☐ Yes, definitely
[2] ☐ Yes, somewhat
[3] ☐ No

15. During your most recent visit, did this provider listen carefully to you?

[1] ☐ Yes, definitely
[2] ☐ Yes, somewhat
[3] ☐ No

16. During your most recent visit, did this provider show respect for what you had to say?

[1] ☐ Yes, definitely
[2] ☐ Yes, somewhat
[3] ☐ No

17. During your most recent visit, did this provider spend enough time with you?

[1] ☐ Yes, definitely
[2] ☐ Yes, somewhat
[3] ☐ No

18. During your most recent visit, did this provider have the medical information they needed about you?

[1] ☐ Yes, definitely
[2] ☐ Yes, somewhat
[3] ☐ No

19. During your most recent visit, did this provider order a blood test, x-ray, or other test for you?

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

20. Did someone from this provider's office follow up to give you those results?

[1] ☐ Yes
[2] ☐ No

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

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

Staff at Provider's Office

22. Staff at a provider's office may talk with you about your visit, help set it up, and remind you about your appointment. Thinking about your most recent visit, did you talk to staff from this provider's office?

1 ☐ Yes
2 ☐ No → **If No, go to #25**

23. Thinking about your most recent visit, was the staff from this provider's office as helpful as you thought they should be?

1 ☐ Yes, definitely
2 ☐ Yes, somewhat
3 ☐ No

24. Thinking about your most recent visit, did the staff from this provider's office treat you with courtesy and respect?

1 ☐ Yes, definitely
2 ☐ Yes, somewhat
3 ☐ No

About You

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

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

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

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

27. 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

28. Are you male or female?

1 ☐ Male
2 ☐ Female

29. 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

30. Are you of Hispanic or Latino origin or descent?

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

31. 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

32. Did someone help you complete this survey?

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

33. 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.

Cervical Cancer Screening (CCS)

SUMMARY OF CHANGES TO HEDIS MY 2023

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

Description

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

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

Eligible Population

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

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

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

Administrative Specification

Denominator The eligible population.

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

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

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

Hybrid Specification

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Data Elements for Reporting

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

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

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

Rules for Allowable Adjustments of HEDIS

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

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

Rules for Allowable Adjustments of Cervical Cancer Screening

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

Child and Adolescent Well-Care Visits (WCV)

SUMMARY OF CHANGES TO HEDIS MY 2023

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

Description

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

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

Eligible Population

Product lines

Commercial, Medicaid (report each product line separately).

Stratifications

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

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

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

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

Administrative Specification

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

Note

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

Data Elements for Reporting

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

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

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

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

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

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

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

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

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

Rules for Allowable Adjustments of HEDIS

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

Chlamydia Screening in Women (CHL)

SUMMARY OF CHANGES TO HEDIS MY 2023

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

Description

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

Eligible Population

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

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

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

The total is the sum of the age stratifications.

Continuous enrollment The measurement year.

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

Anchor date December 31 of the measurement year.

Benefit Medical.

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

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

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

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

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

Contraceptive Medications

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

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

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

Retinoid Medications

Description	Prescription
Retinoid	Isotretinoin

Required exclusions

Exclude members who meet either of the following criteria:

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

Administrative Specification

Denominator The eligible population.

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

Data Elements for Reporting

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

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

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

Rules for Allowable Adjustments of HEDIS

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

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

Rules for Allowable Adjustments of Chlamydia Screening in Women

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

Colorectal Cancer Screening (COL)

SUMMARY OF CHANGES TO HEDIS MY 2023

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

Description

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

Note

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

Eligible Population

Product lines

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

Stratifications

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

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

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

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

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

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

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

Ages

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

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

The total is the sum of the age stratifications.

Continuous enrollment

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

Allowable gap

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

Anchor date

December 31 of the measurement year.

Benefit

Medical.

Event/diagnosis

None.

Required exclusions

Exclude members who meet any of the following criteria:

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

Exclusions

Exclude members who meet any of the following criteria:

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

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

Dementia Medications

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

Administrative Specification

Denominator The eligible population.

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

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

Hybrid Specification

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

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

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

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

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

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

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

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

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

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

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

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

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

Data Elements for Reporting

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Rules for Allowable Adjustments of HEDIS

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

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

Rules for Allowable Adjustments of Colorectal Cancer Screening

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

Controlling High Blood Pressure (CBP)

SUMMARY OF CHANGES TO HEDIS MY 2023

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

Description

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

Definitions

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

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

Eligible Population

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

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

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

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

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

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

Continuous enrollment The measurement year.

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

Anchor date December 31 of the measurement year.

Benefit Medical.

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

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

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

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

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

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

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

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

Exclusions

Exclude members who meet any of the following criteria:

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

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

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

Dementia Medications

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

Administrative Specification

Denominator The eligible population.

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

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

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

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

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

Hybrid Specification

Denominator

A systematic sample drawn from the eligible population.

