OHIC Measure Alignment Work Group
2021 Annual Review of the Primary Care Aligned Measure Sets
Measure Specifications

Breast Cancer Screening (BCS)

SUMMARY OF CHANGES TO HEDIS MY 2022

- Clarified that members in hospice or using hospice services anytime during the measurement year are a required exclusion.
- Clarified in *Optional exclusions* that unilateral mastectomy and bilateral modifier must be from the same procedure.

Description

The percentage of women 50–74 years of age who had a mammogram to screen for breast cancer.

Eligible Population

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

Stratification
For only Medicare, 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
Women 52–74 years as of December 31 of the measurement year.

Continuous enrollment
October 1 two years prior to the measurement year through December 31 of the measurement year.

Allowable gap
No more than one gap in enrollment of up to 45 days for each full calendar year of continuous enrollment (the measurement year and the year prior to 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) during each year of continuous enrollment.

No gaps in enrollment are allowed from October 1 two years prior to the measurement year through December 31 two years prior to the measurement year.

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 in hospice or using hospice services anytime during the measurement year. Refer to *General Guideline 17: Members in Hospice.*
- Members receiving palliative care (Palliative Care Assessment Value Set; Palliative Care Encounter Value Set; Palliative Care Intervention Value Set) 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 one claim/encounter for frailty (Frailty Device Value Set; Frailty Diagnosis Value Set; Frailty Encounter Value Set; Frailty Symptom Value Set) 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 mammograms (Mammography Value Set) any time on or between October 1 two years prior to the measurement year and December 31 of the measurement year.

Exclusion *(optional)*

Bilateral mastectomy any time during the member's history through December 31 of the measurement year. Any of the following meet 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)

Note

- *This measure assesses the use of imaging to detect early breast cancer in women. Because the measure denominator does not remove women at higher risk of breast cancer, all types and methods of mammograms (screening, diagnostic, film, digital or digital breast tomosynthesis) qualify for*

numerator compliance. Do not count MRIs, ultrasounds or biopsies towards the numerator: although these procedures may be indicated for evaluating women at higher risk for breast cancer or for diagnostic purposes, they are performed as an adjunct to mammography and do not alone count toward the numerator.

Data Elements for Reporting

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

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

Metric	Data Element	Reporting Instructions
BreastCancerScreening	EligiblePopulation	Report once
	ExclusionAdminOptional	Report once
	ExclusionAdminRequired	Report once
	NumeratorByAdmin	Report once
	NumeratorBySupplemental	Report once
	Rate	(Percent)

Table BCS-3: Data Elements for Breast Cancer Screening

Metric	SES Stratification	Data Element	Reporting Instructions
BreastCancerScreening	NonLisDeNondisability	EligiblePopulation	For each Stratification
	LisDe	ExclusionAdminOptional	For each Stratification
	Disability	ExclusionAdminRequired	For each Stratification
	LisDeAndDisability	NumeratorByAdmin	For each Stratification
	Other	NumeratorBySupplemental	For each Stratification
	Unknown	Rate	(Percent)
	Total		

Rules for Allowable Adjustments of HEDIS

NCQA's Rules for Allowable Adjustments of HEDIS describe how NCQA's HEDIS measure specifications can be adjusted for non-health plan reporting. Refer to the *Guidelines for the Rules of Allowable Adjustments of HEDIS* for additional information.

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

Rules for Allowable Adjustments for Breast 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 range may be expanded to 40-74 years of age.
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 a population of interest such as gender, 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**
Optional Exclusions	No, if applied	Optional exclusions are not required, but if they are used, only specified exclusions may be applied. Value sets may not be changed.
Required Exclusions	Yes	The hospice 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**
Mammogram	No	Value sets and logic may not be changed.

Cervical Cancer Screening (CCS)

SUMMARY OF CHANGES TO HEDIS MY 2022

- Clarified that members in hospice or using hospice services anytime during the measurement year are a required exclusion.

Description

The percentage of women 21–64 years of age who were screened for cervical cancer using either 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 two 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: • Members in hospice or using hospice services anytime during the measurement year. Refer to *General Guideline 17: Members in Hospice*. • Members receiving palliative care (Palliative Care Assessment Value Set; Palliative Care Encounter Value Set; Palliative Care Intervention Value Set) 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 two 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 four 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.*

Exclusion *(optional)*

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.

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 two 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 four 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.*

Exclusion *(optional)*

Refer to *Administrative Specification* for exclusion criteria. Evidence of a hysterectomy with no residual cervix, cervical agenesis or acquired absence of cervix any time during the member's history through December 31 of the measurement year. The following examples meet criteria for documentation of hysterectomy with no residual cervix:

- Documentation of "complete," "total" or "radical" hysterectomy (abdominal, vaginal or unspecified).
- Documentation of "vaginal hysterectomy."
- Documentation of "vaginal pap smear" in conjunction with documentation of "hysterectomy."
- Documentation of "hysterectomy" in combination with documentation that the patient no longer needs pap testing/cervical cancer screening.
  - Documentation of hysterectomy alone does not meet the criteria, because it is not sufficient evidence that the cervix was removed.

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	
	ExclusionAdminOptional	Report once	
	ExclusionMedRecsOptional	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

NCQA's Rules for Allowable Adjustments of HEDIS describe how NCQA's HEDIS measure specifications can be adjusted for non-health plan reporting. Refer to the *Guidelines for the Rules of Allowable Adjustments of HEDIS* for additional information.

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

Rules for Allowable Adjustments for 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 a population of interest such as gender, 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**
Required Exclusions	Yes	The hospice and palliative care exclusions are not required. Refer to *Exclusions* in the *Guidelines for the Rules for Allowable Adjustments.*
Optional Exclusions	No, if applied	Optional exclusions are not required, but if they are used, only specified exclusions may be applied. Value sets may not be changed.
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 2022

- Added a *Note* in the Description to clarify that the Guidelines for Effectiveness of Care Measures should be used when calculating this measure.
- Clarified that members in hospice or using hospice services anytime during the measurement year are a required exclusion.
- Added instructions to report rates stratified by race and ethnicity for each product line.
- Added new data elements tables for race and ethnicity stratification reporting.
- Added required exclusions to the Rules for Allowable Adjustments.

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 and Alaska Native.
  - Asian.
  - Native Hawaiian and Other Pacific Islander.
  - Some Other Race.
  - Two or More Races.
  - Asked but No Answer.
  - Unknown.
  - Total.
- *Ethnicity:*
  - Hispanic/Latino.
  - Not Hispanic/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 exclusion	Members in hospice or using hospice services anytime during the measurement year. Refer to *General Guideline 17: Members in Hospice.*

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
	AmericanIndianAndAlaskaNative	Total	Rate	(Percent)
	Asian			
	NativeHawaiianAndOtherPacificIslander			
	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.'

Rules for Allowable Adjustments of HEDIS

NCQA's Rules for Allowable Adjustments of HEDIS describe how NCQA's HEDIS measure specifications can be adjusted for non-health plan reporting. Refer to the *Guidelines for the Rules of Allowable Adjustments of HEDIS* for additional information.

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

Rules for Allowable Adjustments for 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 of 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 a population of interest such as gender, 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**
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**
Well-Child Visit(s)	No	Value sets and logic may not be changed.

Childhood Immunization Status (CIS)

SUMMARY OF CHANGES TO HEDIS MY 2022

- Clarified that members in hospice or using hospice services anytime during the measurement year are a required exclusion.
- Revised optional exclusions for immunocompromising conditions (e.g., immunodeficiency) to be required exclusions.
- Revised optional exclusions for anaphylaxis due to vaccine to be numerator compliant for specific indicators.
- Updated value sets and logic for the MMR numerator, because single antigen vaccines are no longer used.
- Added required exclusions and removed optional exclusions in the Rules for Allowable Adjustments.

Description

The percentage of children 2 years of age who had four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV); one measles, mumps and rubella (MMR); three haemophilus influenza type B (HiB); three hepatitis B (HepB), one chicken pox (VZV); four pneumococcal conjugate (PCV); one hepatitis A (HepA); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday. The measure calculates a rate for each vaccine and three combination rates.

Eligible Population

Product lines	Commercial, Medicaid (report each product line separately).
Age	Children who turn 2 years of age 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 continuously enrolled).
Anchor date	Enrolled on the child's second birthday.
Benefit	Medical.
Event/diagnosis	None.
Required exclusions	Exclude members who meet any of the following criteria: • Members in hospice or using hospice services anytime during the measurement year. Refer to *General Guideline 17: Members in Hospice.* • Members who had any of the following on or before their second birthday: – Severe combined immunodeficiency (Severe Combined Immunodeficiency Value Set). – Immunodeficiency (Disorders of the Immune System Value Set). – HIV (HIV Value Set; HIV Type 2 Value Set).

- Lymphoreticular cancer, multiple myeloma or leukemia (Malignant Neoplasm of Lymphatic Tissue Value Set).
- Intussusception (Intussusception Value Set).

Administrative Specification

Denominator The eligible population.

Numerators

DTaP Any of the following on or before the child's second birthday meet criteria:

- At least four DTaP vaccinations (DTaP Immunization Value Set; DTaP Vaccine Procedure Value Set), with different dates of service. Do not count a vaccination administered prior to 42 days after birth.
- Anaphylaxis due to the diphtheria, tetanus or pertussis vaccine (Anaphylaxis Due to Diphtheria, Tetanus or Pertussis Vaccine Value Set).
- Encephalitis due to the diphtheria, tetanus or pertussis vaccine (Encephalitis Due to Diphtheria, Tetanus or Pertussis Vaccine Value Set).

IPV At least three IPV vaccinations (Inactivated Polio Vaccine (IPV) Immunization Value Set; Inactivated Polio Vaccine (IPV) Procedure Value Set), with different dates of service on or before the child's second birthday. Do not count a vaccination administered prior to 42 days after birth.

MMR Either of the following meets criteria:

- At least one MMR vaccination (Measles, Mumps and Rubella (MMR) Immunization Value Set; Measles, Mumps and Rubella (MMR) Vaccine Procedure Value Set) on or between the child's first and second birthdays.
- All of the following anytime on or before the child's second birthday (on the same or different date of service):
  - History of measles illness (Measles Value Set).
  - History of mumps illness (Mumps Value Set).
  - History of rubella illness (Rubella Value Set).

HiB Either of the following on or before the child's second birthday meets criteria:

- At least three HiB vaccinations (Haemophilus Influenzae Type B (HiB) Immunization Value Set; Haemophilus Influenzae Type B (HiB) Vaccine Procedure Value Set), with different dates of service. Do not count a vaccination administered prior to 42 days after birth.
- Anaphylaxis due to the HiB vaccine (SNOMED CT code 433621000124101).

Hepatitis B Any of the following on or before the child's second birthday meet criteria:

- At least three hepatitis B vaccinations (Hepatitis B Immunization Value Set; Hepatitis B Vaccine Procedure Value Set), with different dates of service.
  - One of the three vaccinations can be a newborn hepatitis B vaccination (Newborn Hepatitis B Vaccine Administered Value Set) during the eight-day period that begins on the date of birth and ends seven days after the date of birth. For example, if the member's date of birth is December 1, the newborn hepatitis B vaccination must be on or between December 1 and December 8.
- History of hepatitis B illness (Hepatitis B Value Set).
- Anaphylaxis due to the Hepatitis B vaccine (SNOMED CT code 428321000124101).

VZV Either of the following meets criteria:

- At least one VZV vaccination (Varicella Zoster (VZV) Immunization Value Set; Varicella Zoster (VZV) Vaccine Procedure Value Set), with a date of service on or between the child's first and second birthdays.
- History of varicella zoster (e.g., chicken pox) illness (Varicella Zoster Value Set) on or before the child's second birthday.

Pneumococcal conjugate At least four pneumococcal conjugate vaccinations (Pneumococcal Conjugate Immunization Value Set; Pneumococcal Conjugate Vaccine Procedure Value Set), with different dates of service on or before the child's second birthday. Do not count a vaccination administered prior to 42 days after birth.

Hepatitis A Either of the following meets criteria:

- At least one hepatitis A vaccination (Hepatitis A Immunization Value Set; Hepatitis A Vaccine Procedure Value Set), with a date of service on or between the child's first and second birthdays.
- History of hepatitis A illness (Hepatitis A Value Set) on or before the child's second birthday.

Rotavirus Any of the following on or before the child's second birthday meet criteria. Do not count a vaccination administered prior to 42 days after birth.

- At least two doses of the two-dose rotavirus vaccine (Rotavirus (2 Dose Schedule) Immunization Value Set; Rotavirus Vaccine (2 Dose Schedule) Procedure Value Set) on different dates of service.
- At least three doses of the three-dose rotavirus vaccine (Rotavirus (3 Dose Schedule) Immunization Value Set; Rotavirus Vaccine (3 Dose Schedule) Procedure Value Set) on different dates of service.
- At least one dose of the two-dose rotavirus vaccine (Rotavirus (2 Dose Schedule) Immunization Value Set; Rotavirus Vaccine (2 Dose Schedule) Procedure Value Set) and at least two doses of the three-dose rotavirus vaccine (Rotavirus (3 Dose Schedule) Immunization Value Set; Rotavirus Vaccine (3 Dose Schedule) Procedure Value Set), all on different dates of service.
- Anaphylaxis due to the rotavirus vaccine (SNOMED CT code 428331000124103).

Influenza At least two influenza vaccinations (Influenza Immunization Value Set; Influenza Vaccine Procedure Value Set), with different dates of service on or before the child's second birthday. Do not count a vaccination administered prior to 6 months (180 days) after birth.

– One of the two vaccinations can be an LAIV vaccination (Influenza Virus LAIV Immunization Value Set; Influenza Virus LAIV Vaccine Procedure Value Set) administered on the child's second birthday. Do not count an LAIV vaccination administered before the child's second birthday.

Combination rates

Calculate the following rates for Combinations 3, 7 and 10.

Combination Vaccinations for Childhood Immunization Status

Combination	DTaP	IPV	MMR	HiB	HepB	VZV	PCV	HepA	RV	Influenza
Combination 3	✓	✓	✓	✓	✓	✓	✓			
Combination 7	✓	✓	✓	✓	✓	✓	✓	✓	✓	
Combination 10	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓

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 for the lowest rate or the prior year's audited, product line-specific results for the lowest rate. Refer to the *Guidelines for Calculations and Sampling* for information on reducing sample size.

Numerators

For DTaP, count any of the following:

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

For hepatitis B, count any of the following:

- Evidence of the antigen or combination vaccine.
- Documented history of the illness.
- A seropositive test result.
- Anaphylaxis due to the vaccine.

For MMR, VZV and hepatitis A, count any of the following:

- Evidence of the antigen or combination vaccine.
- Documented history of the illness.
- A seropositive test result.

For HiB and rotavirus, count *either*:

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

For IPV, pneumococcal conjugate and influenza, count only:

- Evidence of the antigen or combination vaccine.

For combination vaccinations that require more than one antigen (DTaP and MMR), the organization must find evidence of all the antigens.

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

Medical record For immunization evidence obtained from the medical record, count members where there is evidence that the antigen was rendered from one 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 illness, a seropositive test result or anaphylaxis, there must be a note indicating the date of the event, which must have occurred by the member's second birthday.

Notes in the medical record indicating that the member received the immunization "at delivery" or "in the hospital" may be counted toward the numerator *only* for immunizations that do not have minimum age restrictions (e.g., before 42 days after birth). A note that the "member is up to date" with all immunizations but which does not list the dates of all immunizations and the names of the immunization agents does not constitute sufficient evidence of immunization for HEDIS reporting.

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

Immunizations documented using a generic header (e.g., polio vaccine) or "IPV/OPV" can be counted as evidence of IPV. The burden on organizations to substantiate the IPV antigen is excessive compared to a risk associated with data integrity.

For rotavirus, if documentation does not indicate whether the two-dose schedule or three-dose schedule was used, assume a three-dose schedule and find evidence that three doses were administered.

Data Elements for Reporting

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

Table CIS-1/2: Data Elements for Childhood Immunization Status

Metric	Data Element	Reporting Instructions	A
DTaP	CollectionMethod	Repeat per Metric	✓
IPV	EligiblePopulation	Repeat per Metric	✓
MMR	ExclusionAdminRequired	Repeat per Metric	✓
HiB	NumeratorByAdminElig	For each Metric	
HepatitisB	CYAR	(Percent)	
VZV	MinReqSampleSize	Repeat per Metric	
PneumococcalConjugate	OversampleRate	Repeat per Metric	
HepatitisA	OversampleRecordsNumber	(Count)	
Rotavirus	ExclusionValidDataErrors	Repeat per Metric	
Influenza	ExclusionEmployeeOrDep	Repeat per Metric	
Combo3	OversampleRecsAdded	Repeat per Metric	
Combo7	Denominator	Repeat per Metric	
Combo10	NumeratorByAdmin	For each Metric	✓
	NumeratorByMedicalRecords	For each Metric	
	NumeratorBySupplemental	For each Metric	✓
	Rate	(Percent)	✓

Rules for Allowable Adjustments of HEDIS

NCQA's Rules for Allowable Adjustments of HEDIS describe how NCQA's HEDIS measure specifications can be adjusted for non-health plan reporting. Refer to the *Guidelines for the Rules of Allowable Adjustments of HEDIS* for additional information.

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

Rules for Allowable Adjustments for Childhood Immunization Status

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 2 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 a population of interest such as gender, 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**
Required Exclusions	Yes, with limits	Apply required exclusions according to specified value sets. 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**
• DTAP • IPV • MMR • HiB • Hepatitis B • VZV • Pneumococcal conjugate • Hepatitis A • Rotavirus • Influenza	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.

Chlamydia Screening in Women (CHL)

SUMMARY OF CHANGES TO HEDIS MY 2022

- Clarified that members in hospice or using hospice services anytime during the measurement year are a required exclusion.
- Added required exclusions to the Rules for Allowable Adjustments.

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	*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	

Required exclusion Members in hospice or using hospice services anytime during the measurement year. Refer to *General Guideline 17: Members in Hospice.*

Administrative Specification

Denominator The eligible population.

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

Exclusion (optional)

Exclude members who qualified for the denominator based on a pregnancy test (Pregnancy Tests Value Set) alone ***and*** who meet either of the following:

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

Retinoid Medications

Description	Prescription
Retinoid	• Isotretinoin

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	ExclusionAdminOptional	For each Stratification
	Total	ExclusionAdminRequired	For each Stratification
		NumeratorByAdmin	For each Stratification
		NumeratorBySupplemental	For each Stratification
		Rate	(Percent)

Rules for Allowable Adjustments of HEDIS

NCQA's Rules for Allowable Adjustments of HEDIS describe how NCQA's HEDIS measure specifications can be adjusted for non-health plan reporting. Refer to the *Guidelines for the Rules of Allowable Adjustments of HEDIS* for additional information.

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

Rules for Allowable Adjustments for 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 a population of interest such as gender, sociodemographic characteristic or geographic region.
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 exclusion is not required. Refer to *Exclusions* in the *Guidelines for the Rules for Allowable Adjustments*.
Optional Exclusions	No, if applied	Optional exclusions are not required, but if they are used, only specified exclusions may be applied. Medication lists, and value sets may not be changed.
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 2022

- Clarified that members in hospice or using hospice services anytime during the measurement year are a required exclusion.
- Added instructions to report rates stratified by race and ethnicity for each product line.
- Revised the Reporting Instructions for the "NumeratorByAdminElig" data element in *Table COL-A-3: Data Elements for Colorectal Cancer Screening* to "For each Stratification" to indicate that it is a stratified value.
- Added new data elements tables for race and ethnicity stratification reporting.

Description

The percentage of members 50–75 years of age who had appropriate screening for colorectal cancer.

Eligible Population

Product lines

Commercial, Medicare (report each product line separately).

Stratification

For only Medicare, 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 and Alaska Native.
  - Asian.
  - Native Hawaiian and Other Pacific Islander.
  - Some Other Race.
  - Two or More Races.
  - Asked but No Answer.
  - Unknown.
  - Total.
- *Ethnicity:*
  - Hispanic/Latino.

- Not Hispanic/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 51–75 years as of December 31 of the measurement year.

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 in hospice or using hospice services anytime during the measurement year. Refer to *General Guideline 17: Members in Hospice*.
- Members receiving palliative care (Palliative Care Assessment Value Set; Palliative Care Encounter Value Set; Palliative Care Intervention Value Set) 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 one claim/encounter for frailty (Frailty Device Value Set; Frailty Diagnosis Value Set; Frailty Encounter Value Set; Frailty Symptom Value Set) 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 four years prior to the measurement year.
- Colonoscopy (Colonoscopy Value Set; History of Colonoscopy Value Set) during the measurement year or the nine years prior to the measurement year.
- CT colonography (CT Colonography Value Set) during the measurement year or the four years prior to the measurement year.
- FIT-DNA test (FIT DNA Lab Test Value Set; FIT DNA Test Result or Finding Value Set) during the measurement year or the two years prior to the measurement year.