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

Identifying the medical record

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

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

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

Numerator

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

Administrative

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

Medical record

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

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

Do not include BP readings:

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

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

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

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

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

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

Note

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

Data Elements for Reporting

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

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

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

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

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

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

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

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

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

Rules for Allowable Adjustments of HEDIS

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

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

Rules for Allowable Adjustments of Controlling High Blood Pressure

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

*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. • *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. • *Depression Remission*. The percentage of members who achieved remission within 4–8 months after the initial elevated PHQ-9 score. • *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). 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. 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. – Product line: ▪ Commercial. ▪ Medicaid. ▪ Medicare. – Age (as of the start of the intake period, for each product line): ▪ 12–17 years (for commercial and Medicaid only). ▪ 18–44 years. ▪ 45–64 years. ▪ 65 years and older. • Depression Remission. – Product line: ▪ Commercial. ▪ Medicaid. ▪ Medicare. – Age (as of the start of the intake period, for each product line): ▪ 12–17 years (for commercial and Medicaid only). ▪ 18–44 years. ▪ 45–64 years. ▪ 65 years and older. • Depression Response. – Product line: ▪ Commercial. ▪ Medicaid. ▪ Medicare. – Age (as of the start of the intake period, for each product line): ▪ 12–17 years (for commercial and Medicaid only). ▪ 18–44 years. ▪ 45–64 years. ▪ 65 years and older.
Risk adjustment	None.
Improvement notation	A higher rate indicates better performance.

Guidance	**Allocation:** The member was enrolled with a medical benefit throughout the participation period. 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. 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. **Requirements:** The measure allows two PHQ-9 assessments. Selection of the appropriate assessment should be based on the member's age. • *PHQ-9:* 12 years of age and older. • *PHQ-9 Modified for Teens:* 12–17 years of age. 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. **Reporting:** The total is the sum of the age stratifications. 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** Members 12 years and older as of the start of the intake period who meet **both** of the following criteria: • The depression encounter and PHQ-9 total score requirements as described by the IESD. • Participation. **Initial population 2** Same as the initial population 1. **Initial population 3** Same as the initial population 1.
Exclusions	**Exclusions 1** Members with any of the following any time during the member's history through the end of the measurement period: • Bipolar disorder. • Personality disorder. • Psychotic disorder. • Pervasive developmental disorder. ***OR*** • Members in hospice or using hospice services any time during the measurement period. **Exclusions 2** Same as exclusions 1. **Exclusions 3** Same as exclusions 1.
Denominator	**Denominator 1** Initial population, minus exclusions. **Denominator 2** Same as denominator 1. **Denominator 3** Same as denominator 1.
Numerator	**Numerator 1—Depression Follow-Up** A PHQ-9 total score in the member's record during the depression follow-up period. **Numerator 2—Depression Remission** 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 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"). Changing the denominator age range is allowed if the limits are within the specified age range (12 years and older). The denominator age may not be expanded.
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 • Depression Remission • 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. • *Unhealthy Alcohol Use Screening*. The percentage of members who had a systematic screening for unhealthy alcohol use. • *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. – 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.

<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:
The member was enrolled with a medical benefit throughout the participation period.

When identifying members in hospice, the requirements described in General Guideline 15 for identification of hospice members using the monthly membership detail data files are not included in the measure calculation logic and need to be programmed manually.

Reporting:
The total is the sum of the age stratifications.

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
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:
“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:

Feedback on alcohol use and harms.
Identification of high-risk situations for drinking and coping strategies.
Increase the motivation to reduce drinking.
Development of a personal plan to reduce drinking.
Documentation of receiving alcohol misuse treatment.

</td></tr>
<tr><td>Initial population</td><td>Initial population 1
Members 18 years and older at the start of the measurement period who also meet criteria for participation.

Initial population 2
Same as the initial population 1.</td></tr>
<tr><td>Exclusions</td><td>Exclusions 1

Members with alcohol use disorder that starts during the year prior to the measurement period.
Members with history of dementia any time during the member’s history through the end of the measurement period.
Members in hospice or using hospice services any time during the measurement period.

Exclusions 2
Same as exclusions 1.</td></tr>
<tr><td>Denominator</td><td>Denominator 1
The initial population, minus exclusions.

Denominator 2
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
Members with a documented result for unhealthy alcohol use screening performed between January 1 and November 1 of the measurement period.

Numerator 2—Follow-Up Care on Positive Screen
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"). Changing the denominator age range is allowed if the limits are within the specified age range (18 years and older). Organizations must consult UPSTSF guidelines when considering whether to expand the age 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 • 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. • *Depression Screening.* The percentage of members who were screened for clinical depression using a standardized instrument. • *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) 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. 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. – Product line: ▪ Commercial. ▪ Medicaid. ▪ Medicare. – Age (as of the start of the measurement period, for each product line): ▪ 12–17 years (for commercial and Medicaid only). ▪ 18–64 years. ▪ 65 years and older. • Follow-Up on Positive Screen. – Product line: ▪ Commercial. ▪ Medicaid. ▪ Medicare. – Age (as of the start of the measurement period, for each product line): ▪ 12–17 years (for commercial and Medicaid only). ▪ 18–64 years. ▪ 65 years and older.
Risk adjustment	None.
Improvement notation	A higher rate indicates better performance.
Guidance	**Allocation:** The member was enrolled with a medical benefit throughout the participation period. When identifying members in hospice, the requirements described in *General Guideline 15* for identification of hospice members using the monthly membership detail data files are not included in the measure calculation logic and need to be programmed manually. **Requirements:** • This measure requires the use of an age-appropriate screening instrument. The member's age is used to select the appropriate depression screening instrument. • 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. **Reporting:** The total is the sum of the age stratifications. 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.
[2]Proprietary; may be cost or licensing requirement associated with use.
</td></tr>
<tr><td>Initial population</td><td>Initial population 1
Members 12 years of age and older at the start of the measurement period who also meet criteria for participation.

Initial population 2
Same as the initial population 1.</td></tr>
<tr><td>Exclusions</td><td>Exclusions 1
• 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.
• Members with depression that starts during the year prior to the measurement period.
• Members in hospice or using hospice services any time during the measurement period.

Exclusions 2
Same as exclusions 1.</td></tr>
<tr><td>Denominator</td><td>Denominator 1
The initial population, minus exclusions.

Denominator 2
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
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.

Numerator 2—Follow-Up on Positive Screen
Members who received follow-up care on or up to 30 days after the date of the first positive screen (31 total days).

Any of the following on or up to 30 days after the first positive screen:
• An outpatient, telephone, e-visit or virtual check-in follow-up visit with a diagnosis of depression or other behavioral health condition.
• 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. • A dispensed antidepressant medication. ***OR*** • 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. ***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). The denominator age may be changed if the range is within the specified age range (12 years and older). The denominator age may not be expanded.
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 • 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.
- When calculating the numerator, modified claims can be included depending on the intent of the modifier:
  - States can explore use of a modifier to indicate that a global developmental screening occurred. For example, Z13.42 can be used to indicate an "Encounter for screening for global developmental delays." Additional guidance on coding is available at: https://downloads.aap.org/AAP/PDF/coding_factsheet_developmentalscreeningtestingandEmotionalBehvioraassessment.pdf.
  - States should exclude a screening with a modifier if the intent of the modifier is to indicate that only a domain-specific screening occurred.
  - Modifiers that indicate that a screening was performed at a certain type of visit can be included.
- To facilitate CMS's understanding of the data reported for this measure, states should use the "Additional Notes/Comments on Measure" section to document whether a medical chart review was conducted to validate the use of the 96110 CPT code for this measure.
- States may calculate this measure using either the administrative specification (which depends on the 96110 CPT code) or the hybrid specification (which does not rely solely on this code).

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

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

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

B. ELIGIBLE POPULATION

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

C. GUIDANCE ON DEVELOPMENTAL SCREENING TOOLS

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

D. ADMINISTRATIVE SPECIFICATION

Denominator

Denominator 1

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

Denominator 2

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

Denominator 3

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

Denominator 4

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

Numerators

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

Numerator 1

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

Numerator 2

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

Numerator 3

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

Numerator 4

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

Claims data

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

Important note about appropriate use of claims data

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

Claims NOT included in this measure

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

Exclusions

None.

E. MEDICAL RECORD SPECIFICATION

Denominator

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

Denominator 1

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

Denominator 2

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

Denominator 3

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

Denominator 4

The entire sample of 411 children.

Numerators

Numerator 1

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

Numerator 2

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

Numerator 3

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

Numerator 4

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

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

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

Tools must meet the following criteria:

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

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

Example developmental screening tools that meet criteria for the measure

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

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

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

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

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

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

Tools that do NOT meet the criteria

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

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

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

Exclusions

None.

F. CALCULATION ALGORITHM

Step 1

Determine the denominators.

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

Step 2

Determine the numerators.

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

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

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

Step 3

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

Step 4

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

Total Numerator: Numerator 1 + Numerator 2 + Numerator 3

Total Denominator: Denominator 1 + Denominator 2 + Denominator 3

Sampling Methodology

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

G. OPTIONAL AGE-SPECIFIC OVERSAMPLING FOR THE DENOMINATOR

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

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

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

Eye Exam for Patients With Diabetes (EED)

SUMMARY OF CHANGES TO HEDIS MY 2023

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

Description

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

Eligible Population

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

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

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

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

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

Continuous enrollment The measurement year.

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

Anchor date December 31 of the measurement year.

Benefit Medical.

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

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

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

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

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

Diabetes Medications

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

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

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

Required exclusions

Exclude members who meet any of the following criteria:

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

Exclusions

Exclude members who meet any of the following criteria:

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

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

Dementia Medications

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

Administrative Specification

Denominator The eligible population.

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

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

Any of the following meet criteria:

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

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

Hybrid Specification

Denominator

A systematic sample drawn from the eligible population.

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

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

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

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

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

Numerator

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

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

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

Administrative

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

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

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

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

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

Note

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

Data Elements for Reporting

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

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

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

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

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

Rules for Allowable Adjustments of HEDIS

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

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

Rules for Allowable Adjustments of Eye Exam for Patients With Diabetes

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

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

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

SUMMARY OF CHANGES TO HEDIS MY 2023

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

Description

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

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

Eligible Population

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

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

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

The total is the sum of the age stratifications.

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

Allowable gap None.

Anchor date None.

Benefit Medical and mental health.