Exclusion *(optional)*

Either of the following any time during the member's history through December 31 of the measurement year:

- Colorectal cancer (Colorectal Cancer Value Set).
- Total colectomy (Total Colectomy Value Set; History of Total Colectomy Value Set).

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. 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 four years prior to the measurement year.
- Colonoscopy during the measurement year or the nine years prior to the measurement year.
- CT colonography during the measurement year or the four years prior to the measurement year.
- FIT-DNA during the measurement year or the two 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 beyond the splenic flexure 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.

Exclusion *(optional)*

Refer to *Administrative Specification* for exclusion criteria. Exclusionary evidence in the medical record must include a note indicating colorectal cancer or total colectomy any time during the member's history through December 31 of the measurement year.

Data Elements for Reporting

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

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

Metric	Data Element	Reporting Instructions	A
ColorectalCancerScreening	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	
	ExclusionAdminOptional	Report once	
	ExclusionMedRecsOptional	Report once	
	ExclusionEmployeeOrDep	Report once	
	OversampleRecsAdded	Report once	
	Denominator	Report once	
	NumeratorByAdmin	Report once	✓
	NumeratorByMedicalRecords	Report once	
	NumeratorBySupplemental	Report once	✓
	Rate	(Percent)	✓

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

Metric	SES Stratification	Data Element	Reporting Instructions	A
ColorectalCancerScreening	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	
		ExclusionAdminOptional	Repeat per Stratification	
		ExclusionMedRecsOptional	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-2/3: Data Elements for Colorectal Cancer Screening: Stratifications by Race

Metric
ColorectalCancerScreening

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

Table COL-C-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.'

Rules for Allowable Adjustments of HEDIS

NCQA's Rules for Allowable Adjustments of HEDIS describe how NCQA's HEDIS measure specifications can be adjusted for non-health plan reporting. Refer to the *Guidelines for the Rules of Allowable Adjustments of HEDIS* for additional information.

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

Rules for Allowable Adjustments for 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 a population of interest such as gender, 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**
Required Exclusions	Yes	The hospice and palliative care exclusions are not required. Refer to *Exclusions* in the *Guidelines for the Rules for Allowable Adjustments*
Optional Exclusions	No, if applied	Optional exclusions are not required, but if they are used, only specified exclusions may be applied. Value sets may not be changed.
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.

Eye Exam for Patients With Diabetes (EED)

SUMMARY OF CHANGES TO HEDIS MY 2022

- This measure resulted from the separation of indicators that replaces the former Comprehensive Diabetes Care measure.
- Clarified that members in hospice or using hospice services anytime during the measurement year are a required exclusion.
- Revised the optional exclusions for polycystic ovarian syndrome, gestational diabetes or steroid-induced diabetes to be required exclusions.
- Updated the Hybrid Specification to clarify the rules for sample size reduction.
- Revised the Reporting Instructions for the "NumeratorByAdminElig" data element in Table EED-3: Data Elements for Eye Exam for Patients With Diabetes to "For each Stratification" to indicate that it is a stratified value.
- Updated the required exclusions criteria and removed optional exclusions in the Rules for Allowable Adjustments.

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 only Medicare, 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 • Empagliflozin-linagliptin	• Empagliflozin-metformin • 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 detemir • Insulin glargine • 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®) • Semaglutide	
Sodium glucose cotransporter 2 (SGLT2) inhibitor	• Canagliflozin	• Dapagliflozin (excluding Farxiga®)	• 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 do 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 anytime during the measurement year. Refer to *General Guideline 17: Members in Hospice.*
- Members receiving palliative care (Palliative Care Assessment Value Set; Palliative Care Encounter Value Set; Palliative Care Intervention Value Set) 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 one claim/encounter for frailty (Frailty Device Value Set; Frailty Diagnosis Value Set; Frailty Encounter Value Set; Frailty Symptom Value Set) 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, 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.*

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

NCQA's Rules for Allowable Adjustments of HEDIS describe how NCQA's HEDIS measure specifications can be adjusted for non-health plan reporting. Refer to the *Guidelines for the Rules of Allowable Adjustments of HEDIS* for additional information.

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

Rules for Allowable Adjustments for 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 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 a population of interest such as gender, sociodemographic characteristic or geographic region.
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 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.

Hemoglobin A1c Control for Patients With Diabetes (HBD)

SUMMARY OF CHANGES TO HEDIS MY 2022

- This measure resulted from the separation of indicators that replaces the former Comprehensive Diabetes Care measure.
- Removed the *Hemoglobin A1c (HbA1c) Testing* indicator.
- Clarified that members in hospice or using hospice services any time during the measurement year are a required exclusion.
- Added instructions to report rates stratified by race and ethnicity for each product line.
- Revised the optional exclusions for polycystic ovarian syndrome, gestational diabetes or steroid-induced diabetes to be required exclusions.
- Updated the Hybrid Specification to clarify the rules for sample size reduction.
- Added new data elements tables for race and ethnicity stratification reporting.
- Updated the required exclusions criteria and removed optional exclusions in the Rules for Allowable Adjustments.

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 and Alaska Native.
  - Asian.
  - Native Hawaiian and Other Pacific Islander.
  - Some Other Race.
  - Two or More Races.
  - Asked but No Answer.
  - Unknown.
  - Total.

- *Ethnicity:*
  - Hispanic/Latino.

- Not Hispanic/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 • Empagliflozin-linagliptin	• Empagliflozin-metformin • 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 detemir • Insulin glargine • 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®) • Semaglutide	
Sodium glucose cotransporter 2 (SGLT2) inhibitor	• Canagliflozin • Dapagliflozin (excluding Farxiga®)	• 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 do 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 anytime during the measurement year. Refer to *General Guideline 17: Members in Hospice.*
- Members receiving palliative care (Palliative Care Assessment Value Set; Palliative Care Encounter Value Set; Palliative Care Intervention Value Set) 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 one claim/encounter for frailty (Frailty Device Value Set; Frailty Diagnosis Value Set; Frailty Encounter Value Set; Frailty Symptom Value Set) 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.

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, 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	✓
AmericanIndianAndAlaskaNative	Total	Denominator	For each Stratification, repeat per Metric	
Asian		Numerator	For each Metric and Stratification	✓
NativeHawaiianAndOtherPacificIslander		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.'

Rules for Allowable Adjustments of HEDIS

NCQA's Rules for Allowable Adjustments of HEDIS describe how NCQA's HEDIS measure specifications can be adjusted for non-health plan reporting. Refer to the *Guidelines for the Rules of Allowable Adjustments of HEDIS* for additional information.

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

Rules for Allowable Adjustments for 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 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 a population of interest such as gender, sociodemographic characteristic or geographic region.
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 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.

MEASURE COB-AD: CONCURRENT USE OF OPIOIDS AND BENZODIAZEPINES

Pharmacy Quality Alliance

A. DESCRIPTION

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

Note: A lower rate indicates better performance.

Data Collection Method: Administrative

Guidance for Reporting:

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

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

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

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

B. DEFINITIONS

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

C. ELIGIBLE POPULATION

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

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

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

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

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

D. ADMINISTRATIVE SPECIFICATION

Denominator

The eligible population as defined above.

Numerator

The number of beneficiaries from the denominator with:

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

Follow the steps below to identify beneficiaries for the numerator.

Step 1

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

Step 2

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

NOTE:

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

Step 3

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

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

Alprazolam Chlordiazepoxide Clobazam Clonazepam	Clorazepate Diazepam Estazolam Flurazepam	Lorazepam Midazolam Oxazepam Quazepam	Temazepam Triazolam

[a] Excludes injectable formulations.

[b] Includes combination products.

Rate

Divide the numerator by the denominator and multiply by 100.

E. ADDITIONAL NOTES

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

Controlling High Blood Pressure (CBP)

SUMMARY OF CHANGES TO HEDIS MY 2022

- Clarified that members in hospice or using hospice services anytime during the measurement year are a required exclusion.
- Added instructions to report rates stratified by race and ethnicity for each product line.
- Updated the Administrative Specification to make it consistent with the Hybrid Specification; replaced the visit type requirement with a visit type exclusion.
- Clarified in the numerator of the Hybrid Specification that BP readings taken by the member are eligible for use in reporting.
- Clarified in the numerator of the Hybrid Specification that ranges and thresholds do not meet criteria.
- Clarified in the numerator of the Hybrid Specification that a BP documented as an "average BP" (e.g., "average BP: 139/70") is eligible for use.
- Added new data elements tables for race and ethnicity stratification reporting.

Description

The percentage of members 18–85 years of age who had a diagnosis of hypertension (HTN) and whose 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 and Alaska Native.
  - Asian.
  - Native Hawaiian and Other Pacific Islander.
  - Some Other Race.
  - Two or More Races.
  - Asked but No Answer.
  - Unknown.

  - Total.
- *Ethnicity:*
  - Hispanic/Latino.
  - Not Hispanic/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 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).

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

- Members in hospice or using hospice services anytime during the measurement year. Refer to *General Guideline 17: Members in Hospice.*
- Members receiving palliative care (Palliative Care Assessment Value Set; Palliative Care Encounter Value Set; Palliative Care Intervention Value Set) 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 one claim/encounter for frailty (Frailty Device Value Set; Frailty Diagnosis Value Set; Frailty Encounter Value Set; Frailty Symptom Value Set) 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 frailty (Frailty Device Value Set; Frailty Diagnosis Value Set; Frailty Encounter Value Set; Frailty Symptom Value Set) 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

Exclusions *(optional)*

- Exclude from the eligible population all members with evidence of end-stage renal disease (ESRD) (ESRD Diagnosis Value Set), dialysis (Dialysis Procedure Value Set), nephrectomy (Nephrectomy Value Set) or kidney transplant (Kidney Transplant Value Set; History of Kidney Transplant Value Set) on or prior to December 31 of the measurement year.
- Exclude from the eligible population female members with a diagnosis of pregnancy (Pregnancy Value Set) during the measurement year.

- Exclude from the eligible population all 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.

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.

Exclusions *(optional)*

Refer to the *Administrative Specification* for exclusion criteria. Exclusionary evidence in the medical record must include a note indicating diagnosis of pregnancy or evidence of a nonacute inpatient admission during the measurement year, ***or*** evidence of ESRD, dialysis, nephrectomy or kidney transplant any time during the member's history through December 31 of the measurement year.

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 just for reference, and is not exhaustive):*
  - *A colonoscopy requires a change in diet (NPO on the day of procedure) and a medication change (a medication is taken to prep the colon).*
  - *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 just for reference, 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	
	ExclusionAdminOptional	Report once	
	ExclusionMedRecsOptional	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	✓
	AmericanIndianAndAlaskaNative	Total	Denominator	For each Stratification	
	Asian		Numerator	For each Stratification	✓
	NativeHawaiianAndOtherPacificIslander		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. '

Rules for Allowable Adjustments of HEDIS

NCQA's Rules for Allowable Adjustments of HEDIS describe how NCQA's HEDIS measure specifications can be adjusted for non-health plan reporting. Refer to the *Guidelines for the Rules of Allowable Adjustments of HEDIS* for additional information.

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

Rules for Allowable Adjustments for 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 a population of interest such as gender, sociodemographic characteristic or geographic region.
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	The hospice and palliative care exclusions are not required. Refer to *Exclusions* in the *Guidelines for the Rules for Allowable Adjustments.*
Optional Exclusions	No, if applied	Optional exclusions are not required, but if they are used, only specified exclusions may be applied. Value sets may not be changed.
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.

FOLLOW-UP, RESPONSE, AND REMISSION MEASURE SPECIFICATIONS AND CALCULATION

Measure Specifications

NOTE: The Index Periods and Assessment Periods detailed in the Measure Specifications below are NOT the dates of service that should be submitted. See the *Data Collection Technical Guide* for instructions to identify the correct service dates for submission.

Summary of Changes	• Preliminary 2021 MY dates added to Measurement Period for reference. • Clarifying language added to Eligible Specialties and Eligible Providers sections. • Clarification regarding permissible administration of the PHQ-9 and PHQ-9M tools added as a footnote. See appendices of Data Collection Technical Guide for specific guidance regarding assessment tool administration.

Depression: Follow-Up, Response & Remission Measurement Period, Denominator & Exclusions		
Description	See measure specific description(s) below.	
Measurement Period	Denominator Identification Period: • FINAL 2020 MY: November 1, 2018 through October 31, 2019 • PRELIMINARY 2021 MY: November 1, 2019 through October 31, 2020 Measure Assessment Period: For each patient, the measure assessment period begins with an index event and is 14 months (12 months + 60 days) in length.	
Eligible Population	**Eligible Specialties for diagnosing Depression/ Dysthymia^**	Family Medicine, Internal Medicine, Geriatric Medicine, Psychiatry, Behavioral Health, Pediatric/Adolescent Medicine
	Eligible Providers for diagnosing Depression/ Dysthymia^	Medical Doctor (MD), Doctor of Osteopathy (DO), Physician Assistant (PA), Advanced Practice Registered Nurses (APRN) These providers are also eligible, if supervised by a physician: Licensed Psychologist (LP), Licensed Independent Clinical Social Worker (LICSW), Licensed Professional Clinical Counselor (LPCC), Licensed Marriage & Family Therapist (LMFT)
	Ages	12 years of age or older at the index event

	Event (Index)	An index event occurs when ALL the following criteria are met during an encounter*: • a PHQ-9 or PHQ-9M result greater than nine • an active diagnosis of Major Depression or Dysthymia (*Major Depression or Dysthymia* Value Set) • the patient is NOT in a prior measure assessment period * For this measure, an encounter includes but is not limited to any of the following: office visit, psychiatry or psychotherapy visit, telephone, or online encounter. PHQ-9 or PHQ-9M score greater than 9 can be documented on the same date or up to seven days prior to the encounter (index event) and this date occurs during the denominator identification measurement period. This allows for pre-visit planning and administering the PHQ-9 or PHQ-9M just prior to an encounter.
Denominator	The eligible population who had index events during the denominator identification period.	
Numerator	See measure specific numerator definition(s) below.	
Required Exclusions	The following exclusions must be applied to the eligible population: • Patient had an active diagnosis of Bipolar Disorder (*Bipolar Disorder* Value Set) any time prior to the end of their measure assessment period • Patient had an active diagnosis of Schizophrenia or Psychotic Disorder (*Schizophrenia Psychotic Disorder* Value Set) any time prior to the end of their measure assessment period	
Allowable Exclusions	The following exclusions can be applied to the eligible population: • Patient had an active diagnosis of Personality Disorder – Emotionally Labile (*Personality Disorder - Emotionally Labile* Value Set) any time prior to the end of their measure assessment period • Patient had an active diagnosis of Pervasive Developmental Disorder (*Pervasive Disorder* Value Set) any time prior to the end of their measure assessment period • Patient was a permanent nursing home resident at any time during the denominator identification period or measure assessment period • Patient was in hospice or receiving palliative care at any time during the denominator identification period or measure assessment period • Patient died prior to the end of their measure assessment period	
Measure Scoring	Rate/Proportion Results are always stratified by age: • Adolescents (12-17 years of age) • Adults (18 years of age or older)	
Interpretation of Score	Higher score indicates better quality	
Measure Type	Outcome	
^Any member of the health care team can administer a PHQ-9 or PHQ-9M assessment tool to a patient. Additionally, patients can self-administer via patient portal, email, or mail		

Depression: Remission at Six Months	
Description	The percentage of adolescent patients (12 to 17 years of age) and adult patients (18 years of age or older) with Major Depression or Dysthymia who reached remission six months (+/- 60 days) after an index event
Numerator	The number of patients in the denominator who reached remission, with a PHQ-9 or PHQ-9M result less than five, six months (+/- 60 days) after an index event

Depression: Remission at Twelve Months	
Description	The percentage of adolescent patients (12 to 17 years of age) and adult patients (18 years of age or older) with Major Depression or Dysthymia who reached remission 12 months (+/- 60 days) after an index event
Numerator	The number of patients in the denominator who reached remission, with a PHQ-9 or PHQ-9M result less than five, 12 months (+/- 60 days) after an index event

Depression: Response at Six Months	
Description	The percentage of adolescent patients (12 to 17 years of age) and adult patients (18 years of age or older) with Major Depression or Dysthymia who demonstrated a response to treatment six months (+/- 60 days) after an index event.
Numerator	The number of patients in the denominator who demonstrated a response to treatment, with a PHQ-9 or PHQ-9M result that is reduced by at least 50 percent since the index PHQ-9/PHQ-9M result, six months (+/- 60 days) after an index event.

Depression: Response at Twelve Months	
Description	The percentage of adolescent patients (12 to 17 years of age) and adult patients (18 years of age or older) with Major Depression or Dysthymia who demonstrated a response to treatment 12 months (+/- 60 days) after an index event.
Numerator	The number of patients in the denominator who demonstrated a response to treatment, with a PHQ-9 or PHQ-9M result that is reduced by at least 50 percent since the index PHQ-9/PHQ-9M result, 12 months (+/- 60 days) after an index event.

Depression: Follow-up at Six Months	
Description	The percentage of adolescent patients (12 to 17 years of age) and adult patients (18 years of age or older) with Major Depression or Dysthymia with an index PHQ-9/PHQ-9M score greater than nine who have a completed PHQ-9 or PHQ-9M tool six months (+/- 60 days) after an index event.
Numerator	The number of patients in the denominator who have a completed PHQ-9 or PHQ-9M tool six months (+/- 60 days) after an index event.

Depression: Follow-up at Twelve Months	
Description	The percentage of adolescent patients (12 to 17 years of age) and adult patients (18 years of age or older) with Major Depression or Dysthymia with an index PHQ-9/PHQ-9M score greater than nine who have a completed PHQ-9 or PHQ-9M tool 12 months (+/- 60 days) after an index event.
Numerator	The number of patients in the denominator who have a completed PHQ-9 or PHQ-9M tool 12 months (+/- 60 days) after an index event.

*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 2022

- Updated the logic for the measure to be expressed in FHIR.
- Refer to the *Technical Release Notes* file in the Digital Measures Package for a comprehensive list of changes.

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	1. Commercial 12–17 years. 2. Commercial 18–44 years. 3. Commercial 45–64 years. 4. Commercial 65 years and older. 5. Medicaid 12–17 years. 6. Medicaid 18–44 years. 7. Medicaid 45–64 years. 8. Medicaid 65 years and older. 9. Medicare 18–44 years. 10. Medicare 45–64 years. 11. Medicare 65 years and older.
Risk adjustment	None.
Improvement notation	A higher rate indicates better performance.
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 diagnosis of major depression or dysthymia ***and*** a PHQ-9 total score >9 documented.
Initial Population	Members 12 years and older as of the start of the Intake Period who meet ***both*** of the following criteria: • A diagnosis of major depression or dysthymia that starts before and overlaps or starts when the PHQ-9 total score >9 is documented during the Intake Period. • Participation.

Exclusions	Members with any of the following at any time during the Intake Period or during 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.
Denominator	The Initial Population, minus Exclusions.
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_MY2022-1.0.0** – Bipolar Disorder (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1044) – 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-1.0.0** – 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_MY2022-1.0.0**
  - 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-1.0.0**
  - codesystem "ConditionClinicalStatusCodes": 'http://terminology.hl7.org/CodeSystem/condition-clinical'
  - codesystem "coverage-type": 'http://terminology.hl7.org/CodeSystem/v3-ActCode'
  - code "active": 'active' from "ConditionClinicalStatusCodes"
  - code "managed care policy": 'MCPOL' from "coverage-type"
  - code "retiree health program": 'RETIRE' from code "coverage-type"
  - code "subsidized health program": 'SUBSIDIZ' from "coverage-type"

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

NCQA's Rules for Allowable Adjustments of HEDIS describe how NCQA's HEDIS measure specifications can be adjusted for non-health plan reporting. Refer to the *Guidelines for the Rules of Allowable Adjustments of HEDIS* for additional information.

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

Rules for Allowable Adjustments for 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 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 a population of interest such as gender, sociodemographic characteristic or geographic region.
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. The 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.

*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 2022

- Updated the logic for the measure to be expressed in FHIR.
- Refer to the T*echnical Release Notes* file in the Digital Measures Package for a comprehensive list of changes.

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	1. Commercial 12–17 years. 2. Commercial 18–64 years. 3. Commercial 65 years and older. 4. Medicaid 12–17 years. 5. Medicaid 18–64 years.