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

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

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

Multiple visits in a 31-day period

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

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

ED visits followed by inpatient admission

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

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

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

Required exclusions

Exclude members who meet either of the following criteria:

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

Administrative Specification

Denominator

The eligible population.

Numerators

30-Day Follow-Up

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

7-Day Follow-Up

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

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

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

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

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

Note

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

Data Elements for Reporting

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

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

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

Rules for Allowable Adjustments of HEDIS

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

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

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

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

*Follow-Up After 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). 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. ***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 • 7-Day Follow-Up	No	Value sets and logic may not be changed.

Follow-Up After Hospitalization for Mental Illness (FUH)

SUMMARY OF CHANGES TO HEDIS MY 2023

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

Description

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

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

Eligible Population

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

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

Acute readmission or direct transfer

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

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

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

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

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

Nonacute readmission or direct transfer

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

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

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

Required exclusions

Exclude members who meet either of the following criteria:

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

Administrative Specification

Denominator

The eligible population.

Numerators

30-Day Follow-Up

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

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

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

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

Note

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

Data Elements for Reporting

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

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

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

Rules for Allowable Adjustments of HEDIS

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

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

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

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

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

Background

OHIC's Aligned Measure Sets include three *Health Equity Measures* that stratify measure performance by REL. 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) Measures* 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 *Health Equity (REL) Measures* 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 first 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. ***For race***: Providers should use the following race categories proposed by NCQA for reporting stratified performance on select HEDIS measures for 2023: • White • Black • American Indian/Alaska Native

	• Asian • Native Hawaiian and Other Pacific Islander • Some Other Race • Two or More Races • Declined • Unknown ***For ethnicity***: Providers should use the following ethnicity categories proposed by NCQA for reporting stratified performance on select HEDIS measures for 2023: • Hispanic/Latino • Not Hispanic/Latino • Declined • Unknown 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. ***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] • English (en) • Spanish (es) • Portuguese (pt) • Other • Unknown ***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*:
	• the Agency for Healthcare Research and Quality[3] for:
	  ○ *Behavioral Health Risk Assessment*
	• CMS' 2023 Core Set of Children's Health Care Quality Measures for Medicaid and CHIP[4] for:
	  ○ *Developmental Screening in the First Three Years of Life*
	• CMS 2023 eCQM specifications for Eligible Professionals / Eligible

[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.

	Clinicians[5], which are designed for reporting by provider organizations for: ○ *Controlling High Blood Pressure* ○ *Eye Exam for Patients with Diabetes* ○ *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%) • CMS' Hospital Inpatient Readmission Measures for 2023[6] ○ *Hospital-Wide Readmit* • NCQA's HEDIS specifications for MY2023 (adapted for provider reporting using the Allowable Adjustments)[7] for: ○ *Prenatal and Postpartum Care*
Sample Reporting Template	 REL Measure Reporting Template

[5] See: https://ecqi.healthit.gov/ep-ec?qt-tabs_ep=1&globalyearfilter=2023.
[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.

Hemoglobin A1c Control for Patients With Diabetes (HBD)

SUMMARY OF CHANGES TO HEDIS MY 2023

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

Description

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

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

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

Eligible Population

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

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

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

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

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

Continuous enrollment The measurement year.

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

Anchor date December 31 of the measurement year.

Benefit Medical.

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

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

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

3. Identify the discharge date for the stay.

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

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

Diabetes Medications

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

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

Required exclusions

Exclude members who meet any of the following criteria:

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

Exclusions

Exclude members who meet any of the following criteria:

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

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

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

Dementia Medications

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

Administrative Specification

Denominator The eligible population.

Numerators

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

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

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

HbA1c Poor Control >9%

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

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

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

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

Hybrid Specification

Denominator

A systematic sample drawn from the eligible population.

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

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

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

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

Numerators

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

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

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

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

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

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

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

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

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

Note

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

Data Elements for Reporting

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

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

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

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

Metric
AdequateHbA1cControl
PoorHbA1cControl

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

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

Metric
AdequateHbA1cControl
PoorHbA1cControl

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

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

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

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

Rules for Allowable Adjustments of HEDIS

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

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

Rules for Allowable Adjustments of Hemoglobin A1c Control for Patients With Diabetes

NONCLINICAL COMPONENTS		
Eligible Population	**Adjustments Allowed (Yes/No)**	**Notes**
Product lines	Yes	Organizations are not required to use product line criteria; product lines may be combined and all (or no) product line criteria may be used.
Ages	Yes, with limits	Age determination dates may be changed (e.g., select, "age as of June 30"). Changing denominator age range is allowed within a specified age range (ages 18–75 years). The denominator age may not be expanded.
Continuous enrollment, allowable gap, anchor date	Yes	Organizations are not required to use enrollment criteria; adjustments are allowed.
Benefits	Yes	Organizations are not required to use a benefit; adjustments are allowed.
Other	Yes	Organizations may use additional eligible population criteria to focus on an area of interest defined by gender, race, ethnicity, socioeconomic or sociodemographic characteristics, geographic region or another characteristic.
CLINICAL COMPONENTS		
Eligible Population	**Adjustments Allowed (Yes/No)**	**Notes**
Event/diagnosis	No	Only events or diagnoses that contain (or map to) codes in the medication lists and value sets may be used to identify visits. Medication lists, value sets and logic may not be changed.
Denominator Exclusions	**Adjustments Allowed (Yes/No)**	**Notes**
Required exclusions	Yes, with limits	Apply required exclusions according to specified value sets. The hospice, deceased member and palliative care exclusions are not required. Refer to *Exclusions* in the *Guidelines for the Rules for Allowable Adjustments*.
Exclusions: I-SNP, LTI, frailty or advanced illness	Yes	These exclusions are not required. Refer to *Exclusions* in the *Guidelines for the Rules for Allowable Adjustments*.
Numerator Criteria	**Adjustments Allowed (Yes/No)**	**Notes**
• HbA1c Control (<8.0%) • HbA1c Poor Control (>9.0%)	No	Value sets and logic may not be changed.