<table>
<tr><td></td><td>6. Medicaid 65 years and older.
7. Medicare 18–64 years.
8. Medicare 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 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 HEDIS reporting is based on eligibility during the Participation Period.</td></tr>
<tr><td>Participation Period</td><td>The Measurement Period.</td></tr>
<tr><td>Depression Screening Instrument</td><td>A standard assessment instrument that has been normalized and validated for the appropriate patient population. Eligible screening instruments with thresholds for positive findings include:
<table>
<tr><th>Instruments for Adolescents (≤17 years)</th><th>Positive Finding</th></tr>
<tr><td>Patient Health Questionnaire (PHQ-9)®</td><td>Total Score ≥10</td></tr>
<tr><td>Patient Health Questionnaire Modified for Teens (PHQ- 9M)®</td><td>Total Score ≥10</td></tr>
<tr><td>Patient Health Questionnaire-2 (PHQ-2)®[1]</td><td>Total Score ≥3</td></tr>
<tr><td>Beck Depression Inventory-Fast Screen (BDI-FS)®[1,2]</td><td>Total Score ≥8</td></tr>
<tr><td>Center for Epidemiologic Studies Depression Scale—Revised (CESD-R)</td><td>Total Score ≥17</td></tr>
<tr><td>Edinburgh Postnatal Depression Scale (EPDS)</td><td>Total Score ≥10</td></tr>
<tr><td>PROMIS Depression</td><td>Total Score (T Score) ≥60</td></tr>
</table>
[1]Brief screening instrument. All other instruments are full-length.
[2]Proprietary; may be cost or licensing requirement associated with use.
<table>
<tr><th>Instruments for Adults (18+ years)</th><th>Positive Finding</th></tr>
<tr><td>Patient Health Questionnaire (PHQ-9)®</td><td>Total Score ≥10</td></tr>
<tr><td>Patient Health Questionnaire-2 (PHQ-2)®[1]</td><td>Total Score ≥3</td></tr>
<tr><td>Beck Depression Inventory-Fast Screen (BDI-FS)®[1,2]</td><td>Total Score ≥8</td></tr>
<tr><td>Beck Depression Inventory (BDI-II)</td><td>Total Score ≥20</td></tr>
<tr><td>Center for Epidemiologic Studies Depression Scale- Revised (CESD-R)</td><td>Total Score ≥17</td></tr>
</table></td></tr>
</table>

<table>
<tr><td></td><td>
<table>
<tr><td>Duke Anxiety-Depression Scale (DUKE-AD)®[2]</td><td>Total Score ≥30</td></tr>
<tr><td>Geriatric Depression Scale Short Form (GDS)[1]</td><td>Total Score ≥5</td></tr>
<tr><td>Geriatric Depression Scale Long Form (GDS)</td><td>Total Score ≥10</td></tr>
<tr><td>Edinburgh Postnatal Depression Scale (EPDS)</td><td>Total Score ≥10</td></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>Members 12 years of age and older at the start of the Measurement Period who also meet criteria for Participation.</td></tr>
<tr><td>Exclusions</td><td>

Members with bipolar disorder in 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.

</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_MY2022-1.0.0**
  - 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)
  - 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)
  - 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)
  - Other Bipolar Disorder (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1399)
- **NCQA_Hospice-1.0.0**
  - 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:

- **DSFE_HEDIS_MY2022-1.0.0**
  - codesystem "ICD-10": 'http://hl7.org/fhir/sid/icd-10-cm'
  - codesystem "LOINC": 'http://loinc.org'
  - codesystem "SNOMEDCT": 'http://snomed.info/sct'
  - 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 "Exercise counseling": 'Z71.82' from "ICD-10" display 'Exercise counseling'
  - 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 "Symptoms of depression (finding)": '394924000' from "SNOMEDCT" display 'Symptoms of depression (finding)'
  - 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_Terminology-1.0.0**
  - codesystem "ConditionClinicalStatusCodes": 'http://terminology.hl7.org/CodeSystem/condition-clinical'
  - codesystem "coverage-type": 'http://terminology.hl7.org/CodeSystem/v3-ActCode’
  - code "active": 'active' from "ConditionClinicalStatusCodes"
  - code "managed care policy": 'MCPOL' from "coverage-type"
  - code "retiree health program": 'RETIRE' from "coverage-type"
  - code "subsidized health program": 'SUBSIDIZ' from "coverage-type"

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

NCQA's Rules for Allowable Adjustments of HEDIS describe how NCQA's HEDIS measure specifications can be adjusted for non-health plan reporting. Refer to the *Guidelines for the Rules of Allowable Adjustments of HEDIS* for additional information.

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

Rules for Allowable Adjustments for 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 a population of interest such as gender, sociodemographic characteristic or geographic region.
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.
  - Additionally, states may encourage use of an ICD-10-CM code or other modifiers most commonly reported by pediatricians in providing preventive care to distinguish among tools. For example, Z13.42 can be used to indicate an "Encounter for screening for global developmental delays." Additional guidance on coding is available at: https://www.aap.org/en-us/Documents/coding_factsheet_developmentalscreeningtestingandEmotionalBehavioraassessment.pdf.
- To facilitate CMS's understanding of the data reported for this measure, states should use the "Additional Notes/Comments on Measure" section to document whether a medical chart review was conducted to validate the use of the 96110 CPT code for this measure.
- States may calculate this measure using either the administrative specification (which depends on the 96110 CPT code) or the hybrid specification (which does not rely solely on this code).
  - More information about the developmental screening tools that meet the measure criteria is available at: https://pediatrics.aappublications.org/content/pediatrics/suppl/2019/12/13/peds.2019-3449.DCSupplemental/PEDS_20193449SupplementaryData.pdf.
- During the development of this measure, it was determined that the ASQ:SE and M-CHAT screening tools were too specific because they screen for a domain-specific

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

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

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

B. ELIGIBLE POPULATION

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

C. ADMINISTRATIVE SPECIFICATION

Denominator

Denominator 1

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

Denominator 2

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

Denominator 3

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

Denominator 4

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

Numerators

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

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

Numerator 1

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

Numerator 2

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

Numerator 3

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

Numerator 4

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

Claims data

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

Important note about appropriate use of claims data

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

Claims NOT included in this measure

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

Exclusions

None.

D. MEDICAL RECORD SPECIFICATION

Denominator

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

Denominator 1

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

Denominator 2

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

Denominator 3

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

Denominator 4

The entire sample of 411 children.

Numerators

Numerator 1

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

Numerator 2

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

Numerator 3

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

Numerator 4

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

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

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

Tools must meet the following criteria:

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

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

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

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

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

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

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

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

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

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

Exclusions

None.

E. CALCULATION ALGORITHM

Step 1

Determine the denominators.

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

Step 2

Determine the numerators.

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

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

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

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

Step 3

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

Step 4

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

Total Numerator: Numerator 1 + Numerator 2 + Numerator 3

Total Denominator: Denominator 1 + Denominator 2 + Denominator 3

Sampling Methodology

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

F. OPTIONAL AGE-SPECIFIC OVERSAMPLING FOR THE DENOMINATOR

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

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

Ambulatory Care (AMB)

SUMMARY OF CHANGES TO HEDIS MY 2022

- Clarified that members in hospice or using hospice services anytime during the measurement year are a required exclusion.
- Removed stratified reporting by Medicaid eligibility category.
- Updated the "Member Months" definition in Calculations to indicate that IDSS produces member years data for all product lines.
- Clarified in the Note that supplemental data may not be used for the mental health and chemical dependency required exclusion.
- Clarified the clinical components headers in the Rules for Allowable Adjustments.
- Added required exclusions to the Rules for Allowable Adjustments.
- Clarified allowable adjustments to the calculations criteria in the Rules for Allowable Adjustments.

Description

This measure summarizes utilization of ambulatory care in the following categories:

- Outpatient Visits Including Telehealth.
- ED Visits.

Calculations

Product lines

Medicaid.

Member months

For each table, report all member months for the measurement year. IDSS automatically produces member years data for all product lines. Refer to *Specific Instructions for Utilization Tables* for more information.

Required exclusions

Apply the following required exclusions:

- Exclude visits for mental health or chemical dependency. Any of the following meet criteria:
  - A principal diagnosis of mental health or chemical dependency (Mental and Behavioral Disorders Value Set).
  - Psychiatry (Psychiatry Value Set).
  - Electroconvulsive therapy (Electroconvulsive Therapy Value Set).
- Members in hospice or using hospice services anytime during the measurement year. Refer to *General Guideline 17: Members in Hospice.*

Counting multiple services

For combinations of multiple ambulatory services falling in different categories on the same day, report each service that meets the criteria in the appropriate category.

Outpatient visits including telehealth

Identify outpatient visits using any of the following.

- Outpatient visits (Ambulatory Outpatient Visits Value Set).
- Telephone visits (Telephone Visits Value Set).
- E-visits or virtual check-ins (Online Assessments Value Set).

Count multiple codes with the same practitioner on the same date of service as a single visit. Count visits with different practitioners separately (count visits with different providers on the same date of service as different visits).

Report services without regard to practitioner type, training or licensing.

ED visits Count each visit to an ED once, regardless of the intensity or duration of the visit. Count multiple ED visits on the same date of service as one visit. Identify ED visits using either of the following:

- An ED visit (ED Value Set).
- A procedure code (ED Procedure Code Value Set) with an ED place of service code (ED POS Value Set).

Do not include ED visits that result in an inpatient stay (Inpatient Stay Value Set).

Note

- *This measure provides a reasonable proxy for professional ambulatory encounters. It is neither a strict accounting of all ambulatory resources nor an effort to be all-inclusive.*
- *Supplemental data may not be used for this measure. In addition, supplemental data may not be used for the mental health and chemical dependency required exclusion.*

Data Elements for Reporting

Table AMB-1: Data Elements for Ambulatory Care

Metric	Age	Data Element	Reporting Instructions
Outpatient	LessThan1	MemberMonths	For each Stratification, repeat per Metric
ED	1-9	VisitCount	For each Metric and Stratification
	10-19	Rate	12,000 * VisitCount / MemberMonths
	20-44		
	45-64		
	65-74		
	75-84		
	85+		
	Unknown		
	Total		

Rules for Allowable Adjustments of HEDIS

NCQA's Rules for Allowable Adjustments of HEDIS describe how NCQA's HEDIS measure specifications can be adjusted for non-health plan reporting. Refer to the *Guidelines for the Rules of Allowable Adjustments of HEDIS* for additional information.

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

Rules for Allowable Adjustments for Ambulatory 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. Organizations can choose whether to apply age band criteria.
Continuous enrollment, Allowable gap, Anchor Date	NA	There are no continuous enrollment, Allowable gap or Anchor date requirements for this measure. Organizations are not required to calculate member months.
Benefits	NA	There are no required benefits for this measure.
Other	Yes	Organizations may use additional eligible population criteria to focus on a population of interest such as gender, sociodemographic characteristic or geographic region.
CLINICAL COMPONENTS		
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*.
Calculations Criteria	**Adjustments Allowed (Yes/No)**	**Notes**
Ambulatory services	Yes, with limits	Value sets and logic may not be changed. Organizations may include denied claims to calculate the number of ambulatory services.

Fluoride Varnish

Rhode Island Department of Health

A. DESCRIPTION

The percentage of children who received a fluoride varnish application in primary care in the 12 months preceding their first, second, or third birthday.

Guidance for Reporting:

- This measure includes three age-specific indicators assessing whether children are screened by their first, second or third birthdays. Four rates, one for each age group and a combined rate, are to be calculated and reported.

B. ELIGIBLE POPULATION

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

C. DATA SOURCE

C.1 – Administrative Specifications

Denominator

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

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

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

Denominator 4: All children in the eligible population who turned 1, 2, or 3 during the measurement year, i.e., the sum of denominators 1, 2, and 3.

Numerators

The numerators identify children who received a fluoride varnish application by a medical practice. National recommendations call for application among young children. The measure is based on three, age-specific indicators.

Numerator 1: Children in Denominator 1 who had a claim with CPT code 99188 or CDT code D1206 billed by a medical practice by their first birthday.

Numerator 2: Children in Denominator 2 who had a claim with CPT code 99188 or CDT code D1206 billed by a medical practice after their first and before or on their second birthdays.

Numerator 3: Children in Denominator 3 who had a claim with CPT code 99188 or CDT code D1206 billed by a medical practice after their second and before or on their third birthdays.

Numerator 4: Children in the entire eligible population who had claim with CPT code 99188 or CDT code D1206 billed by a medical practice in the 12 months preceding their 1st, 2nd, or 3rd birthday (the sum of numerators 1, 2 and 3).

Claims data: CPT code 99188 (application of topical fluoride varnish by a physician or other qualified health care professional) or CDT code D1206 (topical application of fluoride varnish) when billed by a medical practice.

C.2 – Medical Record Specifications

Denominator

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

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

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

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

Denominator 4: The entire sample of 411 children.

Numerators

Numerator 1: Children in Denominator 1 who had received a fluoride varnish application that was documented by their first birthday

Numerator 2: Children in Denominator 2 who had received a fluoride varnish application that was documented after their first and before or on their second birthday

Numerator 3: Children in Denominator 3 who received a fluoride varnish application that was documented after their second and before or on their third birthday

Numerator 4: Children in Denominator 4 who had received a fluoride varnish application that was documented in the 12 months preceding their first, second or third birthday (the sum of numerators 1, 2 and 3).

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

- A note indicating the date on which the test was performed, and
- Evidence of a fluoride varnish application

D. EXCLUSIONS

None.

E. CALCULATION ALGORITHM

Step 1:

Determine the denominators.

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

Step 2:

Determine the numerators.

For each age cohort, and for the total, identify children who had received a fluoride varnish application by their birthday as found through claims data or documented in the medical chart.

Claims Data:

Children for whom a claim of 99188 or D1206 billed by a medical practice was submitted for services in the 12 months preceding their birthday.

Medical Record:

Children who had documentation in the medical record of receiving a fluoride varnish application, validated tool in the 12 months preceding their birthday.

Documentation must include the date of screening and evidence that the fluoride varnish application was completed.

Step 3:

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

Step 4: Create the overall measure of screening based on the age-specific numerators and denominators.

Total Numerator: Numerator 1 + Numerator 2 + Numerator 3

Total Denominator: Denominator 1 + Denominator 2 + Denominator 3

Sampling Methodology

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

F. OPTIONAL AGE-SPECIFIC OVERSAMPLING FOR THE DENOMINATOR

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

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

*Immunizations for Adolescents (IMA)**

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

SUMMARY OF CHANGES TO HEDIS MY 2022

- Clarified that members in hospice or using hospice services anytime during the measurement year are a required exclusion.
- Revised the optional exclusions for anaphylaxis due to vaccine to be numerator compliant for specific indicators.
- Clarified in the example for the two-dose HPV vaccination series that the second vaccine must be on or after July 25.
- Added required exclusions and removed optional exclusions in the Rules for Allowable Adjustments.

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).
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 exclusion	Members in hospice or using hospice services anytime during the measurement year. Refer to *General Guideline 17: Members in Hospice.*

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-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)	✓

Rules for Allowable Adjustments of HEDIS

NCQA's Rules for Allowable Adjustments of HEDIS describe how NCQA's HEDIS measure specifications can be adjusted for non-health plan reporting. Refer to the *Guidelines for the Rules of Allowable Adjustments of HEDIS* for additional information.

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

Rules for Allowable Adjustments for 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 a population of interest such as gender, 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**
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**
• 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.

Inpatient Utilization—General Hospital/Acute Care (IPU)

SUMMARY OF CHANGES TO HEDIS MY 2022

- Clarified that members in hospice or using hospice services anytime during the measurement year are a required exclusion.
- Removed stratified reporting by Medicaid eligibility category.
- Updated the "Member Months" definition in Calculations to indicate that IDSS produces member years data for all product lines.
- Clarified the clinical components headers in the Rules for Allowable Adjustments.
- Added required exclusions to the Rules for Allowable Adjustments.
- Clarified allowable adjustments to the calculations criteria in the Rules for Allowable Adjustments.

Description

This measure summarizes utilization of acute inpatient care and services in the following categories:

- Maternity.
- Surgery.
- Medicine.
- Total inpatient (the sum of Maternity, Surgery and Medicine).

Calculations

Product lines	Medicaid.
Member months	For each table, report all member months for the measurement year. IDSS automatically produces member years data for all product lines. Refer to *Specific Instructions for Utilization Tables* for more information. Maternity rates are reported per 1,000 male and per 1,000 female total member months for members 10–64 years in order to capture deliveries as a percentage of the total inpatient discharges.
Required exclusion	Members in hospice or using hospice services anytime during the measurement year. Refer to *General Guideline 17: Members in Hospice.*
Days	Count all days associated with the identified discharges. Report days for total inpatient, maternity, surgery and medicine.
ALOS	Refer to *Specific Instructions for Utilization Tables* for the formula. Calculate average length of stay for total inpatient, maternity, surgery and medicine.

Use the following steps to identify and categorize inpatient discharges.

Step 1 Identify all acute inpatient discharges on or between January 1 and December 31 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.

Step 2 Exclude discharges with a principal diagnosis of mental health or chemical dependency (Mental and Behavioral Disorders Value Set) on the discharge claim.

Exclude newborn care rendered from birth to discharge home from delivery (only include care rendered during subsequent rehospitalizations after the delivery discharge). Identify newborn care by a principal diagnosis of live-born infant (Deliveries Infant Record Value Set). Organizations must develop methods to differentiate between the mother's claim and the newborn's claim, if needed.

Step 3 Report total inpatient, using all discharges identified after completing steps 1 and 2.

Step 4 Report maternity. A delivery is not required for inclusion in the *Maternity* category; any maternity-related stay is included. Include birthing center deliveries and count them as one day of stay.

Starting with all discharges identified in step 3, identify maternity using either of the following:

- A maternity-related principal diagnosis (Maternity Diagnosis Value Set).
- A maternity-related stay (Maternity Value Set).

Step 5 Report surgery. From discharges remaining after removing maternity (identified in step 4) from total inpatient (identified in step 3), identify surgery (Surgery Value Set).

Step 6 Report medicine. Categorize as medicine the discharges remaining after removing maternity (identified in step 4) and surgery (identified in step 5) from total inpatient (identified in step 3).

Note

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

Data Elements for Reporting

Table IPU-1: Data Elements for Inpatient Utilization—General Hospital/Acute Care

Metric	Age	Data Element	Reporting Instructions
Total	LessThan1	MemberMonths	For each Stratification, repeat per Metric
Maternity*	1-9	Days	For each Metric and Stratification
Surgery	10-19	Discharges	For each Metric and Stratification
Medicine	20-44	Rate	12,000 * Discharges / MemberMonths
	45-64	Rate	12,000 * Days / MemberMonths
	65-74	Rate	Days / Discharges
	75-84		
	85+		
	Unknown		
	Total		

*For Maternity, only report Ages 10–19, 20–44, 45–64 and Unknown

Rules for Allowable Adjustments of HEDIS

NCQA's Rules for Allowable Adjustments of HEDIS describe how NCQA's HEDIS measure specifications can be adjusted for non-health plan reporting. Refer to the *Guidelines for the Rules of Allowable Adjustments of HEDIS* for additional information.

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

Rules for Allowable Adjustments for Inpatient Utilization—General Hospital/Acute 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. Organizations can choose whether to apply age band criteria.
Continuous enrollment, Allowable gap, Anchor Date	NA	There are no continuous enrollment, Allowable gap or Anchor date requirements for this measure. Organizations are not required to calculate member months.
Benefits	No	There are no required benefits for this measure.
Other	Yes	Organizations may use additional eligible population criteria to focus on a population of interest such as gender, sociodemographic characteristic or geographic region.
CLINICAL COMPONENTS		
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*.
Calculations Criteria	**Adjustments Allowed (Yes/No)**	**Notes**
Inpatient Services	Yes, with limits	Value sets and logic may not be changed. Organizations may include denied claims to calculate inpatient services.

*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 2022

- Clarified that members in hospice or using hospice services anytime during the measurement year are a required exclusion.

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 Follow the steps below to identify the eligible population.

Step 1 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 • Empagliflozin-linagliptin	• Empagliflozin-metformin • 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 detemir • Insulin glargine • 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	

Description	Prescription		
Glucagon-like peptide-1 (GLP1) agonists	• Albiglutide • Dulaglutide • Exenatide	• Liraglutide (excluding Saxenda®) • Semaglutide	
Sodium glucose cotransporter 2 (SGLT2) inhibitor	• Canagliflozin	• Dapagliflozin (excluding Farxiga®)	• 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.*

Step 2: Required exclusions Exclude members who meet any of the following criteria:

- 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 anytime during the measurement year. Refer to *General Guideline 17: Members in Hospice.*
- Members receiving palliative care (Palliative Care Assessment Value Set; Palliative Care Encounter Value Set; Palliative Care Intervention Value Set) during the measurement year.

Step 3: 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 one claim/encounter for frailty (Frailty Device Value Set; Frailty Diagnosis Value Set; Frailty Encounter Value Set; Frailty Symptom Value Set) 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 frailty (Frailty Device Value Set; Frailty Diagnosis Value Set; Frailty Encounter Value Set; Frailty Symptom Value Set) 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).

Exclusions *(optional)*

Members who do 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.

If the member was included in the measure based on claim or encounter data, as described in the event/ diagnosis criteria, the optional exclusions do not apply because the member had a diagnosis of diabetes.

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	ExclusionAdminOptional	For each Stratification
	75-85	ExclusionAdminRequired	For each Stratification
	Total	NumeratorByAdmin	For each Stratification
		NumeratorBySupplemental	For each Stratification
		Rate	(Percent)

Rules for Allowable Adjustments of HEDIS

NCQA's Rules for Allowable Adjustments of HEDIS describe how NCQA's HEDIS measure specifications can be adjusted for non-health plan reporting. Refer to the *Guidelines for the Rules of Allowable Adjustments of HEDIS* for additional information.