Hybrid Hospital-Wide Readmission Measure with Claims and Electronic Health Record Data

CMIT Measure ID: 356 | **CMIT ID:** 00356-07-C-HIQR | **Measure Type:** Outcome

Date of Information: 11/15/2022 | **Revision:** 5 | **Program:** Hospital Inpatient Quality Reporting

View Description

Properties

Date of Information	11/15/2022
Abbreviated Measure Title	Not Available
Description	This measure estimates a hospital-level, risk-standardized readmission rate (RSRR) of unplanned, all-cause readmission within 30 days of hospital discharge for any eligible condition. The measure reports a single summary RSRR, derived from the volume-weighted results of five different models, one for each of the following specialty cohorts based on groups of discharge condition categories or procedure categories: surgery/gynecology, general medicine, cardiorespiratory, cardiovascular, and neurology. The outcome is defined as unplanned readmission for any cause within 30 days of the discharge date for the index admission (the admission included in the measure cohort). A specified set of readmissions are planned and do not count in the readmission outcome. The target population is Medicare Fee-for-Service (FFS) beneficiaries who are 65 years or older, and hospitalized in non-federal short-term acute care hospitals and critical access hospitals. This Hybrid HWR measure is a re-engineered version of the HWR measure 1789, the Hospital-Wide Readmission Measure, which was developed for patients 65 years and older using Medicare claims and is currently publicly reported in the Hospital Inpatient Quality Reporting Program. This reengineered measure uses clinical data elements from the electronic health record in addition to Claims for risk adjustment.
Numerator	The outcome for this measure is 30-day readmission. We define readmission as an inpatient acute care admission for any cause, with the exception of certain planned readmissions, within 30 days from the date of discharge from an eligible index admission. If a patient has more than one unplanned admission (for any reason) within 30

	days after discharge from the index admission, only one is counted as a readmission. The measure looks for a dichotomous yes or no outcome of whether each admitted patient has an unplanned readmission within 30 days. However, if the first readmission after discharge is considered planned, any subsequent unplanned readmission is not counted as an outcome for that index admission because the unplanned readmission could be related to care provided during the intervening planned readmission rather than during the index admission.
Denominator	The measure includes admissions for patients that meet all of the following inclusion criteria: 1. Enrolled in Medicare FFS Part A for the 12 months prior to the date of admission and during the index admission; 2. Aged 65 or over; 3. Discharged alive from a non-federal short-term acute care hospital; 4. Not transferred to another acute care facility
Denominator Exclusions	The measure excludes index admissions for patients: 1. Admitted to Prospective Payment System (PPS)-exempt cancer hospitals; 2. Without at least 30 days post-discharge enrollment in Medicare FFS; 3. Discharged against medical advice (AMA); 4. Admitted for primary psychiatric diagnoses; 5. Admitted for rehabilitation; or 6. Admitted for medical treatment of cancer
Rationale	The goal of this measure is to improve patient outcomes by providing patients, physicians, hospitals, and policy makers with information about hospital-level, risk-standardized all cause unplanned readmission rates among Medicare beneficiaries 65 years and older admitted to all non-federal US acute care hospitals. Measurement of patient outcomes allows for a broad view of quality of care that encompasses more than what can be captured by individual process-of-care measures. Complex and critical aspects of care, such as communication between providers, prevention of and response to complications, patient safety, and coordinated transitions to the outpatient environment, all contribute to patient outcomes but are difficult to measure by individual process measures. The goal of outcomes measurement is to risk-adjust for patients conditions at the time of hospital admission and then evaluate patient outcomes. This measure was developed to identify institutions whose performance is better or worse than would be expected based on their patient case mix and hospital service mix, and therefore promote hospital quality improvement and better inform consumers about care quality. Hospital-wide readmission is a priority area for outcomes measure development as it is an outcome that is likely attributable to care processes and is an important outcome for patients. Measuring and reporting readmission rates will inform healthcare providers and facilities about opportunities to improve care, strengthen incentives for quality improvement, and ultimately improve the quality of care received by Medicare patients. The measure will also provide patients with information that could guide their choices, as well as increase transparency for consumers. This Hybrid HWR measure incorporates both data from claims as well as clinical data elements pulled from the EHR in risk adjustment of the readmission models. Some benefits of including the clinical data elements are: 1. Inclusion of patient-level clinical data related to severity of