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

Rules for Allowable Adjustments for 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 a population of interest such as gender, sociodemographic characteristic or geographic region.
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 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*.
Optional Exclusions	No, if applied	Optional exclusions are not required, but if they are used, only specified exclusions may be applied. Value sets may not be changed.
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 2022

- Clarified that members in hospice or using hospice services anytime during the measurement year are a required exclusion.
- Added required exclusions to the Rules for Allowable Adjustments.

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 exclusion	Members in hospice or using hospice services anytime during the measurement year. Refer to *General Guideline 17: Members in Hospice*.

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 and Lead Screening in Children 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	
	ExclusionAdminOptional	Report once	
	ExclusionMedRecsOptional	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

NCQA's Rules for Allowable Adjustments of HEDIS describe how NCQA's HEDIS measure specifications can be adjusted for non-health plan reporting. Refer to the *Guidelines for the Rules of Allowable Adjustments of HEDIS* for additional information.

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

Rules for Allowable Adjustments for 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 a population of interest such as gender, 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**
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**
Lead capillary or venous blood test	No	Value sets and logic may not be changed.

Maternal Depression Screening

NQF Endorsement Status	Endorsement Removed
NQF ID	1401
Measure Type	Process
Measure Content Last Updated	2021-06-30
Info As Of	Not Available

Properties

Description	The percentage of children who turned 6 months of age during the measurement year, who had a face-to-face visit between the clinician and the child during child's first 6 months, and who had a maternal depression screening for the m at least once between 0 and 6 months of life.
Numerator	Children who had documentation of a maternal depression screening for the m at least once between 0 and 6 months of life.
Denominator	Children with a visit who turned 6 months of age in the measurement year.
Denominator Exclusions	None
Rationale	This measure encourages health care providers to screen new ms for maternal depression. Periodic screening for maternal depression has been recommended and found to be feasible during an infant health supervision visits. Pediatricians have an opportunity to screen and intervene during well child visits.
Evidence	Not Available

Developer/Steward

Steward	National Committee for Quality Assurance
Contact	Not Available
Measure Developer	National Committee for Quality Assurance

Maternal Depression Screening

Development Stage	Fully Developed

Characteristics

Measure Type	Process
Meaningful Measure Area	Prevention, Treatment, and Management of Mental Health
Healthcare Priority	Promote Effective Prevention & Treatment of Chronic Disease
eCQM Spec Available	Not Available
NQF Endorsement Status	Endorsement Removed
NQF ID	1401
Last NQF Update	2014-07-31
Target Population Age	6 months
Target Population Age (High)	Not Available
Target Population Age (Low)	6
Reporting Level	Clinicians: Group/Practice
Conditions	Behavioral/Mental Health
Subconditions	Depression
Care Settings	Ambulatory Care: Ambulatory Surgery Center (ASC); Behavioral Health : Outpatient; Clinician; Hospital Outpatient; Hospital Outpatient Surgery Department/Ambulatory Surgery Center; Outpatient

Groups

Core Measure Set	Not Available

Measure Group	Group Identifier

Maternal Depression Screening

Measure Group	Group Identifier
qpp quality id	
qpp quality id	#372

Measure Links

Measure Program: Merit-Based Incentive Payment System (MIPS) Program

Info As Of	Not Available
Program / Model Notes	
Data Sources	Paper Medical Records; Electronic Clinical Data (non-EHR); Electronic Health Record
Purposes	Not Available
Quality Domain	Community, Population and Public Health
Reporting Frequency	Not Available
Impacts Payment	Not Available
Reporting Status	Inactive
Data Reporting Begin Date	Not Available
Data Reporting End Date	2020-01-01

Measure Program Links

https://qpp.cms.gov/mips/overview

Maternal Depression Screening

Milestones

Milestone: Removed

Effective Date	2021-10-01
Comments	Not Available

Milestone: Implemented

Effective Date	2018-10-01
Comments	Not Available

Milestone: Finalized

Effective Date	2016-11-04
Comments	Not Available

Milestone: Proposed

Effective Date	2016-05-09
Comments	Not Available
Milestone Links	https://www.federalregister.gov/articles/2016/05/09/2016-10032/medicare-program-merit-based-incentive-payment-system-mips-and-alternative-payment-model-apm#p-2773

Milestone: Reference

Effective Date	1900-01-01
Comments	Not Available
Milestone Links	https://www.federalregister.gov/documents/2016/11/04/2016-25240/medicare-program-merit-based-incentive-payment-system-mips-and-alternative-payment-model-apm

Measure Program: Medicare and Medicaid Electronic Health Record Incentive

Maternal Depression Screening

Program for Eligible Professionals

Info As Of	Not Available
Program / Model Notes	
Data Sources	Not Specified
Purposes	Not Available
Quality Domain	Community, Population and Public Health
Reporting Frequency	Not Available
Impacts Payment	Not Available
Reporting Status	Inactive
Data Reporting Begin Date	Not Available
Data Reporting End Date	2018-10-01

Measure Program Links

Milestones

Milestone: Removed

Effective Date	2018-10-01
Comments	Not Available

Measure Program: Physician Compare

Info As Of	Not Available
Program / Model Notes	
Data Sources	EHR; Paper Medical Records; Electronic Clinical Data (non-EHR)

Maternal Depression Screening

Purposes	Not Available
Quality Domain	Not Available
Reporting Frequency	Not Available
Impacts Payment	Not Available
Reporting Status	Active
Data Reporting Begin Date	2018-01-01
Data Reporting End Date	Not Available

Measure Program Links

https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Compare-DAC

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

Questions

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

Composites

Adult Version

Talking With You About Taking Care of Your Own Health

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

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

Child Version

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

PCMH4. Respondent and provider talked about age-appropriate behaviors

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

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

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

Provider's Advice on Keeping Your Child Safe and Healthy

PCMH7. Respondent and provider talked about injury prevention

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

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

SDOH Screening Measure Specifications

Social Determinants of Health (SDOH) Screening
Steward: Rhode Island Executive Office of Health and Human Services
As of April 8, 2021

SUMMARY OF CHANGES FOR 2021 (PERFORMANCE YEAR 4)

- Updated to include guidance on how to attribute patients and providers to AEs.
- Updated to include an example of ICD-10 Z codes in use by at least one AE to capture SDOH screening results electronically.
- Updated to include information about patient and provider attribution to AEs.

Description

Social Determinants of Health are the "conditions in the places where people live, learn, work, and play [that] affect a wide range of health risks and outcomes."[1]

The percentage of attributed patients who were screened for Social Determinants of Health using a screening tool once per measurement year, where the primary care clinician has documented the completion of the screening and the results. Please note that for organizations participating in the Medicaid Accountable Entity (AE) program, the screening tool must be approved by EOHHS to count as meeting numerator requirements.

Eligible Population

Note: *Patients in hospice care or who refuse to participate are excluded from the eligible population. Additional details on exclusions can be found below.*

Product lines	Medicaid, Commercial
Stratification	None
Ages	All ages
Continuous enrollment	Enrolled in the MCO for 11 out of 12 months during the measurement year.
Allowable gap	No break in coverage lasting more than 30 days.
Anchor date	December 31 of the measurement year.
Lookback period	12 months
Benefit	Medical
Event/diagnosis	• The patient has been seen by an AE/ACO-affiliated primary care clinician anytime within the last 12 months • 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

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

	codes for determining a primary care visit: 99201-99205; 99212-99215; 99324-99337; 99341-99350; 99381 – 99387; 99391-99397; 99490; 99495-99496 ○ 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 provider rosters that are in place as of December of the performance year.
Provider Attribution to AEs	Each primary care provider (PCP) bills under a Taxpayer Identification Number (TIN), typically the TIN of the entity that employs that PCP or through which the PCP contracts with public and/or private payers. Some PCPs may contract through more than one TIN. Each TIN is permitted to affiliate with at most one AE at any given time, and each PCP is permitted to affiliate with as most one AE at any given time. That is, even if a PCP contracts through more than one TIN and those TINs are affiliated with different AEs, the PCP may only be affiliated with one of the AEs. For more information about which primary care providers are eligible for attribution to an AE, please refer to "Attachment M: Attribution Guidance."[2]

Electronic Data Specifications

The percentage of attributed patients who were screened for Social Determinants of Health using an EOHHS-approved screening tool, where the primary care practice has documentation of the completion of the screening, the date of the screen, and the results.

[2] https://eohhs.ri.gov/sites/g/files/xkgbur226/files/2021-03/Attachment%20M%20-%20PY4%20Attribution%20Guidance.pdf.

Denominator	The eligible population
Numerator	Individuals attributed to the primary care clinician who were screened for Social Determinants of Health once per measurement year and for whom results are in the primary care clinician's EHR. 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. AEs can, but not required to, use ICD-10 Z codes to track performance for this measure electronically. An example of two Z codes in use by at least one AE is provided below: • Z04 ○ Definition: Encounter for examination and observation for other reasons ○ Meaning: SDOH screening completed • Z53 ○ Definition: Persons encountering health services for specific procedure and treatment, not carried out ○ 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 either be embedded in the EHR or a PDF of the screening results must be accessible in the EHR, i.e., the primary care clinician must not be required to leave the EHR to access a portal or other electronic location to view the screening results. 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

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 2022

- Clarified that members in hospice or using hospice services anytime during the measurement year are a required exclusion.

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-day 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 Follow the steps below to identify the eligible population.

Step 1 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) 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.

Step 2: Required exclusions

Exclude members who meet any of the following criteria:

- Female 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 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 anytime during the measurement year. Refer to *General Guideline 17: Members in Hospice*.
- Members receiving palliative care (Palliative Care Assessment Value Set; Palliative Care Encounter Value Set; Palliative Care Intervention Value Set) during the measurement year.

Estrogen Agonists Medications

Description	Prescription
Estrogen agonists	• Clomiphene

Step 3: 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 one claim/encounter for frailty (Frailty Device Value Set; Frailty Diagnosis Value Set; Frailty Encounter Value Set; Frailty Symptom Value Set) 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

NCQA's Rules for Allowable Adjustments of HEDIS describe how NCQA's HEDIS measure specifications can be adjusted for non-health plan reporting. Refer to the *Guidelines for the Rules of Allowable Adjustments of HEDIS* for additional information.

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

Rules for Allowable Adjustments for 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 a population of interest such as gender, sociodemographic characteristic or geographic region.
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 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 2022

- Updated the logic for the measure to be expressed in FHIR.
- Refer to the *Technical Release Notes* file in the Digital Measures Package for a comprehensive list of changes.

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. • *Alcohol Counseling or Other Follow-up Care*. 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	1. Commercial 18–44 years. 2. Commercial 45–64 years. 3. Commercial 65 years and older. 4. Medicaid 18–44 years. 5. Medicaid 18–44 years. 6. Medicaid 65 years and older. 7. Medicare 18–44 years. 8. Medicare 45–64 years. 9. Medicare 65 years and older.
Risk adjustment	None.

<table>
<tr><td>Improvement notation</td><td>A higher rate indicates better performance.</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 to include AUDIT, AUDIT-C and a Single-Question Screen. Screening requires completion of one or more instruments. The threshold for a positive finding is indicated below for each instrument.
<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>
<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></td></tr>
<tr><td>Alcohol Counseling or Other Follow-Up Care</td><td>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>Members 18 years and older at the start of the Measurement Period who also meet criteria for Participation.</td></tr>
<tr><td>Exclusions</td><td>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.</td></tr>
<tr><td>Denominator</td><td>Denominator 1
The Initial Population, minus Exclusions.</td></tr>
</table>

	Denominator 2 All members in Numerator 1 with a positive finding for unhealthy alcohol use screeningbetween January 1 and November 1 of the Measurement Period.
Numerator	**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—Counseling or Other Follow-Up 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).

Data criteria (element level)

Value Sets:

- **ASFE_HEDIS_MY2022-1.0.0**
  - 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-1.0.0**
  - 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_MY2022-1.0.0**
  - codesystem "ICD-10": '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" 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 "Other specified counseling": 'Z71.89' from "ICD-10" display 'Other specified counseling'
  - 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-1.0.0**
  - codesystem "ConditionClinicalStatusCodes": 'http://terminology.hl7.org/CodeSystem/condition-clinical'
  - codesystem "coverage-type": 'http://terminology.hl7.org/CodeSystem/v3-ActCode'
  - code "active": 'active' from "ConditionClinicalStatusCodes"
  - code "managed care policy": 'MCPOL' from "coverage-type"
  - code "retiree health program": 'RETIRE' from "coverage-type"
  - code "subsidized health program": 'SUBSIDIZ' from "coverage-type"

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

NCQA's Rules for Allowable Adjustments of HEDIS describe how NCQA's HEDIS measure specifications can be adjusted for non-health plan reporting. Refer to the *Guidelines for the Rules of Allowable Adjustments of HEDIS* for additional information.

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

Rules for Allowable Adjustments for 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 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 a population of interest such as gender, sociodemographic characteristic or geographic region.
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.

Quality ID #431 (NQF 2152): Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling
– National Quality Strategy Domain: Community/Population Health
– Meaningful Measure Area: Prevention and Treatment of Opioid and Substance Use Disorders

2021 COLLECTION TYPE:
MIPS CLINICAL QUALITY MEASURES (CQMS)

MEASURE TYPE:
Process

DESCRIPTION:
Percentage of patients aged 18 years and older who were screened for unhealthy alcohol use using a systematic screening method at least once within the last 12 months AND who received brief counseling if identified as an unhealthy alcohol user

INSTRUCTIONS:
This measure is to be submitted **once per performance period** for patients seen during the performance period. This measure is intended to reflect the quality of services provided for preventive screening for unhealthy alcohol use. There is no diagnosis associated with this measure. This measure may be submitted by Merit-based Incentive Payment System (MIPS) eligible clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding. For the purposes of the measure, the most recent denominator eligible encounter should be used to determine if the numerator action for the submission criteria was performed within the 12-month look back period.

This measure will be calculated with 3 performance rates:

1) Percentage of patients aged 18 years and older who were screened for unhealthy alcohol use using a systematic screening method at least once within the last 12 months
2) Percentage of patients aged 18 years and older who were identified as unhealthy alcohol users who received brief counseling
3) Percentage of patients aged 18 years and older who were screened for unhealthy alcohol use using a systematic screening method at least once within the last 12 months AND who received brief counseling if identified as unhealthy alcohol users

The denominator of submission criteria 2 is a subset of the resulting numerator for submission criteria 1, as submission criteria 2 is limited to assessing if patients identified as unhealthy alcohol users received brief counseling. For all patients, submission criteria 1 and 3 are applicable, but submission criteria 2 will only be applicable for those patients who are identified as unhealthy alcohol users. Therefore, data for every patient that meets the age and encounter requirements will only be submitted for submission criteria 1 and 3, whereas data submitted for submission criteria 2 will be for a subset of patients who meet the age and encounter requirements, as the denominator has been further limited to those who were identified as unhealthy alcohol users.
NOTE: *Patient encounters for this measure conducted via telehealth (e.g., encounters coded with GQ, GT, 95, or POS 02 modifiers) are allowable.*

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

Payment Program (QPP) website.

THERE ARE THREE SUBMISSION CRITERIA FOR THIS MEASURE:

1) All patients who were screened for unhealthy alcohol use using a systematic screening method

AND

2) All patients who were identified as unhealthy alcohol users who received brief counseling

AND

3) All patients who were screened for unhealthy alcohol use using a systematic screening method and, if identified as unhealthy alcohol users received brief counseling, or were not identified as unhealthy alcohol users

This measure contains three submission criteria which aim to identify patients who were screened for unhealthy alcohol use using a systematic screening method (submission criteria 1), patients who were identified as unhealthy alcohol users and who received brief counseling (submission criteria 2), and a comprehensive look at the overall performance on unhealthy alcohol use screening and brief counseling (submission criteria 3). By separating this measure into various submission criteria, the MIPS eligible professional or MIPS eligible clinician will be able to better ascertain where gaps in performance exist, and identify opportunities for improvement. The overall rate (submission criteria 3) should be utilized to compare performance to published versions of this measure prior to the 2021 performance year, when the measure had a single performance rate. For accountability reporting in the CMS MIPS program, the rate for submission criteria 2 is used for performance.

SUBMISSION CRITERIA 1: ALL PATIENTS WHO WERE SCREENED FOR UNHEALTHY ALCOHOL USE

DENOMINATOR (SUBMISSION CRITERIA 1):
All patients aged 18 years and older seen for at least two visits or at least one preventive visit during the measurement period

> ***DENOMINATOR NOTE:*** **Signifies that this CPT Category I code is a non-covered service under the Medicare Part B Physician Fee Schedule (PFS). These non-covered services should be counted in the denominator population for MIPS CQMs.*
>
> **Denominator Criteria (Eligible Cases):**
> Patients aged ≥ 18 years
> **AND**
> **At least two patient encounters during the performance period (CPT or HCPCS):** 90791, 90792, 90832, 90834, 90837, 90845, 96156, 96158, 97165, 97166, 97167, 97168, 97802, 97803, 97804, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, G0270, G0271
> **OR**
> **At least one preventive encounter during the performance period (CPT or HCPCS):** 99385*, 99386*, 99387*, 99395*, 99396*, 99397*, 99401*, 99402*, 99403*, 99404*, 99411*, 99412*, 99429*, G0438, G0439

NUMERATOR (SUBMISSION CRITERIA 1):
Patients who were screened for unhealthy alcohol use using a systematic screening method at least once within the last 12 months

> **Definitions:**
> **Systematic screening method** – For purposes of this measure, one of the following systematic methods to assess unhealthy alcohol use must be utilized. "Systematic screening methods" and thresholds for defining unhealthy alcohol use include:
> - AUDIT Screening Instrument (score ≥ 4)

- AUDIT-C Screening Instrument (score ≥ 4 for men; score ≥ 3 for women)
- Single Question Screening - 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? (response ≥ 1)

NUMERATOR NOTE:
To satisfy the intent of this measure, a patient must have at least one screening for unhealthy alcohol use during the 12-month period. If a patient has multiple screenings for unhealthy alcohol use during the 12-month period, only the most recent screening, which has a documented status of unhealthy alcohol user or unhealthy alcohol non-user, will be used to satisfy the measure requirements.

Denominator Exception(s) are determined on the date of the most recent denominator eligible encounter.

Numerator Options:

Performance Met:	Patient identified as an unhealthy alcohol user when screened for unhealthy alcohol use using a systematic screening method **(G2196)**
OR	
Performance Met:	Patient screened for unhealthy alcohol use using a systematic screening method and not identified as an unhealthy alcohol user **(G2197)**
OR	
Denominator Exception:	Documentation of medical reason(s) for not screening for unhealthy alcohol use using a systematic screening method (e.g., limited life expectancy, other medical reasons) **(G2198)**
OR	
Performance Not Met:	Patient not screened for unhealthy alcohol use using a systematic screening method, reason not given **(G2199)**

SUBMISSION CRITERIA 2: ALL PATIENTS WHO WERE IDENTIFIED AS UNHEALTHY ALCOHOL USERS AND WHO RECEIVED BRIEF COUNSELING

DENOMINATOR (SUBMISSION CRITERIA 2):
All patients aged 18 years and older seen for at least two visits or at least one preventive visit during the measurement period who were screened for unhealthy alcohol use and identified as an unhealthy alcohol user

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

Denominator Criteria (Eligible Cases):
Patients aged ≥ 18 years
AND
All eligible instances when **G2196** is submitted for Performance Met (patient identified as an unhealthy alcohol user when screened for unhealthy alcohol use using a systematic screening method) in the numerator of Submission Criteria 1
AND
At least two patient encounters during the performance period (CPT or HCPCS): 90791, 90792, 90832, 90834, 90837, 90845, 96156, 96158, 97165, 97166, 97167, 97168, 97802, 97803, 97804, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, G0270, G0271

OR

At least one preventive encounter during the performance period (CPT or HCPCS): 99385*, 99386*, 99387*, 99395*, 99396*, 99397*, 99401*, 99402*, 99403*, 99404*, 99411*, 99412*, 99429*, G0438, G0439

NUMERATOR (SUBMISSION CRITERIA 2):

Patients who received brief counseling

Definitions:

Brief counseling – "Brief counseling" for unhealthy alcohol use refers to one or more counseling sessions, a minimum of 5-15 minutes, which may include: feedback on alcohol use and harms; identification of high risk situations for drinking and coping strategies; increased motivation and the development of a personal plan to reduce drinking.

NUMERATOR NOTE:

In the event that a patient is screened for unhealthy alcohol use and identified as an unhealthy user but did not receive brief alcohol cessation counseling submit G2202.

Denominator Exception(s) are determined on the date of the most recent denominator eligible encounter for all submission criteria.

Numerator Options:

Performance Met:	Patient identified as an unhealthy alcohol user received brief counseling **(G2200)**
OR	
Denominator Exception:	Documentation of medical reason(s) for not providing brief counseling (e.g., limited life expectancy, other medical reasons) **(G2201)**
OR	
Performance Not Met:	Patient did not receive brief counseling if identified as an unhealthy alcohol user, reason not given **(G2202)**

SUBMISSION CRITERIA 3: ALL PATIENTS WHO WERE SCREENED FOR UNHEALTHY ALCOHOL USE AND, IF IDENTIFIED AS AN UNHEALTHY ALCOHOL USER RECEIVED BRIEF COUNSELING, OR WERE NOT IDENTIFIED AS AN UNHEALTHY ALCOHOL USER

DENOMINATOR (SUBMISSION CRITERIA 3):

All patients aged 18 years and older seen for at least two visits or at least one preventive visit during the measurement period

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

Denominator Criteria (Eligible Cases):

Patients aged ≥ 18 years

AND

At least two patient encounters during the performance period (CPT or HCPCS): 90791, 90792, 90832, 90834, 90837, 90845, 96156, 96158, 97165, 97166, 97167, 97168, 97802, 97803, 97804, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, G0270, G0271

OR

At least one preventive encounter during the performance period (CPT or HCPCS): 99385*, 99386*,

99387*, 99395*, 99396*, 99397*, 99401*, 99402*, 99403*, 99404*, 99411*, 99412*, 99429*, G0438, G0439

NUMERATOR (SUBMISSION CRITERIA 3):
Patients who were screened for unhealthy alcohol use using a systematic screening method at least once within 12 months **AND** who received brief counseling if identified as an unhealthy alcohol user

Definitions:
Brief counseling – "Brief counseling" for unhealthy alcohol use refers to one or more counseling sessions, a minimum of 5-15 minutes, which may include: feedback on alcohol use and harms; identification of high risk situations for drinking and coping strategies; increased motivation and the development of a personal plan to reduce drinking.

NUMERATOR NOTE: *To satisfy the intent of this measure, a patient must have at least one unhealthy alcohol use screening during the 12-month period. If a patient has multiple unhealthy alcohol use screenings during the 12-month period, only the most recent screening, which has a documented status of unhealthy alcohol user or unhealthy alcohol non-user, will be used to satisfy the measure requirements.*

In the event that a patient is screened for unhealthy alcohol use and identified as an unhealthy user but did not receive brief alcohol cessation counseling submit G9624.

Denominator Exception(s) are determined on the date of the most recent denominator eligible encounter for all submission criteria.

Numerator Options:

Performance Met:	Patient identified as an unhealthy alcohol user when screened for unhealthy alcohol use using a systematic screening method and received brief counseling **(G9621)**
OR	
Performance Met:	Patient not identified as an unhealthy alcohol user when screened for unhealthy alcohol use using a systematic screening method **(G9622)**
OR	
Denominator Exception:	Documentation of medical reason(s) for not screening for unhealthy alcohol use (e.g., limited life expectancy, other medical reasons) **(G9623)**
OR	
Denominator Exception:	Documentation of medical reason(s) for not providing brief counseling if identified as an unhealthy alcohol user (e.g., limited life expectancy, other medical reasons) **(G2203)**
OR	
Performance Not Met:	Patient not screened for unhealthy alcohol use using a systematic screening method or patient did not receive brief counseling if identified as an unhealthy alcohol user, reason not given **(G9624)**

RATIONALE:
This measure is intended to promote unhealthy alcohol use screening and brief counseling which have been shown to be effective in reducing alcohol consumption, particularly in primary care settings.

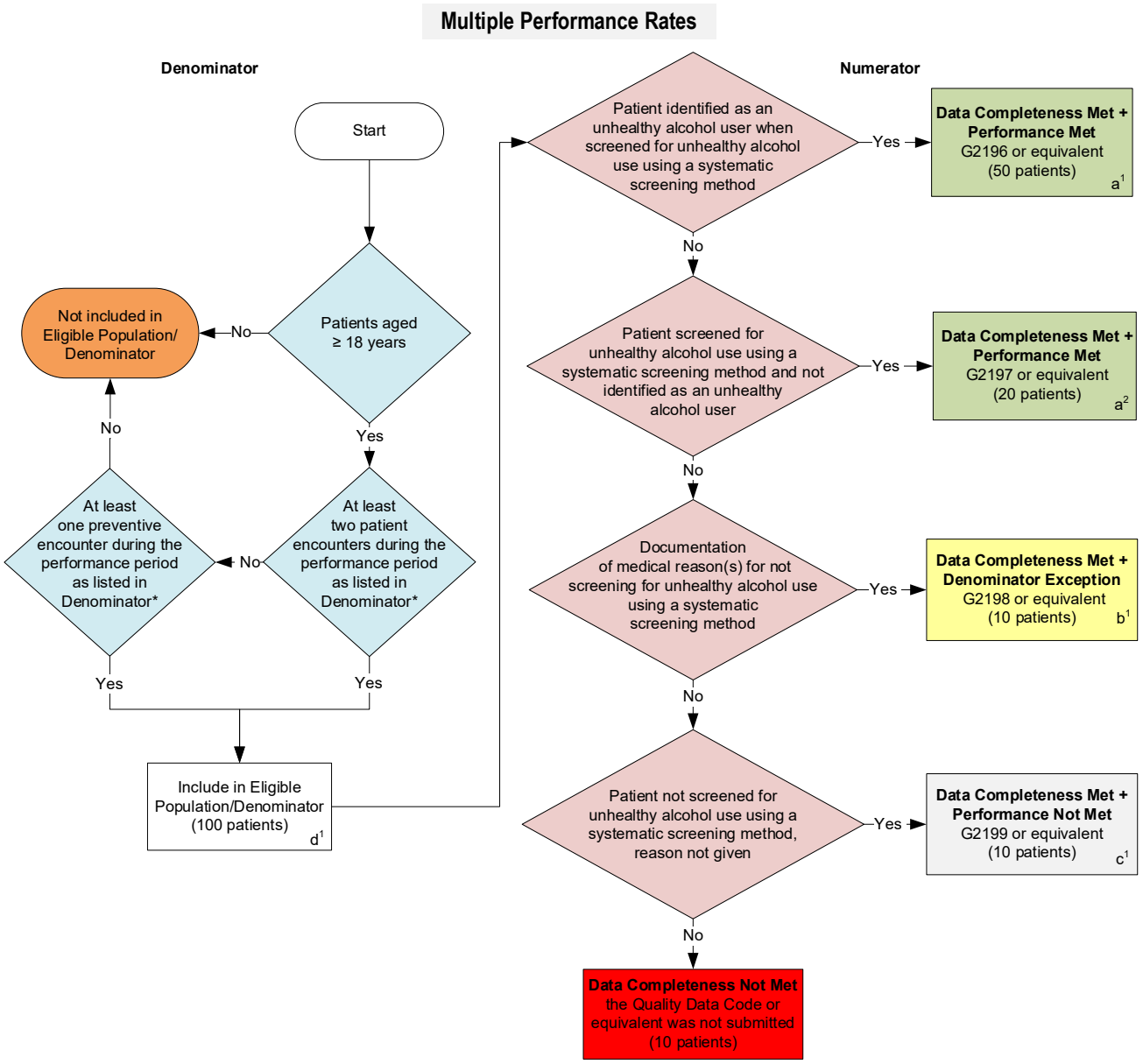
A number of studies, including patient and provider surveys, have documented low rates of alcohol misuse screening and counseling in primary care settings. According to a study analyzing the quality of health care in the United States, on average, 45% of patients (n=6,676) were screened for problem drinking. (MCGlynn, et. al, 2003). In the national Healthcare for Communities Survey, only 8.7% of problem drinkers reported having been asked and counseled about their alcohol use in the last 12 months. (D'Amico, et. al., 2005)) A nationally representative sample of 648 primary care physicians were surveyed to determine how such physicians identify--or fail to identify--substance abuse in their patients, what efforts they make to help these patients and what are the barriers to effective diagnosis and treatment. Of physicians who conducted annual health histories, less than half ask about the quantity and frequency of alcohol use (45.3 percent). Only 31.8 percent say they ever administer standard alcohol or drug use screening instruments to patients. (CASA, 2000) A national systematic sample of 2,000 physicians practicing general internal medicine, family medicine, obstetrics-gynecology, and psychiatry were surveyed to determine the frequency of screening and intervention for alcohol problems. Of the 853 respondent physicians, 88% usually or always ask new outpatients about alcohol use. When evaluating patients who drink, 47% regularly inquire about maximum amounts on an occasion, and 13% use formal alcohol screening tools. Only 82% routinely offer intervention to diagnosed problem drinkers. (Friedman, et. al., 2000). In 2014, the CDC analyzed data from 17 states and the District of Columbia via the Behavioral Risk Factor Surveillance System to estimate the prevalence of adults who reported receiving elements of alcohol screening and brief intervention. While 77.7% of adults reported being asked about alcohol use by a health professional, only 32.9% were asked about binge-level alcohol consumption and among binge drinkers only 37.2% reported being counseled on the harms of binge drinking. Only 18.1% reported being advised to cut down on alcohol consumption or to quit drinking. (McKnight-Eily, et. al., 2017). A multi-site, cross-sectional survey of primary care residents from six primary care residency programs administered from March 2010 through December 2012 found that a minority of the residents appropriately screen or provide intervention for at risk alcohol users. While 60% (125/208) stated they screen patients at an initial visit, only 17% (35/208) screened patients at subsequent visits. 54% (108/202) reported they did not feel they had adequate training to provide brief intervention to patients found to be at-risk alcohol users and 21% (43/208) felt they could really help at-risk drinkers. (Barnes et. al., 2015). A study evaluating self-reported prevalence of alcohol screening using information drawn from the ConsumerStyles survey (a random internet panel) found that only 24.7% (n=2,592) of adults reported being asked about their alcohol use While prevalence among men and women were about the same, there was lower prevalence of screening among Black non-Hispanics than white non-Hispanics (16.2% vs. 26.9%) and college graduates reported a higher prevalence of screening than those with a high school degree or less (38.1% vs. 20.8%). (Denny et. al., 2015). A cross-sectional analysis using 2016 DocStyles data that evaluated with use of different screening tools used to screen for alcohol misuse by 1,506 primary care providers found that while most providers screen for alcohol misuse (96%) only 38% reported using a USPSTF recommended screening tool. (Tan et. al., 2018).

CLINICAL RECOMMENDATION STATEMENTS:

The USPSTF recommends screening for unhealthy alcohol use in primary care settings in adults 18 years or older, including pregnant women, and providing persons engaged in risky or hazardous drinking with brief behavioral counseling interventions to reduce unhealthy alcohol use. (Grade B recommendation) (USPSTF, 2018)

2021 Clinical Quality Measure Flow for Quality ID #431 (NQF 2152): Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling Submission Criteria One

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



SAMPLE CALCULATIONS: SUBMISSION CRITERIA ONE

Data Completeness=

Performance Met (a^1+a^2=70 patients) + Denominator Exception (b^1=10 patients) + Performance Not Met (c^1=10 patients) = 90 patients = **90.00%**

Eligible Population / Denominator (d^1=100 patients) = 100 patients

Performance Rate=

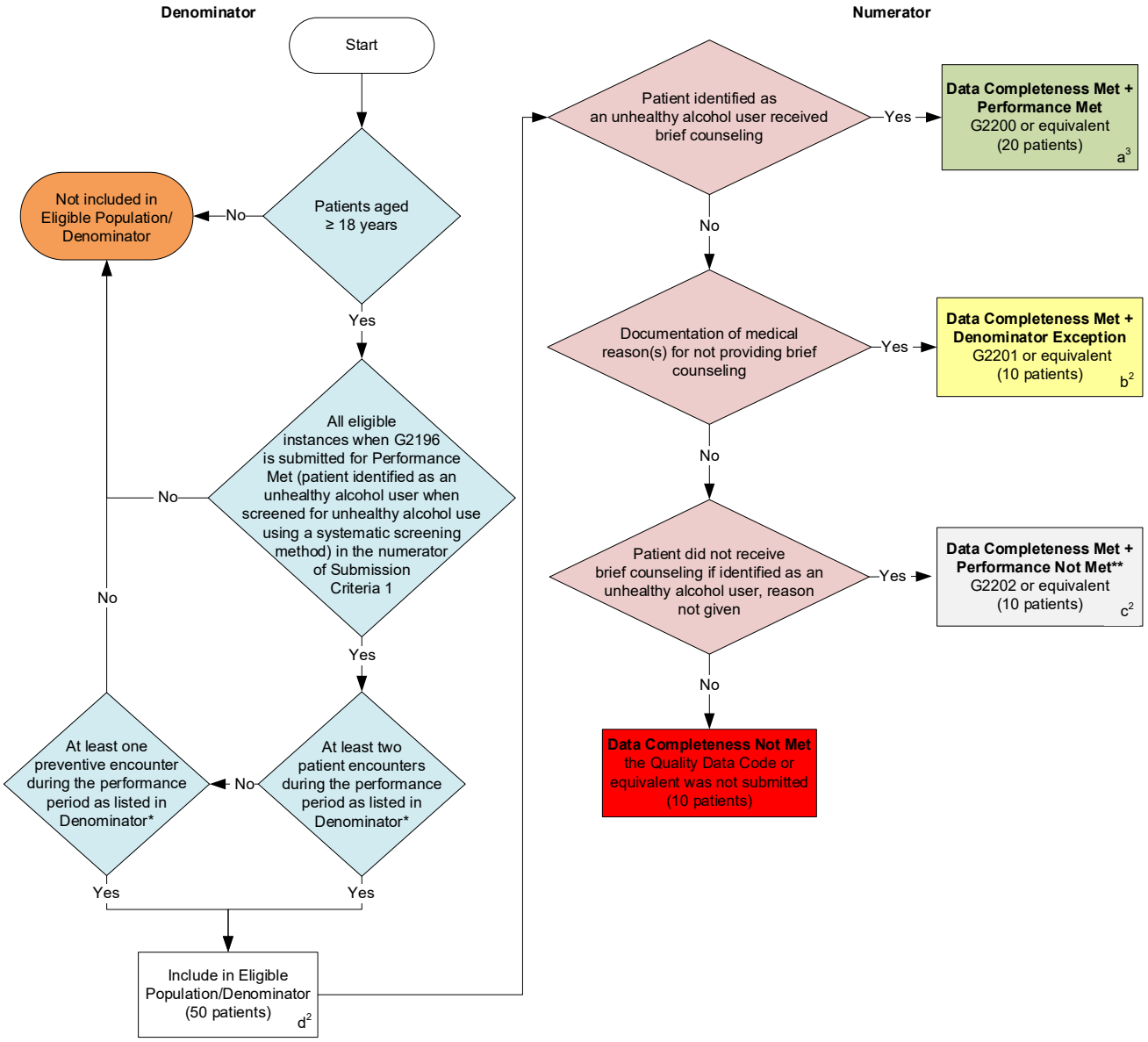
Performance Met (a^1+a^2=70 patients) = 70 patients = **87.50%**

Data Completeness Numerator (90 patients) – Denominator Exception (b^1=10 patients) = 80 patients

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

Note: Submission Frequency: Patient-Process

Submission Criteria Two



SAMPLE CALCULATIONS: SUBMISSION CRITERIA TWO

Data Completeness=

Performance Met (a^3=20 patients) + Denominator Exception (b^2=10 patients) + Performance Not Met (c^2=10 patients) = 40 patients = **80.00%**

Eligible Population / Denominator (d^2=50 patients) = 50 patients

Performance Rate=

Performance Met (a^3=20 patients) = 20 patients = **66.67%**

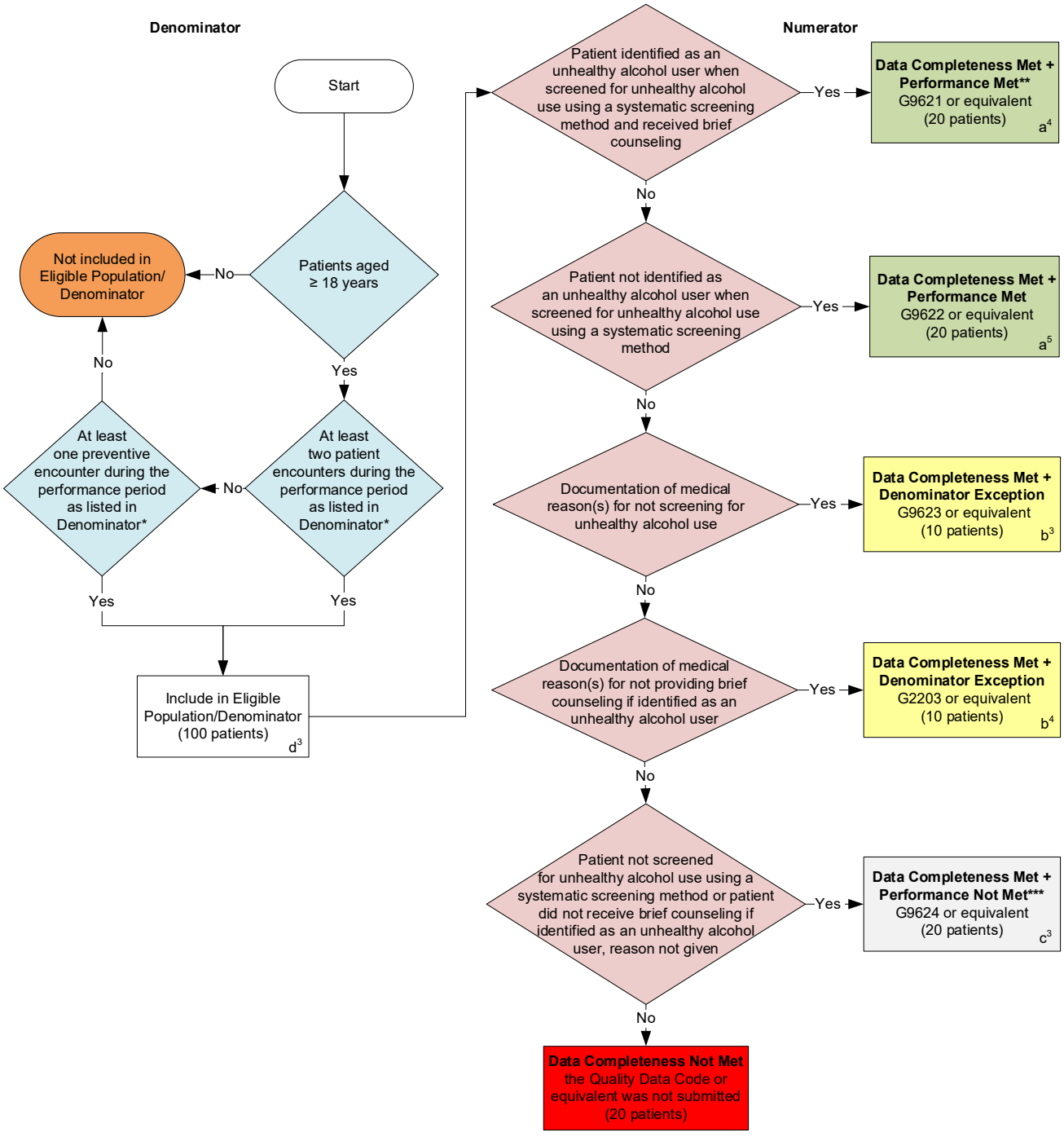
Data Completeness Numerator (40 patients) – Denominator Exception (b^2=10 patients) = 30 patients

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

**In the event that a patient is screened for unhealthy alcohol use and identified as an unhealthy user but did not receive brief alcohol cessation counseling submit G2202.

Note: Submission Frequency: Patient-Process

Submission Criteria Three



SAMPLE CALCULATIONS: SUBMISSION CRITERIA THREE

Data Completeness=

Performance Met (a^4+a^5=40 patients) + Denominator Exception (b^3+b^4=20 patients) + Performance Not Met (c^3=20 patients) = 80 patients = **80.00%**

Eligible Population / Denominator (d^3=100 patients) = 100 patients

Performance Rate=

Performance Met (a^4+a^5=40 patients) = 40 patients = **66.67%**

Data Completeness Numerator (80 patients) – Denominator Exception (b^3+b^4=20 patients) = 60 patients

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

**Brief counseling for unhealthy alcohol use refers to one or more counseling sessions, a minimum of 5-15 minutes, which may include: feedback on alcohol use and harms; identification of high risk situations for drinking and coping strategies; increased motivation and the development of a personal plan to reduce drinking.

***In the event that a patient is screened for unhealthy alcohol use and identified as an unhealthy user but did not receive brief alcohol cessation counseling submit G9624.