	illness is responsive to providers who continue to express preference for using patient-level clinical data, and provides an opportunity to incorporate clinical data into outcome measures. 2. Hospitals will increasingly use EHR data to assess severity of illness and patients risk of poor outcomes. This provides an opportunity to align the measure with clinical decision support systems that many providers utilize to alert care teams about patients at increased risk of poor outcomes in real time during the inpatient stay. 3. Collecting a simple core set of clinical data elements that perform well as risk-adjustment variables (for illness severity) across conditions can greatly reduce the cost and effort of future measure development, improve harmonization, and create opportunity for longitudinal assessment of patient status and quality of care across settings. 4. These core clinical data elements will provide measure developers with a standard set of reliable data that can be used as a starting place when building risk-adjustment models for quality measures using clinical data.
Evidence	Not Available
Denominator Exceptions	Not applicable
Numerator Exceptions	Not applicable
Risk Adjusted	Yes
Program Name Abbreviation	HIQR
Program Status	Active

*Immunizations for Adolescents (IMA)**

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

SUMMARY OF CHANGES TO HEDIS MY 2023

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

Description

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

Eligible Population

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

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

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

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

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

Continuous enrollment 12 months prior to the member's 13th birthday.

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

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

Benefit Medical.

Event/diagnosis None.

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

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

Administrative Specification

Denominator The eligible population.

Numerators

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

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

Tdap Any of the following meet criteria:

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

HPV Any of the following meet criteria:

- At least two HPV vaccines (HPV Immunization Value Set; HPV Vaccine Procedure Value Set), on or between the member's 9th and 13th birthdays and with dates of service at least 146 days apart. For example, if the service date for the first vaccine was March 1, then the service date for the second vaccine must be on or after July 25.
- At least three HPV vaccines (HPV Immunization Value Set; HPV Vaccine Procedure Value Set), with different dates of service on or between the member's 9th and 13th birthdays.
- Anaphylaxis due to the HPV vaccine (SNOMED CT code 428241000124101) any time on or before the member's 13th birthday.

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

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

Hybrid Specification

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

Numerators For meningococcal, Tdap and HPV, count *either:*

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

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

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

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

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

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

For meningococcal, *do not count* meningococcal recombinant (serogroup B) (MenB) vaccines. Immunizations documented under a generic header of

"meningococcal" and generic documentation that "meningococcal vaccine," "meningococcal conjugate vaccine" or "meningococcal polysaccharide vaccine" were administered meet criteria.

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

Note

- *To align with Advisory Committee on Immunization Practices (ACIP) recommendations, only the quadrivalent meningococcal vaccine (serogroups A, C, W and Y) is included in the measure.*
- *To align with ACIP recommendations, the minimum interval for the two-dose HPV vaccination schedule is 150 days (5 months), with a 4-day grace period (146 days).*

Data Elements for Reporting

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

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

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

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

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

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

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

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

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

Rules for Allowable Adjustments of HEDIS

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

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

Rules for Allowable Adjustments of Immunizations for Adolescents

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

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"). 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 • 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: • 18–64. • 65–74. • 75–85. • Total. The total is the sum of the age stratifications.
Continuous enrollment	The measurement year.
Allowable gap	No more than one gap in enrollment of up to 45 days during the measurement year. To determine continuous enrollment for a Medicaid beneficiary for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage (e.g., a member whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).
Anchor date	December 31 of the measurement year.
Benefit	Medical.
Event/diagnosis	There are two ways to identify members with diabetes: by claim/encounter data and by pharmacy data. The organization must use both methods to identify the eligible population, but a member only needs to be identified by one method to be included in the measure. Members may be identified as having diabetes during the measurement year or the year prior to the measurement year.

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

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

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

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

Diabetes Medications

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

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

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

Required exclusions

Exclude members who meet any of the following criteria:

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

Exclusions

Exclude members who meet any of the following criteria:

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

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

Dementia Medications

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

Administrative Specification

Denominator The eligible population.

Numerator

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

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

Data Elements for Reporting

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

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

Metric	Age	Data Element	Reporting Instructions
KidneyHealthEvaluation	18-64	EligiblePopulation	For each Stratification
	65-74	ExclusionAdminRequired	For each Stratification
	75-85	NumeratorByAdmin	For each Stratification
	Total	NumeratorBySupplemental	For each Stratification
		Rate	(Percent)

Rules for Allowable Adjustments of HEDIS

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

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

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

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

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: • 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 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"). 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. Members must be 18 and older as of the earliest Index Discharge Date. The plan population is based on members, not discharges. Count members only once in the plan population. Assign members to the product/product line in which they are enrolled at the start of the continuous enrollment period of their earliest IHS. If the member has a gap at the beginning of this continuous enrollment period, assign the member

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

Eligible Population

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

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

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

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

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

Administrative Specification

Denominator The eligible population.

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

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

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

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

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

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

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

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

Step 4 Exclude hospital stays for the following reasons:

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

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

Step 5 Calculate continuous enrollment.