Note: Submission Frequency: Patient-Process

2021 Clinical Quality Measure Flow Narrative for Quality ID #431 (NQF 2152): Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling

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

Multiple Performance Rates

Submission Criteria One:

1. Start with Denominator
2. Check *Patients aged greater than or equal to 18 years*:
    a. If *Patients aged greater than or equal to 18 years* equals No, do not include in *Eligible Population/Denominator*. Stop processing.
    b. If *Patients aged greater than or equal to 18 years* equals Yes, proceed to check *At least two patient encounters during the performance period as listed in Denominator**.
3. Check *At least two patient encounters during the performance period as listed in Denominator**:
    a. If *At least two patient encounters during the performance period as listed in Denominator** equals No, proceed to check *At least one preventive encounter during the performance period as listed in Denominator**.
    b. If *At least two patient encounters during the performance period as listed in Denominator** equals Yes, include in *Eligible Population/Denominator*.
4. Check *At least one preventive encounter during the performance period as listed in Denominator**:
    a. If *At least one preventive encounter during the performance period as listed in Denominator** equals No, do not include in *Eligible Population/Denominator*. Stop processing.
    b. If *At least one preventive encounter during the performance period as listed in Denominator** equals Yes, include in *Eligible Population/Denominator*.
5. Denominator Population:
    a. Denominator Population is all Eligible Patients in the Denominator. Denominator is represented as Denominator in the Sample Calculation listed at the end of this document. Letter d^1 equals 100 patients in the Sample Calculation.
6. Start Numerator
7. Check *Patient identified as an unhealthy alcohol user when screened for unhealthy alcohol use using a systematic screening method*:
    a. If *Patient identified as an unhealthy alcohol user when screened for unhealthy alcohol use using a systematic screening method* equals Yes, include in *Data Completeness Met and Performance Met*.
        - *Data Completeness Met and Performance Met* letter is represented in the Data Completeness and Performance Rate in the Sample Calculation listed at the end of this document. Letter a^1 equals 50 patients in the Sample Calculation.
    b. If *Patient identified as an unhealthy alcohol user when screened for unhealthy alcohol use using a*

systematic screening method equals No, proceed to check *Patient screened for unhealthy alcohol use using a systematic screening method and not identified as an unhealthy alcohol user*.

8. Check *Patient screened for unhealthy alcohol use using a systematic screening method and not identified as an unhealthy alcohol user*:

    a. If *Patient screened for unhealthy alcohol use using a systematic screening method and not identified as an unhealthy alcohol user* equals Yes, include *in Data Completeness Met and Performance Met*.

        - *Data Completeness Met and Performance Met* letter is represented in the Data Completeness and Performance Rate in the Sample Calculation listed at the end of this document. Letter a^2 equals 20 patients in the Sample Calculation.

    b. If *Patient screened for unhealthy alcohol use using a systematic screening method and not identified as an unhealthy alcohol user* equals No, proceed to check *Documentation of medical reason(s) for not screening for unhealthy alcohol use using a systematic screening method*.

9. Check *Documentation of medical reason(s) for not screening for unhealthy alcohol use using a systematic screening method*:

    a. If *Documentation of medical reason(s) for not screening for unhealthy alcohol use using a systematic screening method* equals Yes, include in *Data Completeness Met and Denominator Exception*.

        - *Data Completeness Met and Denominator Exception* letter is represented in the Data Completeness and Performance Rate in the Sample Calculation listed at the end of this document. Letter b^1 equals 10 patients in the Sample Calculation.

    b. If *Documentation of medical reason(s) for not screening for unhealthy alcohol use using a systematic screening method* equals No, proceed to check *Patient not screened for unhealthy alcohol use using a systematic screening method, reason not given*.

10. Check *Patient not screened for unhealthy alcohol use using a systematic screening method, reason not given*:

    a. If *Patient not screened for unhealthy alcohol use using a systematic screening method, reason not given* equals Yes, include in *Data Completeness Met and Performance Not Met*.

        - *Data Completeness Met and Performance Not Met* letter is represented in the Data Completeness in the Sample Calculation listed at the end of this document. Letter c^1 equals 10 patients in the Sample Calculation.

    b. If *Patient not screened for unhealthy alcohol use using a systematic screening method, reason not given* equals No, proceed to check *Data Completeness Not Met*.

11. Check *Data Completeness Not Met*:

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

Sample Calculations: Submission Criteria One

Data Completeness equals Performance Met (a^1 plus a^2 equals 70 patients) plus Denominator Exception (b^1 equals 10 patients) plus Performance Not Met (c^1 equals 10 patients) divided by Eligible Population / Denominator (d^1 equals 100 patients). All equals 90 patients divided by 100 patients. All equals 90.00 percent.

Performance Rate equals Performance Met (a^1 plus a^2 equals 70 patients) divided by Data Completeness Numerator (90 patients) minus Denominator Exception (b^1 equals 10 patients). All equals 70 patients divided by 80 patients. All equals 87.50 percent.

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

Note: Submission Frequency: Patient-Process

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

Submission Criteria Two:

1. Start with Denominator
2. Check *Patients aged greater than or equal to 18 years*:
    a. If *Patients aged greater than or equal to 18 years* equals No, do not include in *Eligible Population/Denominator*. Stop processing.
    b. If *Patients aged greater than or equal to 18 years* equals Yes, proceed to check *All eligible instances of Performance Met when patient identified as an unhealthy alcohol user when screened for unhealthy alcohol use using a systematic screening method in the numerator of Submission Criteria 1*.
3. Check *All eligible instances of Performance Met when patient identified as an unhealthy alcohol user when screened for unhealthy alcohol use using a systematic screening method in the numerator of Submission Criteria 1:*
    a. If *All eligible instances of Performance Met when patient identified as an unhealthy alcohol user when screened for unhealthy alcohol use using a systematic screening method in the numerator of Submission Criteria 1* equals No, do not include in *Eligible Population/Denominator*. Stop processing.
    b. If *All eligible instances of Performance Met when patient identified as an unhealthy alcohol user when screened for unhealthy alcohol use using a systematic screening method in the numerator of Submission Criteria 1* equals Yes, proceed to check *At least two patient encounters during the performance period as listed in Denominator**.
4. Check *At least two patient encounters during the performance period as listed in Denominator**:
    a. If *At least two patient encounters during the performance period as listed in Denominator** equals No, proceed to check *At least one preventive encounter during the performance period as listed in Denominator**.
    b. If *At least two patient encounters during the performance period as listed in Denominator** equals Yes, include in *Eligible Population/Denominator*.
5. Check *At least one preventive encounter during the performance period as listed in Denominator**:
    a. If *At least one preventive encounter during the performance period as listed in Denominator** equals No, do not include in *Eligible Population/Denominator*. Stop processing.
    b. If *At least one preventive encounter during the performance period as listed in Denominator** equals Yes, include in *Eligible Population/Denominator*.

6. Denominator Population:

    a. Denominator Population is all Eligible Patients in the Denominator. Denominator is represented as Denominator in the Sample Calculation listed at the end of this document. Letter d^2 equals 50 patients in the Sample Calculation.

7. Start Numerator

8. Check *Patient identified as an unhealthy alcohol user received brief counseling*:

    a. If *Patient identified as an unhealthy alcohol user received brief counseling* equals Yes, include in *Data Completeness Met and Performance Met*.

        - *Data Completeness Met and Performance Met* letter is represented in the Data Completeness and Performance Rate in the Sample Calculation listed at the end of this document. Letter a^3 equals 20 patients in the Sample Calculation.

    b. If *Patient identified as an unhealthy alcohol user received brief counseling* equals No, proceed to check *Documentation of medical reason(s) for not providing brief counseling*.

9. Check *Documentation of medical reason(s) for not providing brief counseling*:

    a. If *Documentation of medical reason(s) for not providing brief counseling* equals Yes, include in *Data Completeness Met and Denominator Exception*.

        - *Data Completeness Met and Denominator Exception* letter is represented in the Data Completeness and Performance Rate in the Sample Calculation listed at the end of this document. Letter b^2 equals 10 patients in the Sample Calculation.

    b. If *Documentation of medical reason(s) for not providing brief counseling* equals No, proceed to check *Patient did not receive brief counseling if identified as an unhealthy alcohol user, reason not given*.

10. Check *Patient did not receive brief counseling if identified as an unhealthy alcohol user, reason not given*:

    a. If *Patient did not receive brief counseling if identified as an unhealthy alcohol user, reason not given* equals Yes, include in *Data Completeness Met and Performance Not Met***.

        - *Data Completeness Met and Performance Not Met*** letter is represented in the Data Completeness in the Sample Calculation listed at the end of this document. Letter c^2 equals 10 patients in the Sample Calculation.

    b. If *Patient did not receive brief counseling if identified as an unhealthy alcohol user, reason not given* equals No, proceed to check *Data Completeness Not Met*.

11. Check *Data Completeness Not Met*:

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

Sample Calculations: Submission Criteria Two

Data Completeness equals Performance Met (a^3 equals 20 patients) plus Denominator Exception (b^2 equals 10 patients) plus Performance Not Met (c^2 equals 10 patients) divided by Eligible Population / Denominator (d^2 equals 50 patients).

All equals 40 patients divided by 50 patients. All equals 80.00 percent.

Performance Rate equals Performance Met (a^3 equals 20 patients) divided by Data Completeness Numerator (40 patients) minus Denominator Exception (b^2 equals 10 patients). All equals 20 patients divided by 30 patients. All equals 66.67 percent.

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

**In the event that a patient is screened for unhealthy alcohol use and identified as an unhealthy alcohol user but did not receive brief alcohol cessation counseling submit G2202.

Note: Submission Frequency: Patient-Process

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

Submission Criteria Three:

1. Start with Denominator
2. Check *Patients aged greater than or equal to 18 years*:
    a. If *Patients aged greater than or equal to 18 years* equals No, do not include in *Eligible Population/Denominator*. Stop processing.
    b. If *Patients aged greater than or equal to 18 years* equals Yes, proceed to check *At least two patient encounters during the performance period as listed in Denominator**.
3. Check *At least two patient encounters during the performance period as listed in Denominator**:
    a. If *At least two patient encounters during the performance period as listed in Denominator** equals No, proceed to check *At least one preventive encounter during the performance period as listed in Denominator**.
    b. If *At least two patient encounters during the performance period as listed in Denominator** equals Yes, include in *Eligible Population/Denominator*.
4. Check *At least one preventive encounter during the performance period as listed in Denominator**:
    a. If *At least one preventive encounter during the performance period as listed in Denominator** equals No, do not include in *Eligible Population/Denominator*. Stop processing.
    b. If *At least one preventive encounter during the performance period as listed in Denominator** equals Yes, include in *Eligible Population/Denominator*.
5. Denominator Population:
    a. Denominator Population is all Eligible Patients in the Denominator. Denominator is represented as Denominator in the Sample Calculation listed at the end of this document. Letter d^3 equals 100 patients in the Sample Calculation.
6. Start Numerator

7. Check *Patient identified as an unhealthy alcohol user when screened for unhealthy alcohol use using a systematic screening method and received brief counseling*:

    a. If *Patient identified as an unhealthy alcohol user when screened for unhealthy alcohol use using a systematic screening method and received brief counseling* equals Yes, include in *Data Completeness Met and Performance Met***.

        - *Data Completeness Met and Performance Met*** letter is represented in the Data Completeness and Performance Rate in the Sample Calculation listed at the end of this document. Letter a^4 equals 20 patients in the Sample Calculation.

    b. If *Patient identified as an unhealthy alcohol user when screened for unhealthy alcohol use using a systematic screening method and received brief counseling* equals No, proceed to check *Patient not identified as an unhealthy alcohol user when screened for unhealthy alcohol use using a systematic screening method*.

8. Check *Patient not identified as an unhealthy alcohol user when screened for unhealthy alcohol use using a systematic screening method*:

    a. If *Patient not identified as an unhealthy alcohol user when screened for unhealthy alcohol use using a systematic screening method* equals Yes, include *in Data Completeness Met and Performance Met*.

        - *Data Completeness Met and Performance Met* letter is represented in the Data Completeness and Performance Rate in the Sample Calculation listed at the end of this document. Letter a^5 equals 20 patients in the Sample Calculation.

    b. If *Patient not identified as an unhealthy alcohol user when screened for unhealthy alcohol use using a systematic screening method* equals No, proceed to check *Documentation of medical reason(s) for not screening for unhealthy alcohol use*.

9. Check *Documentation of medical reason(s) for not screening for unhealthy alcohol use*:

    a. If *Documentation of medical reason(s) for not screening for unhealthy alcohol use* equals Yes, include in *Data Completeness Met and Denominator Exception*.

        - *Data Completeness Met and Denominator Exception* letter is represented in the Data Completeness and Performance Rate in the Sample Calculation listed at the end of this document. Letter b^3 equals 10 patients in the Sample Calculation.

    b. If *Documentation of medical reason(s) for not screening for unhealthy alcohol use* equals No, proceed to check *Documentation of medical reason(s) for not providing brief counseling if identified as an unhealthy alcohol user.*

10. Check *Documentation of medical reason(s) for not providing brief counseling if identified as an unhealthy alcohol user*:

    a. If *Documentation of medical reason(s) for not providing brief counseling if identified as an unhealthy alcohol user* equals Yes, include in *Data Completeness Met and Denominator Exception*.

        - *Data Completeness Met and Denominator Exception* letter is represented in the Data Completeness and Performance Rate in the Sample Calculation listed at the end of this document. Letter b^4 equals 10 patients in the Sample Calculation.

    b. If *Documentation of medical reason(s) for not providing brief counseling if identified as an unhealthy*

alcohol user equals No, proceed to check *Patient not screened for unhealthy alcohol use using a systematic screening method or patient did not receive brief counseling if identified as an unhealthy alcohol user, reason not given*.

11. Check *Patient not screened for unhealthy alcohol use using a systematic screening method or patient did not receive brief counseling if identified as an unhealthy alcohol user, reason not given*:

    a. If *Patient not screened for unhealthy alcohol use using a systematic screening method or patient did not receive brief counseling if identified as an unhealthy alcohol user, reason not given* equals Yes, include in *Data Completeness Met and Performance Not Met****.

        - *Data Completeness Met and Performance Not Met**** letter is represented in the Data Completeness in the Sample Calculation listed at the end of this document. Letter c^3 equals 20 patients in the Sample Calculation.

    b. If *Patient not screened for unhealthy alcohol use using a systematic screening method or patient did not receive brief counseling if identified as an unhealthy alcohol user, reason not given* equals No, proceed to check *Data Completeness Not Met*.

12. Check *Data Completeness Not Met*:

    a. If *Data Completeness Not Met*, the Quality Data Code or equivalent was not submitted. 20 patients have been subtracted from the Data Completeness Numerator in the Sample Calculation.

Sample Calculations: Submission Criteria Three

Data Completeness equals Performance Met (a^4 plus a^5 equals 40 patients) plus Denominator Exception (b^3 plus b^4 equals 20 patients) plus Performance Not Met (c^3 equals 20 patients) divided by Eligible Population / Denominator (d^3 equals 100 patients). All equals 80 patients divided by 100 patients. All equals 80.00 percent.

Performance Rate equals Performance Met (a^4 plus a^5 equals 40 patients) divided by Data Completeness Numerator (80 patients) minus Denominator Exception (b^3 plus b^4 equals 20 patients). All equals 40 patients divided by 60 patients. All equals 66.67 percent.

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

**Brief counseling for unhealthy alcohol use refers to one or more counseling sessions, a minimum of 5-15 minutes, which may include: feedback on alcohol use and harms; identification of high risk situations for drinking and coping strategies; increased motivation and the development of a personal plan to reduce drinking.

***In the event that a patient is screened for unhealthy alcohol use and identified as an unhealthy user but did not receive brief alcohol cessation counseling submit G9624.

Note: Submission Frequency: Patient-Process

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

*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 2022

- Updated the logic for the measure to be expressed in FHIR.
- Refer to the *Technical Release Notes* file in the Digital Measures Package for a comprehensive list of changes.

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	1. Commercial 12–17 years. 2. Commercial 18–44 years. 3. Commercial 45–64 years. 4. Commercial 65 years and older. 5. Medicaid 12–17 years. 6. Medicaid 18–44 years. 7. Medicaid 45–64 years. 8. Medicaid 65 years and older. 9. Medicare 18–44 years. 10. Medicare 45–64 years. 11. Medicare 65 years and older.
Risk adjustment	None.
Improvement notation	A higher rate indicates better performance.
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	Members with any of the following at any time during the Measurement Period: • Bipolar disorder. • Personality disorder. • Psychotic disorder. • Pervasive developmental disorder. • In hospice or using hospice services.
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_MY2022-1.0.0** – 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-1.0.0**
  - 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_MY2022-1.0.0**
  - 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-1.0.0**
  - codesystem "ConditionClinicalStatusCodes": 'http://terminology.hl7.org/CodeSystem/condition-clinical'
  - codesystem "coverage-type": 'http://terminology.hl7.org/CodeSystem/v3-ActCode’
  - code "active": 'active' from "ConditionClinicalStatusCodes"
  - code "managed care policy": 'MCPOL' from "coverage-type"
  - code "retiree health program": 'RETIRE' from "coverage-type"
  - code "subsidized health program": 'SUBSIDIZ' from "coverage-type"

Data Elements for Reporting

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

Table DMS-E-1/2: Data Elements for Utilization of the PHQ-9 to Monitor Depression Symptoms for Adolescents and Adults

Metric	TimePeriod	Age	Data Element	Reporting Instructions
PHQ9Utilization	1	12-17	InitialPopulationByEHR	For each Stratification
	2	18-44	InitialPopulationByCaseManagement	For each Stratification
	3	45-64	InitialPopulationByHIERegistry	For each Stratification
	Total	65+	InitialPopulationByAdmin	For each Stratification
		Total	InitialPopulation	(Sum over SSoRs)
			ExclusionsByEHR	For each Stratification
			ExclusionsByCaseManagement	For each Stratification
			ExclusionsByHIERegistry	For each Stratification
			ExclusionsByAdmin	For each Stratification
			Exclusions	(Sum over SSoRs)
			Denominator	For each Stratification
			NumeratorByEHR	For each Stratification
			NumeratorByCaseManagement	For each Stratification
			NumeratorByHIERegistry	For each Stratification
			NumeratorByAdmin	For each Stratification
			Numerator	(Sum over SSoRs)
			Rate	(Percent)

Table DMS-E-3: Data Elements for Utilization of the PHQ-9 to Monitor Depression Symptoms for Adolescents and Adults

Metric	TimePeriod	Age	Data Element	Reporting Instructions
PHQ9Utilization	1	18-44	InitialPopulationByEHR	For each Stratification
	2	45-64	InitialPopulationByCaseManagement	For each Stratification
	3	65+	InitialPopulationByHIERegistry	For each Stratification
	Total	Total	InitialPopulationByAdmin	For each Stratification
			InitialPopulation	(Sum over SSoRs)
			ExclusionsByEHR	For each Stratification
			ExclusionsByCaseManagement	For each Stratification
			ExclusionsByHIERegistry	For each Stratification
			ExclusionsByAdmin	For each Stratification
			Exclusions	(Sum over SSoRs)
			Denominator	For each Stratification
			NumeratorByEHR	For each Stratification
			NumeratorByCaseManagement	For each Stratification
			NumeratorByHIERegistry	For each Stratification
			NumeratorByAdmin	For each Stratification
			Numerator	(Sum over SSoRs)
			Rate	(Percent)

Rules for Allowable Adjustments of HEDIS

NCQA's Rules for Allowable Adjustments of HEDIS describe how NCQA's HEDIS measure specifications can be adjusted for non-health plan reporting. Refer to the *Guidelines for the Rules of Allowable Adjustments of HEDIS* for additional information.

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

Rules for Allowable Adjustments for 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 and older). Expanding the denominator age range to 11 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 a population of interest such as gender, sociodemographic characteristic or geographic region.
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. The 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.

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

SUMMARY OF CHANGES TO HEDIS MY 2022

- Clarified that members in hospice or using hospice services anytime during the measurement year are a required exclusion.
- Clarified in the *Notes* that services rendered during a telephone visit, e-visit or virtual check-in meet criteria for the BMI Percentile indicator.
- Revised the Reporting Instructions for the "NumeratorByAdminElig" data element in Table WCC-1/2 to read "For each Metric and Stratification," to indicate that the value is stratified.
- Added required exclusions to the Rules for Allowable Adjustments.

Description

The percentage of members 3–17 years of age who had an outpatient visit with a PCP or OB/GYN and who had evidence of the following during the measurement year.

- BMI percentile documentation*.
- Counseling for nutrition.
- Counseling for physical activity.

**Because BMI norms for youth vary with age and gender, this measure evaluates whether BMI percentile is assessed rather than an absolute BMI value.*

Definitions

BMI percentile — The percentile ranking based on the CDC's BMI-for-age growth charts, which indicates the relative position of the patient's BMI number among others of the same gender and age.

Eligible Population

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

Ages — 3–17 years as of December 31 of the measurement year. Report two age stratifications and a total for each of the three indicators:

- 3–11 years.
- 12–17 years.
- Total.

The total is the sum of the age stratifications.

Continuous enrollment — The measurement year.

Allowable gap	No more than one gap in 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	An outpatient visit (Outpatient Value Set) with a PCP or an OB/GYN during the measurement year.
Required exclusion	Members in hospice or using hospice services anytime during the measurement year. Refer to *General Guideline 17: Members in Hospice.*

Administrative Specification

Denominator	The eligible population.
Numerators	
BMI Percentile	BMI percentile (BMI Percentile Value Set) during the measurement year.
Counseling for Nutrition	Counseling for nutrition (Nutrition Counseling Value Set) during the measurement year.
Counseling for Physical Activity	Counseling for physical activity (Physical Activity Counseling Value Set) during the measurement year.