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

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

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

Risk Adjustment Determination

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

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

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

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

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

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

Risk Adjustment Weighting

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

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

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

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

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

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

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

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

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

OR

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Reporting: Number of Members in Plan Population

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

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

Reporting: Number of Outliers

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

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

Calculated: Outlier Rate

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

Reporting: Denominator

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

Reporting: SES Stratification (Medicare only)

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

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

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

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

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

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

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

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

Reporting: Numerator

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

Calculated: Observed Readmission Rate

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

Reporting: Count of Expected 30-Day Readmissions

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

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

Calculated: Expected Readmission Rate

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

Reporting: Variance

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

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

Calculated: O/E Ratio

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

Note

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

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

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

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

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

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

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

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

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

Rules for Allowable Adjustments of HEDIS

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

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

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

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

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

Rules for Allowable Adjustments of HEDIS

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

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

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

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

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

Prenatal and Postpartum Care (PPC)

SUMMARY OF CHANGES TO HEDIS MY 2023

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

Description

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

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

Definitions

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

Eligible Population

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

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

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

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

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

Age None specified.

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

Allowable gap None.

Anchor date Date of delivery.

Benefit Medical.

Event/diagnosis Delivered a live birth on or between October 8 of the year prior to the measurement year and October 7 of the measurement year. Include members who delivered in any setting.

Multiple births. Members who had two separate deliveries (different dates of service) between October 8 of the year prior to the measurement year and October 7 of the measurement year count twice. Members who had multiple live births during one pregnancy count once.

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

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

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

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

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

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

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

Administrative Specification

Denominator The eligible population.

Numerator

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

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

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

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

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

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

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

- A bundled service (Prenatal Bundled Services Value Set) where the organization can identify the date when prenatal care was initiated (because bundled service codes are used on the date of delivery, these codes may be used only if the claim form indicates when prenatal care was initiated).
- A visit for prenatal care (Stand Alone Prenatal Visits Value Set).
- A prenatal visit (Prenatal Visits Value Set; Telephone Visits Value Set; Online Assessments Value Set) ***with*** a pregnancy-related diagnosis code (Pregnancy Diagnosis Value Set).

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

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

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

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

Hybrid Specification

Denominator

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

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

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

Numerator

Timeliness of Prenatal Care

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

Administrative

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

Medical record

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

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

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

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

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

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

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

Note

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

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

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

Data Elements for Reporting

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

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

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

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

Metric
TimelinessPrenatalCare
PostpartumCare

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

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

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

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

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

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

Rules for Allowable Adjustments of HEDIS

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

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

Rules for Allowable Adjustments of Prenatal and Postpartum Care

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

SDOH Screening Measure Specifications

Social Determinants of Health (SDOH) Screening
Steward: Rhode Island Executive Office of Health and Human Services
As of April 25, 2023

SUMMARY OF CHANGES FOR 2023 (PERFORMANCE YEAR 6)

- Clarified that there are two options for demonstrating numerator compliance, one of which includes using ICD-10 Z codes.

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 • 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. • Follow the below to determine a primary care visit: ○ The following are the eligible CPT/HCPCS office visit codes for determining a primary care visit: 99201-99205; 99212-99215; 99324-99337; 99341-99350; 99381 – 99387; 99391-99397; 99490; 99495-99496

[1] Definition from the CDC: www.cdc.gov/socialdeterminants/index.htm. Last accessed on 3/18/19.

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

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 TIN 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.

Denominator	The eligible population
Numerator – Option 1	Individuals attributed to the primary care clinician who were

[2] https://eohhs.ri.gov/initiatives/accountable-entities/resource-documents.

	screened for Social Determinants of Health once per measurement year and for whom results are in the primary care clinician's EHR. Notes: • Screens may be rendered asynchronously, i.e., at a time and through a modality other than a visit with a primary care clinician that triggered inclusion in the denominator. • Screens rendered during a telephone visit, e-visit or virtual check-in meet numerator criteria.
Numerator – Option 2	Individuals attributed to the primary care clinician who were screened for Social Determinants of Health once per measurement year and for whom results are electronically documented using ICD-10 Z codes in the primary care clinician's EHR. Notes: • Screens may be rendered asynchronously, i.e., at a time and through a modality other than a visit with a primary care clinician that triggered inclusion in the denominator. • Screens rendered during a telephone visit, e-visit or virtual check-in meet numerator criteria. Identify screening using the following ICD-10 Z codes: • Z04.89 o Definition: Encounter for examination and observations for other specified reasons o Meaning: SDOH screening completed • Z53.8 o Definition: Procedure and treatment not carried out for other reasons o 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. The screening results must a) be embedded in the EHR, b) be accessible in the EHR as a PDF of the screening results, or c) be accessible from within the EHR without requiring the primary care clinician to leave the EHR to access another electronic location to search for the patient's record and locate and view the screening

	results. An integrated EHR interface with Unite Us that allows providers to view a patient's screening results meets the documentation requirements. 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; 2. Food insecurity; 3. Transportation; 4. Interpersonal violence; and 5. Utility assistance. Note: If primary care clinicians are conducting the screen during a telephone visit, e-visit or virtual check-in or independent of a visit, they may use their discretion whether to ask questions related to interpersonal violence. The interpersonal violence domain must, however, be included for screens administered during in-person visits.