Exclusions *(optional)*

Female members who have a diagnosis of pregnancy (Pregnancy Value Set) during the measurement year. The denominator for all rates must be the same. An organization that excludes these members must do so for all rates.

Hybrid Specification

Denominator	A systematic sample drawn from the eligible population for each product line for the Total age band (3–17 years). The Total sample is stratified by age to report rates for the 3–11 and 12–17 age stratifications. Organizations may reduce the sample size using the current year's administrative rate or the prior year's audited, product line-specific rate for the lowest of the three indicator rates for the Total age band. Refer to the *Guidelines for Calculations and Sampling* for information on reducing the sample size.
Numerators	
BMI Percentile	BMI percentile during the measurement year as identified by administrative data or medical record review.
Administrative	Refer to *Administrative Specification* to identify positive numerator hits from the administrative data.

Medical record

Documentation must include height, weight and BMI percentile during the measurement year. The height, weight and BMI percentile must be from the same data source.

Either of the following meets criteria for BMI percentile:

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

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

Member-collected biometric values (height, weight, BMI percentile) that meet the requirements of *General Guideline 40: Member-Reported Services and Biometric Values* are eligible for use in reporting.

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

Counseling for Nutrition

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

Administrative

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

Medical record

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

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

Counseling for Physical Activity

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

Administrative

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

Medical record

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

- Discussion of current physical activity behaviors (e.g., exercise routine, participation in sports activities, exam for sports participation).
- Checklist indicating physical activity was addressed.
- Counseling or referral for physical activity.
- Member received educational materials on physical activity during a face-to-face visit.
- Anticipatory guidance specific to the child's physical activity.

- Weight or obesity counseling.

Exclusions *(optional)*

Refer to *Administrative Specification* for exclusion criteria. Exclusionary evidence in the medical record must include a note indicating a diagnosis of pregnancy. The diagnosis must have occurred during the measurement year.

Note

- *The following notations or examples of documentation do not count as numerator compliant:*
  - ***BMI***
    - *No BMI percentile documented in medical record or plotted on age-growth chart.*
    - *Notation of BMI value only.*
    - *Notation of height and weight only.*
  - ***Nutrition***
    - *No counseling/education on nutrition and diet.*
    - *Counseling/education before or after the measurement year.*
    - *Notation of "health education" or "anticipatory guidance" without specific mention of nutrition.*
    - *A physical exam finding or observation alone (e.g., well-nourished) is not compliant because it does not indicate counseling for nutrition.*
    - *Documentation related to a member's "appetite" does not meet criteria.*
  - ***Physical Activity***
    - *No counseling/education on physical activity.*
    - *Notation of "cleared for gym class" alone without documentation of a discussion.*
    - *Counseling/education before or after the measurement year.*
    - *Notation of "health education" or "anticipatory guidance" without specific mention of physical activity.*
    - *Notation of anticipatory guidance related solely to safety (e.g., wears helmet or water safety) without specific mention of physical activity recommendations.*
    - *Notation solely related to screen time (computer or television) without specific mention of physical activity.*
- *Services may be rendered during a visit other than a well-child visit. These services count if the specified documentation is present, regardless of the primary intent of the visit; however, services specific to the assessment or treatment of an acute or chronic condition do not count toward the Counseling for Nutrition and Counseling for Physical Activity indicators.*

  For example, the following documentation is specific to the assessment or treatment of an acute or chronic condition and does not meet criteria:
  - *Notation that a member with chronic knee pain is able to run without limping.*
  - *Notation that a member has exercise-induced asthma.*
  - *Notation that a member with diarrhea is following the BRAT diet.*
  - *Notation that a member has decreased appetite as a result of an acute or chronic condition.*
- *Services rendered for obesity or eating disorders may be used to meet criteria for the Counseling for Nutrition and Counseling for Physical Activity indicators if the specified documentation is present.*
- *Referral to the Special Supplemental Nutrition Program for Women, Infants and Children (WIC) may be used to meet criteria for the Counseling for Nutrition indicator.*

- *The BMI Percentile, Counseling for Nutrition and Counseling for Physical Activity indicators do not require a specific setting; therefore, services rendered during a telephone visit, e-visit or virtual check-in meet criteria.*
- *Refer to Appendix 3 for the definition of* PCP *and* OB/GYN and other prenatal care practitioner.

Data Elements for Reporting

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

Table WCC-1/2: Data Elements for Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents

Metric	Age	Data Element	Reporting Instructions	A
BMIPercentile	3-11	CollectionMethod	For each Metric, repeat per Stratification	✓
NutritionCounseling	12-17	EligiblePopulation*	For each Metric and Stratification	✓
PhysicalActivityCounseling	Total	ExclusionAdminRequired*	For each Metric and Stratification	✓
		NumeratorByAdminElig	For each Metric and Stratification	
		CYAR	Only for Total (Percent)	
		MinReqSampleSize	Repeat per Metric and Stratification	
		OversampleRate	Repeat per Metric and Stratification	
		OversampleRecordsNumber	(Count)	
		ExclusionValidDataErrors	Repeat per Metric and Stratification	
		ExclusionAdminOptional	Repeat per Metric and Stratification	
		ExclusionMedRecsOptional	Repeat per Metric and Stratification	
		ExclusionEmployeeOrDep	Repeat per Metric and Stratification	
		OversampleRecsAdded	Repeat per Metric and Stratification	
		Denominator	For each Stratification, repeat per Metric	
		NumeratorByAdmin	For each Metric and Stratification	✓
		NumeratorByMedicalRecords	For each Metric and Stratification	
		NumeratorBySupplemental	For each Metric and Stratification	✓
		Rate	(Percent)	✓

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

Rules for Allowable Adjustments of HEDIS

NCQA's Rules for Allowable Adjustments of HEDIS describe how NCQA's HEDIS measure specifications can be adjusted for non-health plan reporting. Refer to the *Guidelines for the Rules of Allowable Adjustments of HEDIS* for additional information.

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

Rules for Allowable Adjustments for Weight Assessment and Counseling for Nutrition and Physical Activity for Children/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 as of June 30"). The denominator age may be changed if the range is within the specified age range (3–17 years). Organizations must consult UPSTSF guidelines when considering whether to expand the age ranges outside of the current thresholds.
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 a population of interest such as gender, sociodemographic characteristic or geographic region.
CLINICAL COMPONENTS		
Eligible Population	**Adjustments Allowed (Yes/No)**	**Notes**
Event/Diagnosis	No	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.
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*.
Optional Exclusions	No, if applied	Optional exclusions are not required, but if they are used, only specified exclusions may be applied. Value sets may not be changed.
Numerator Criteria	**Adjustments Allowed (Yes/No)**	**Notes**
• BMI Percentile • Counseling for Nutrition • Counseling for Physical Activity	No	Value sets and logic may not be changed.

Medical Assistance With Smoking and Tobacco Use Cessation (MSC)

SUMMARY OF CHANGES TO HEDIS MY 2020 & MY 2021

- No changes to this measure.

Description

The following components of this measure assess different facets of providing medical assistance with smoking and tobacco use cessation:

Advising Smokers and Tobacco Users to Quit	A rolling average[5] represents the percentage of members 18 years of age and older who were current smokers or tobacco users and who received advice to quit during the measurement year.
Discussing Cessation Medications	A rolling average represents the percentage of members 18 years of age and older who were current smokers or tobacco users and who discussed or were recommended cessation medications during the measurement year.
Discussing Cessation Strategies	A rolling average represents the percentage of members 18 years of age and older who were current smokers or tobacco users and who discussed or were provided cessation methods or strategies during the measurement year.

Eligible Population

Product lines	Commercial, Medicaid, Medicare (report each product line separately).
Ages	18 years and older as of December 31 of the measurement year.
Continuous enrollment	*Commercial:* The measurement year. *Medicaid:* The last six months of the measurement year. *Medicare:* Six months prior to the CMS administration of the survey.
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 beneficiary for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage (a member whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).
Anchor date	December 31 of the measurement year.
Current enrollment	Currently enrolled at the time the survey is completed.

[5] Refer to the *Calculations* section in the MSC measure specifications for additional details about Medicare reporting/scoring.

Protocol and Survey Instrument

Commercial, Medicaid

Collected annually as part of the CAHPS Health Plan Survey 5.0H, Adult Version using rolling average methodology.

Refer to *HEDIS Volume 3: Specifications for Survey Measures* for the CAHPS questionnaires and data collection protocols.

Note: *There will be separate releases of the Volume 3 publication for MY 2020 and MY 2021.*

Medicare

Collected by CMS using the Medicare CAHPS Survey. Only the Advising Smokers and Tobacco Users to Quit rate is collected for the Medicare product line (no rolling average methodology is used).

To learn more about the MA and PDP CAHPS surveys, including background information, policy updates, survey administration protocols and procedures, training opportunities and participating in the survey, visit the MA and PDP CAHPS website at www.MA-PDPCAHPS.org.

Questions Included in the Measure

Table MSC-1: Medical Assistance With Smoking and Tobacco Use Cessation—Commercial Product Line

	Question	Response Choices
Q35	Do you now smoke cigarettes or use tobacco every day, some days, or not at all?	Every day Some days Not at all ➔If Not at all, Go to Question 39 Don't know ➔If Don't know, Go to Question 39
Q36	In the last 12 months, how often were you advised to quit smoking or using tobacco by a doctor or other health provider in your plan?	Never Sometimes Usually Always
Q37	In the last 12 months, how often was medication recommended or discussed by a doctor or health provider to assist you with quitting smoking or using tobacco? Examples of medication are: nicotine gum, patch, nasal spray, inhaler, or prescription medication.	Never Sometimes Usually Always
Q38	In the last 12 months, how often did your doctor or health provider discuss or provide methods and strategies other than medication to assist you with quitting smoking or using tobacco? Examples of methods and strategies are: telephone helpline, individual or group counseling, or cessation program.	Never Sometimes Usually Always

Table MSC-2: Medical Assistance With Smoking and Tobacco Use Cessation—Medicaid Product Line

	Question	Response Choices
Q32	Do you now smoke cigarettes or use tobacco every day, some days, or not at all?	Every day Some days Not at all ➔If Not at all, Go to Question 36 Don't know ➔If Don't know, Go to Question 36

	Question	Response Choices
Q33	In the last 6 months, how often were you advised to quit smoking or using tobacco by a doctor or other health provider in your plan?	Never Sometimes Usually Always
Q34	In the last 6 months, how often was medication recommended or discussed by a doctor or health provider to assist you with quitting smoking or using tobacco? Examples of medication are: nicotine gum, patch, nasal spray, inhaler, or prescription medication.	Never Sometimes Usually Always
Q35	In the last 6 months, how often did your doctor or health provider discuss or provide methods and strategies other than medication to assist you with quitting smoking or using tobacco? Examples of methods and strategies are: telephone helpline, individual or group counseling, or cessation program.	Never Sometimes Usually Always

Table MSC-3: Medical Assistance With Smoking and Tobacco Use Cessation—Medicare Product Line

	Question	Response Choices
Q54	Do you now smoke cigarettes or use tobacco every day, some days, or not at all?	Every day Some days Not at all ➔If Not at all, Go to Question 56 Don't know ➔If Don't know, Go to Question 56
Q55	In the last 6 months, how often were you advised to quit smoking or using tobacco by a doctor or other health provider?	Never Sometimes Usually Always I had no visits in the last 6 months

Calculation of Medical Assistance With Smoking and Tobacco Use Cessation

For the commercial and Medicaid product lines, rolling averages are calculated using the formula below.

Rate = (Year 1 Numerator + Year 2 Numerator) / (Year 1 Denominator + Year 2 Denominator)

- If the denominator is less than 100, NCQA assigns a measure result of *NA.*
- If the denominator is 100 or more, NCQA calculates a rate.

If the health plan did not report results for the current year (Year 2) NCQA assigns a measure result of *NR*. If the health plan did not report results in the prior year (Year 1), but reports results for the current year and achieves a denominator of 100 or more, NCQA calculates a rate; if the denominator is less than 100, NCQA assigns a measure result of *NA*.

Changes in submission entity

If a health plan, for example, reports HMO and POS products separately in the prior year and reports HMO/POS combined in the current year, Year 1 numerators and denominators are created by combining data from the separate HMO and POS results using the methodology described below. The combined Year 1 numerators and denominators and Year 2 numerators and denominators are used for rolling average calculations.

Alternatively, if the health plan, for example, reports HMO/POS combined in the prior year and reports HMO and POS separately in the current year, the

reporting entity is considered changed and prior year data are not used for rolling average calculations.

Calculating Combined Year 1 Numerators and Denominators for Rolling Average Calculations

Rotate Submission ID1:	The submission ID of the HMO survey sample in Year 1.
Rotate Submission ID2:	The submission ID of the POS survey sample in Year 1.
Yr1_Num1:	Year 1 Numerator for Rotate Submission ID1.
Yr1_Num2:	Year 1 Numerator for Rotate Submission ID2.
Yr1_Denom1:	Year 1 Denominator for Rotate Submission ID1.
Yr1_Denom2:	Year 1 Denominator for Rotate Submission ID2.
SampleFrame1Yr1:	The sample frame size in year 1 of Rotate Submission ID1.
SampleFrame2Yr1:	The sample frame size in year 1 of Rotate Submission ID2.
Yr1_Num =	[Yr1_Num1 * (SampleFrame1Yr1/(SampleFrame1Yr1 + SampleFrame2Yr1))] + [Yr1_Num2 * (SampleFrame1Yr1/(SampleFrame1Yr1 + SampleFrame2Yr1))]
Yr1_Denom =	[Yr1_Denom1 * (SampleFrame1Yr1/(SampleFrame1Yr1 + SampleFrame2Yr1))] + [Yr1_Denom2 * (SampleFrame1Yr1/(SampleFrame1Yr1 + SampleFrame2Yr1))]

Question numbers reference the adult survey for the commercial product line. The rate for the Medicaid product line is calculated by substituting the corresponding questions and response options.

Advising Smokers and Tobacco Users to Quit—Commercial and Medicaid Product Lines

Denominator	The number of members who responded to the survey and indicated that they were current smokers or tobacco users. Member response choices *must* be as follows to be included in the denominator: *Q35* = “Every day” or “Some days.” *Q36* = “Never” or “Sometimes” or “Usually” or “Always.”
Numerator	The number of members in the denominator who indicated that they received advice to quit from a doctor or other health provider by answering “Sometimes” or “Usually” or “Always” to Q36.

Advising Smokers and Tobacco Users to Quit—Medicare Product Line

Denominator The number of members who responded to the survey and indicated that they were current smokers or tobacco users. Member response choices *must* be as follows to be included in the denominator:

Q54 = "Every day" or "Some days."

Q55 = "Never" or "Sometimes" or "Usually" or "Always."

Note: *Medicare results for the Advising Smokers and Tobacco Users to Quit rate requires a minimum denominator of at least 30 responses.*

Numerator The number of members in the denominator who indicated that they received advice to quit from a doctor or other health provider by answering "Sometimes" or "Usually" or "Always" to Q55.

Discussing Cessation Medications—Commercial and Medicaid Product Lines

Denominator The number of members who responded to the survey and indicated that they were current smokers or tobacco users. Member response choices *must* be as follows to be included in the denominator:

Q35 = "Every day" or "Some days."

Q37 = "Never" or "Sometimes" or "Usually" or "Always."

Numerator The number of members in the denominator who indicated that their doctor or health provider recommended or discussed cessation medications by answering "Sometimes" or "Usually" or "Always" to Q37.

Discussing Cessation Strategies—Commercial and Medicaid Product Lines

Denominator The number of members who responded to the survey and indicated that they were current smokers or tobacco users. Member response choices *must* be as follows to be included in the denominator:

Q35 = "Every day" or "Some days."

Q38 = "Never" or "Sometimes" or "Usually" or "Always."

Numerator The number of members in the denominator who indicated that their doctor or health provider discussed or provided cessation methods and strategies by answering "Sometimes" or "Usually" or "Always" to Q38.

Percentage of Current Smokers and Tobacco Users—Supplemental Calculation

This calculation is provided to support analysis of Medical Assistance With Smoking and Tobacco Use Cessation rates and provides additional context for NA results. A health plan with a small number of smokers or tobacco users may not be able to obtain a large enough denominator to achieve reportable rates (and may receive *NA* results).

The percentage of current smokers and tobacco users is calculated using data collected during the current reporting year only (not calculated as a rolling average).

Denominator	The number of members who responded “Every day,” “Some days,” “Not at all” or “Don’t know” to the question “Do you now smoke cigarettes or use tobacco every day, some days, or not at all?”
Numerator	The number of members in the denominator who responded “Every day” or “Some days” to the question “Do you now smoke cigarettes or use tobacco every day, some days, or not at all?”

Quality ID #402 (NQF 2803): Tobacco Use and Help with Quitting Among Adolescents
– National Quality Strategy Domain: Community/Population Health
– Meaningful Measure Area: Prevention and Treatment of Opioid and Substance Use Disorders

2021 COLLECTION TYPE:
MIPS CLINICAL QUALITY MEASURES (CQMS)

MEASURE TYPE:
Process

DESCRIPTION:
The percentage of adolescents 12 to 20 years of age with a primary care visit during the measurement year for whom tobacco use status was documented and received help with quitting if identified as a tobacco user

INSTRUCTIONS:
This measure is to be submitted **once per performance period** for patients seen during the performance period. This measure is intended to reflect the quality of services provided for preventive screening for tobacco use. This measure may be submitted by Merit-based Incentive Payment System (MIPS) eligible clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

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

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

DENOMINATOR:
All patients aged 12-20 years with a visit during the measurement period

Denominator Criteria (Eligible Cases):
Patients aged 12-20 years on date of encounter
AND
Patient encounter during the performance period (CPT or HCPCS): 90791, 90792, 90832, 90834, 90837, 90839, 90845, 92002, 92004, 92012, 92014, 96156, 96158, 97165, 97166, 97167, 97168, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99406, 99407, G0438, G0439

NUMERATOR:
Patients who were screened for tobacco use at least once within 18 months (during the measurement period or the six months prior to the measurement period) **AND** who received tobacco cessation counseling intervention if identified as a tobacco user

Definitions:
Tobacco Use Status – Any documentation of smoking or tobacco use status, including 'never' or 'non-use'.
Tobacco User – Any documentation of active or current use of tobacco products, including smoking.

NUMERATOR NOTE: *In the event that a patient is screened for tobacco use and identified as a user but did not receive tobacco cessation counseling, submit* ***G9460****.*

Numerator Options:

Performance Met:	Patient documented as tobacco user AND received tobacco cessation intervention (must include at least one of the following: advice given to quit smoking or tobacco use, counseling on the benefits of quitting smoking or tobacco use, assistance with or referral to external smoking or tobacco cessation support programs, or current enrollment in smoking or tobacco use cessation program) if identified as a tobacco user **(G9458)**
OR	
Performance Met:	Currently a tobacco non-user **(G9459)**
OR	
Performance Not Met:	Tobacco assessment OR tobacco cessation intervention not performed, reason not given **(G9460)**

RATIONALE:

This measure is intended to promote adolescent tobacco screening and tobacco cessation interventions for those who use tobacco products. There is good evidence that tobacco screening and brief cessation intervention (including counseling and/or pharmacotherapy) is successful in helping tobacco users quit. Tobacco users who are able to stop smoking lower their risk for heart disease, lung disease, and stroke.