Code List

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

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

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

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. 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"). The denominator age may be changed if the range is within the specified age range (ages 21–75 or 40–75 years). The denominator age may not be expanded.
Continuous enrollment, allowable gap, anchor date	Yes	Organizations are not required to use enrollment criteria; adjustments are allowed.
Benefits	Yes	Organizations are not required to use 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. 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 • Rate 2: Statin Adherence 80%	No	Medication lists, value sets 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. • *Unhealthy Alcohol Use Screening*. The percentage of members who had a systematic screening for unhealthy alcohol use. • *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. – 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.

<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:
The member was enrolled with a medical benefit throughout the participation period.

When identifying members in hospice, the requirements described in General Guideline 15 for identification of hospice members using the monthly membership detail data files are not included in the measure calculation logic and need to be programmed manually.

Reporting:
The total is the sum of the age stratifications.

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
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:
“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:

Feedback on alcohol use and harms.
Identification of high-risk situations for drinking and coping strategies.
Increase the motivation to reduce drinking.
Development of a personal plan to reduce drinking.
Documentation of receiving alcohol misuse treatment.

</td></tr>
<tr><td>Initial population</td><td>Initial population 1
Members 18 years and older at the start of the measurement period who also meet criteria for participation.

Initial population 2
Same as the initial population 1.</td></tr>
<tr><td>Exclusions</td><td>Exclusions 1

Members with alcohol use disorder that starts during the year prior to the measurement period.
Members with history of dementia any time during the member’s history through the end of the measurement period.
Members in hospice or using hospice services any time during the measurement period.

Exclusions 2
Same as exclusions 1.</td></tr>
<tr><td>Denominator</td><td>Denominator 1
The initial population, minus exclusions.

Denominator 2
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
Members with a documented result for unhealthy alcohol use screening performed between January 1 and November 1 of the measurement period.

Numerator 2—Follow-Up Care on Positive Screen
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"). Changing the denominator age range is allowed if the limits are within the specified age range (18 years and older). Organizations must consult UPSTSF guidelines when considering whether to expand the age 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 • Counseling Or Other Follow-Up On Positive Screen	No	Value sets, direct reference codes and logic may not be changed.

*Utilization of the PHQ-9 to Monitor Depression Symptoms for Adolescents and Adults (DMS-E)**

***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). 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. 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. 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. – Product line: ▪ Commercial. ▪ Medicaid. ▪ Medicare. – Age (as of the start of the measurement period, for each product line): ▪ 12–17 years (for commercial and Medicaid only). ▪ 18–44 years. ▪ 45–64 years. ▪ 65 years and older. • Utilization of PHQ-9 Period 2. – Product line: ▪ Commercial. ▪ Medicaid. ▪ Medicare. – Age (as of the start of the measurement period, for each product line): ▪ 12–17 years (for commercial and Medicaid only). ▪ 18–44 years. ▪ 45–64 years. ▪ 65 years and older. • Utilization of PHQ-9 Period 3. – Product line: ▪ Commercial. ▪ Medicaid. ▪ Medicare. – Age (as of the start of the measurement period, for each product line): ▪ 12–17 years (for commercial and Medicaid only). ▪ 18–44 years. ▪ 45–64 years. ▪ 65 years and older.
Risk adjustment	None.
Improvement notation	A higher rate indicates better performance.

Guidance	**Allocation:** The member was enrolled with a medical benefit throughout the participation period. When identifying members in hospice, the requirements described in *General Guideline 15* for identification of hospice members using the monthly membership detail data files are not included in the measure calculation logic and need to be programmed manually. **Requirements:** • 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. • The measure allows the use of two PHQ-9 assessments. Selection of the appropriate assessment should be based on the member's age: – *PHQ-9:* 12 years of age and older. – *PHQ-9 Modified for Teens:* 12–17 years of age. • 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. **Reporting:** The total is the sum of the age stratifications. Product line stratifications are not included in the measure calculation logic and need to be programmed manually. 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: • *Assessment period 1*: January 1–April 30. • *Assessment period 2*: May 1–August 31. • *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** 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. **Initial population 2** 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. **Initial population 3** 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** Members with any of the following any time during the member's history through the end of the measurement period: • Bipolar disorder. • Personality disorder. • Psychotic disorder. • Pervasive developmental disorder. ***OR*** • Members in hospice or using hospice services any time during the measurement period. **Exclusions 2** Same as exclusions 1. **Exclusions 3** Same as exclusions 1.
Denominator	**Denominator 1** The initial population 1, minus exclusions. **Denominator 2** The initial population 2, minus exclusions. **Denominator 3** The initial population 3, minus exclusions.
Numerator	**Numerator 1—Utilization of PHQ-9 Period 1** A PHQ-9 score in the member’s record during assessment period 1. **Numerator 2—Utilization of PHQ-9 Period 2** A PHQ-9 score in the member’s record during assessment period 2. **Numerator 3—Utilization of PHQ-9 Period 3** 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)

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"). Changing the denominator age range is allowed if the limits are within the specified age range (12 years and older). Expanding the denominator age range to 11 years and older is allowed.
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.

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)