CLINICAL RECOMMENDATION STATEMENTS:

The following evidence statements are quoted verbatim from the referenced clinical guidelines:

The U.S. Preventive Services Task Force recommends that primary care clinicians provide interventions, including education or brief counseling, to prevent initiation of tobacco use in school-aged children and adolescents. (Strength of Recommendation = B) (U.S. Preventive Services Task Force, 2013)

All patients should be asked if they use tobacco and should have their tobacco use status documented on a regular basis. Evidence has shown that clinic screening systems, such as expanding the vital signs to include tobacco use status or the use of other reminder systems such as chart stickers or computer prompts, significantly increase rates of clinician intervention. (Strength of Evidence = A) (U.S. Department of Health and Human Services. Public Health Service, 2008)

All physicians should strongly advise every patient who smokes to quit because evidence shows that physician advice to quit smoking increases abstinence rates. (Strength of Evidence = A) (U.S. Department of Health and Human Services. Public Health Service, 2008)

Minimal interventions lasting less than 3 minutes increase overall tobacco abstinence rates. Every tobacco user should be offered at least a minimal intervention, whether or not he or she is referred to an intensive intervention. (Strength of Evidence = A) (U.S. Department of Health and Human Services. Public Health Service, 2008)

The combination of counseling and medication is more effective for smoking cessation than either medication or counseling alone. Therefore, whenever feasible and appropriate, both counseling and medication should be provided to patients trying to quit smoking. (Strength of Evidence = A) (U.S. Department of Health and Human Services. Public Health Service, 2008)

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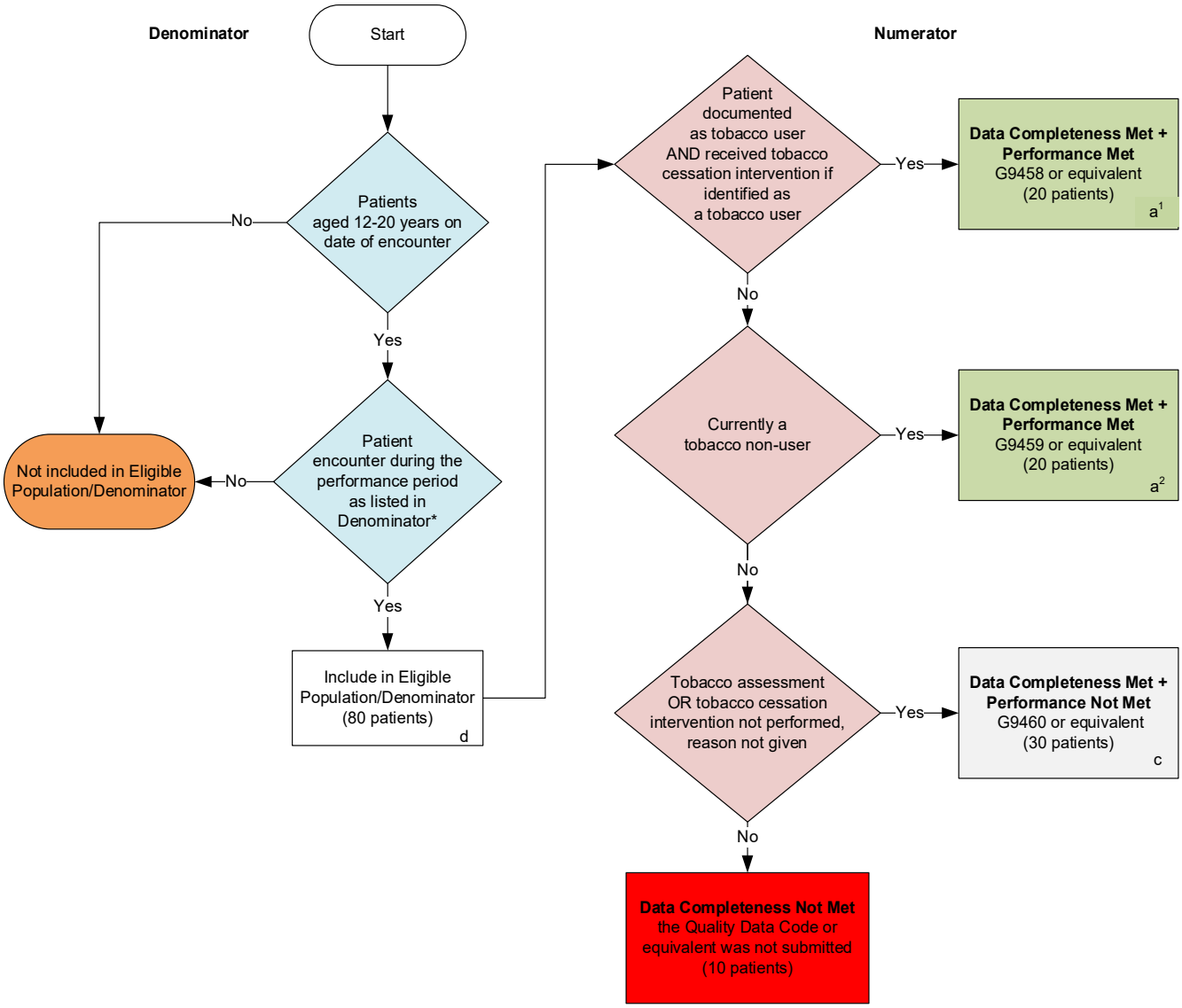
2021 Clinical Quality Measure Flow for Quality ID #402 (NQF: 2803): Tobacco Use and Help with Quitting Among Adolescents

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



SAMPLE CALCULATIONS

Data Completeness=
Performance Met (a^1+a^2=40 patients) + Performance Not Met (c=30 patients) = 70 patients = **87.50%**
Eligible Population / Denominator (d=80 patients) = 80 patients

Performance Rate=
Performance Met (a^1+a^2=40 patients) = 40 patients = **57.14%**
Data Completeness Numerator (70 patients) = 70 patients

*See the posted measure specification for specific coding and instructions to submit this measure.
NOTE: Submission Frequency: Patient-Process

2021 Clinical Quality Measure Flow Narrative for Quality ID #402 (NQF 2803): Tobacco Use and Help with Quitting Among Adolescents

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

1. Start with Denominator
2. Check *Patients aged 12-20 years on date of encounter*:
    a. If *Patients aged 12-20 years on date of encounter* equals No, do not include in *Eligible Population/Denominator*. Stop processing.
    b. If *Patients aged 12-20 years on date of encounter* equals Yes, proceed to check *Patient encounter during the performance period as listed in Denominator**.
3. Check *Patient encounter during the performance period as listed in Denominator**:
    a. If *Patient encounter during the performance period as listed in Denominator** equals No, do not include in *Eligible Population/Denominator*. Stop processing.
    b. If *Patient encounter during the performance period as listed in Denominator** equals Yes, include in *Eligible Population/Denominator*.
4. Denominator Population:
    - Denominator Population is all Eligible Patients in the Denominator. Denominator is represented as Denominator in the Sample Calculation listed at the end of this document. Letter d equals 80 patients in the Sample Calculation.
5. Start Numerator
6. Check *Patient documented as tobacco user AND received tobacco cessation intervention if identified as a tobacco user*:
    a. If *Patient documented as tobacco user AND received tobacco cessation intervention if identified as a tobacco user* equals Yes, include in *Data Completeness Met and Performance Met*.
        - *Data Completeness Met and Performance Met* letter is represented as Data Completeness and Performance Rate in the Sample Calculation listed at the end of this document. Letter a^1 equals 20 patients in Sample Calculation.
    b. If *Patient documented as tobacco user AND received tobacco cessation intervention if identified as a tobacco user* equals No, proceed to check *Currently a tobacco non-user*.
7. Check *Currently a tobacco non-user*:
    a. If *Currently a tobacco non-user* equals Yes, include in *Data Completeness Met and Performance Met*.
        - *Data Completeness Met and Performance Met* letter is represented as Data Completeness and Performance Rate in the Sample Calculation listed at the end of this document. Letter a^2 equals 20 patients in the Sample Calculation.
    b. If *Currently a tobacco non-user* equals No, proceed to check *Tobacco assessment OR tobacco cessation intervention not performed, reason not given.*
8. Check *Tobacco assessment OR tobacco cessation intervention not performed, reason not given*:

a. If *Tobacco assessment OR tobacco cessation intervention not performed, reason not given* equals Yes, include in the *Data Completeness Met and Performance Not Met*.

    - *Data Completeness Met and Performance Not Met* letter is represented as Data Completeness in the Sample Calculation listed at the end of this document. Letter c equals 30 patients in the Sample Calculation.

b. If *Tobacco assessment OR tobacco cessation intervention not performed, reason not given* equals No, proceed to check *Data Completeness Not Met*.

9. Check *Data Completeness Not Met*:

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

Sample Calculations

Data Completeness equals Performance Met (a^1 plus a^2 equals 40 patients) plus Performance Not Met (c equals 30 patients) divided by Eligible Population/Denominator (d equals 80 patients). All equals 70 patients divided by 80 patients. All equals 87.50 percent.

Performance Rate equals Performance Met (a^1 plus a^2 equals 40 patients) divided by Data Completeness Numerator (70 patients). All equals 40 patients divided by 70 patients. All equals 57.14 percent.

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

NOTE: Submission Frequency: Patient-Process

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

Definitions:

Screening – Completion of a clinical or diagnostic tool used to identify people at risk of developing or having a certain disease or condition, even in the absence of symptoms.

Standardized Depression Screening Tool – A normalized and validated depression screening tool developed for the Member population in which it is being utilized. The name of the age appropriate standardized depression screening tool utilized must be documented in the medical record.

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

- **Adolescent Screening Tools (12-17 years):** Patient Health Questionnaire for Adolescents (PHQ-A), Beck Depression Inventory-Primary Care Version (BDI-PC), Mood Feeling Questionnaire (MFQ), Center for Epidemiologic Studies Depression Scale (CES-D), and PRIME MD-PHQ2
- **Adult Screening Tools (18 years and older):** Patient Health Questionnaire (PHQ-9 or PHQ-2), Beck Depression Inventory (BDI or BDI-II), Center for Epidemiologic Studies Depression Scale (CES-D), Depression Scale (DEPS), Duke Anxiety-Depression Scale (DADS), Geriatric Depression Scale (GDS), Cornell Scale Screening, and PRIME MD-PHQ2

Substance Use Assessment in Primary Care

Methodology: IEHP-Defined Quality Measure

Measure Description: The percentage of members 18 years and older who were screened for substance use during the measurement year (2020).

CODES TO IDENTIFY SUBSTANCE USE ASSESSMENT IN PRIMARY CARE:			
Service	**Code Type**	**Code**	**Code Description**
Substance Use Assessment in Primary Care	CPT	99408	Alcohol and/or Substance (other than tobacco) Abuse Structured Screening (e.g. Audit DAST) and Brief Intervention (SBI) Services 15 to 30 Minutes
Substance Use Assessment in Primary Care	CPT	99409	Alcohol and/or Substance (other than tobacco) Abuse Structured Screening (e.g. Audit DAST) and Brief Intervention (SBI) Services Greater than 30 Minutes
Substance Use Assessment in Primary Care	HCPCS	G0396	Alcohol and/or Substance (other than tobacco) Abuse Structured Screening (e.g. Audit DAST) and Brief Intervention 15 to 30 Minutes

CODES TO IDENTIFY SUBSTANCE USE ASSESSMENT IN PRIMARY CARE:			
Service	**Code Type**	**Code**	**Code Description**
Substance Use Assessment in Primary Care	HCPCS	G0397	Alcohol and/or Substance (other than tobacco) Abuse Structured Screening (e.g. Audit DAST) and Brief Intervention Greater than 30 Minutes
Substance Use Assessment in Primary Care	HCPCS	G0442	Annual Alcohol Misuse Screening 15 Minutes
Substance Use Assessment in Primary Care	HCPCS	G0443	Brief face-to-face behavioral counseling for alcohol misuse, 15 minutes
Substance Use Assessment in Primary Care	HCPCS	H0049	Alcohol and/or Drug Assessment
Substance Use Assessment in Primary Care	HCPCS	H0050	Alcohol and/or Drug Service Brief Intervention Per 15 Minutes

Denominator: All Members aged 18 years and older during the measurement year (2020). Member counted only once in the denominator.

Numerator: Members who were screened for substance use at least once during the measurement year (2020).

Population: Women

Breast Cancer Screening (BCS)

Methodology: HEDIS®

Measure Description: The percentage of women 50–74 years of age who had a mammogram to screen for breast cancer any time on or between October 1 two years prior to the measurement year (2018) and December 31 of the measurement year (2020).

- The eligible population in the measure meets all of the following criteria:
    1. Women 52-74 years as of December 31 of the measurement year (2020).
    2. Continuous enrollment from October 1 two years prior to the measurement year (2018) through December 31 of the measurement year (2020) with no more than one gap in enrollment of up to 45 days for each calendar year of continuous enrollment. No gaps in enrollment are allowed from October 1 two years prior to the measurement year (2018) through December 31 two years prior to the measurement year (2018).

Alcohol and Drug Misuse

Screening, Brief Intervention and Referral to Treatment (SBIRT)

Measure Basic Information

Name and date of specifications used: The measure specifications were developed by OHA in collaboration with a workgroup including CCOs and clinics and included clinical piloting. The measure calls for use of standardized assessment tools.

URL of Specifications: N/A. Value sets used in this measure may be accessed through the Value Set Authority Center (VSAC): https://vsac.nlm.nih.gov/.

Measure Type:

☐ HEDIS ☐ PQI ☐ Survey ■ Other. Specify: OHA-developed

Measure Utility:

■ CCO Incentive ☐ State Quality ☐ CMS Adult Core Set ☐ CMS Child Core Set

☐ Other. Specify:

Data Source: Electronic Health Records

Measurement Period: January 1, 2021 – December 31, 2021

Benchmark:

	2019	**2020-2021**
Benchmark for OHA measurement year	n/a *	n/a*
Source		

* CCOs must report minimum population threshold and other reporting parameters as specified in OHA reporting guidance to qualify for 100% of quality pool (in addition to meeting 75% of remaining measures).

Note on telehealth: This measure is telehealth eligible. The denominator for SBIRT rate 1 (screening) is the same as the depression screening and follow-up measure (CMS2), which is telehealth eligible according to CMS 2021 telehealth guidance. For further information specific to Oregon, the Health Evidence Review Commission (HERC) has provided this guideline on telehealth services.

Changes in Specifications from 2020 to 2021:

- For the Rate 1 denominator, SBIRT uses the same eligible encounters as CMS2v10, depression screening and follow-up. The CMS2v10 denominator criteria have changed as follows:

- New data element was added to allow for Physical Therapy Evaluation as an eligible encounter, per specialty society request.
- Value set (2.16.840.1.113883.3.600.1916) was renamed to Encounter to Screen for Depression to align with best practices, based on expert review and/or public feedback.

- For the dementia or mental degenerations exclusions (used in CMS149v8), new codes were added to the value set.
- For the Patient Reason exception, the value set has been replaced to remain consistent with the exception used in CMS2v10.
- For the Medical Reason exception, the value set has been replaced to remain consistent with the exception used in CMS2v10.

Value Set Name and OID	Status
Value set (2.16.840.1.113883.3.600.1916)	**Renamed** to Encounter to Screen for Depression to align with best practices, based on expert review and/or public feedback.
Value set Encounter to Screen for Depression (2.16.840.1.113883.3.600.1916)	Added 2 CPT codes (96156, 96158) and deleted 2 CPT codes (96150, 96151) based on terminology update. Deleted 1 SNOMED CT code (32537008) based on terminology update.
Value set Physical Therapy Evaluation (2.16.840.1.113883.3.526.3.1022)	Added Physical Therapy Evaluation based on expert review and/or public feedback.
Value set Dementia & Mental Degenerations (2.16.840.1.113883.3.526.3.1005)	Added 46 SNOMED CT codes.
SNOMED CT value set Patient Reason refused (2.16.840.1.113883.3.600.791)	**Replaced** with grouping value set Patient Declined (2.16.840.1.113883.3.526.3.1582) to align with best practices, based on expert review and/or public feedback.
SNOMED CT value set Medical or Other reason not done (2.16.840.1.113883.3.600.1.1502)	**Replaced** with grouping value set Medical Reason (2.16.840.1.113883.3.526.3.1007) for harmonization purposes, based on expert review and/or public feedback.

Denied claims: n/a

Measure Details

Measure Components and Scoring

Detailed measure specifications for the depression screening and follow-up measure, which is used in SBIRT for the Rate 1 denominator and for denominator exceptions, are available in the eCQI Resource Center: https://ecqi.healthit.gov/ecqm/ep/2021/cms002v10. Detailed value set contents are available in the Value Set Authority Center.

Two rates are reported for this SBIRT measure:

(1) The percentage of patients who received age-appropriate screening and

(2) The percentage of patients with a positive full screen who received a brief intervention, a referral to treatment, or both

Screening in an ambulatory setting is required once per measurement year. This measure does not require screening to occur at all encounters.

Rate 1

Data elements required denominator: All patients aged 12 years and older before the beginning of the measurement period with at least one eligible encounter during the measurement period.

These denominator criteria for SBIRT Rate 1 are identical to the denominator criteria for the depression screening and follow-up measure (NQF0418e/ CMS2v10). The denominator *exclusions* for depression screening and follow-up, however, are different from the exclusions for SBIRT. SBIRT exclusions are set out below. Eligible encounters are identified through the value sets Encounter to Screen for Depression (2.16.840.1.113883.3.600.1916) and Physical Therapy Evaluation (2.16.840.1.113883.3.526.3.1022).

Required denominator exclusions and exceptions: See below.

Data elements required numerator: Patients who received an age-appropriate screening, using an SBIRT screening tool approved by OHA, during the measurement period **AND** had either a brief screen with a negative result or a full screen.

> **Note**: This measure leaves flexibility for clinical preferences on whether to do a brief screen before a full screen. Although a negative brief screen is numerator compliant, a positive brief screen, by itself, is **not** numerator compliant. If a patient has a positive brief screen, then a full screen must be completed for numerator compliance on Rate 1. A full screen is numerator compliant, regardless of the result.
>
> **Note**: Approved SBIRT screening tools are available on the HSD-Approved Evidence-Based Screening Resources/ Tools (SBIRT) page: https://www.oregon.gov/oha/HSD/AMH/Pages/EB-Tools.aspx . The name of the screening tool used must be documented in the medical record, but it does not need to be captured in a queryable field.
>
> The clinician should interpret the age-appropriate screening tool to determine if the result is positive or negative. Where the screening tool includes guidance on interpreting scores, the clinician should consult that guidance. This is the same approach used to identify positive or negative results for depression screening in NQF0418e/ CMS2. There may be instances in which it is appropriate for clinicians to use their discretion in interpreting whether a result is positive or negative, such as for patients reporting use of topical medicinal marijuana.
>
> **Note**: The screening(s) and result(s) must be captured as queryable structured data in the EHR. The EHR does not need to capture each response to each question in the screening tool as structured data. It is acceptable to capture the interpretation and the follow-up as structured

data, without having a field for each question in the screening tool used. For supporting documentation, keeping a scan or other non-structured documentation of the screening tool (including the name of the screening tool used) is acceptable. The intent of this guidance is that the data elements needed to calculate the measure can be reported out of the EHR, without chart review. OHA does not intend to be prescriptive about how supporting documentation is maintained in a patient's medical record.

Required exclusions for numerator: SBIRT services received in an emergency department (Place of Service 23) or hospital setting (POS 21).

Rate 2

Data elements required denominator: All patients in Rate 1 denominator who had a positive full screen during the measurement period.

Required denominator exclusions and exceptions: See below.

Data elements required numerator: Patients who received a brief intervention, a referral to treatment, or both that is documented within 48 hours of the date of a positive full screen.

Note – Brief Intervention: Brief interventions are interactions with patients that are intended to induce a change in a health-related behavior. They are short, one-on-one counseling sessions ideally suited for people who use substances or drink in ways that are harmful or abusive. Examples of brief interventions include assessment of the patient's commitment to quit and offer of pharmacological or behavioral support, provision of self-help material, or referral to other supportive resources.

As explained by SAMHSA:

> "Brief interventions are evidence-based practices designed to motivate individuals at risk of substance abuse and related health problems to change their behavior by helping them understand how their substance use puts them at risk and to reduce or give up their substance use. Healthcare providers can also use brief interventions to encourage those with more serious dependence to accept more intensive treatment within the primary care setting or a referral to a specialized alcohol and drug treatment agency.
>
> "In primary care settings, brief interventions last from 5 minutes of brief advice to 15-30 minutes of brief counseling. Brief interventions are not intended to treat people with serious substance dependence, but rather to treat problematic or risky substance use. Skillfully conducted, brief interventions are essential to successful SBIRT implementation. The two most common behavioral therapies used in SBIRT programs are brief versions of cognitive behavioral therapy and motivational interviewing, or some combination of the two."

https://www.integration.samhsa.gov/clinical-practice/sbirt/brief-interventions

A brief intervention of less than 15 minutes can count for Rate 2 numerator compliance. Because reimbursement codes for brief intervention services may require services of at least 15

minutes, such codes would undercount services that qualify for the Rate 2 numerator. Although clinics may bill for SBIRT services when appropriate, this measure (unlike the earlier claims-based CCO SBIRT measure) does not require use of billing codes to determine whether screening or a brief intervention or referral occurred. Documentation in the medical record (e.g., through checkboxes, flowsheets, or other structured data) that a brief intervention was completed is sufficient.

Note – Referral to Treatment: A referral is counted for Rate 2 numerator compliance when the referral is made. Given the challenges of documenting whether a referral was completed (that is, whether the patient actually saw the provider to whom the patient was referred), numerator compliance is not dependent on referral completion.

Required exclusions for numerator: SBIRT services received in an emergency department or hospital setting.

Denominator Exclusions and Exceptions – Rate 1 and Rate 2

Required exclusions for denominator: Patients with:

Exclusions	Value Set Name	Value Set OID
Active diagnosis of alcohol or drug dependency	Alcohol and Drug Dependence	2.16.840.1.113883.3.464.1003.106.12.1001
Engagement in treatment	Alcohol and Drug Dependence Treatment	2.16.840.1.113883.3.464.1003.106.12.1005
Dementia or mental degeneration	Dementia & Mental Degenerations	2.16.840.1.113883.3.526.3.1005
Limited life expectancy	Limited Life Expectancy	2.16.840.1.113883.3.526.3.1259
Palliative care (includes comfort care and hospice)	Palliative or Hospice Care	2.16.840.1.113883.3.600.1.1579

Note: As with the earlier, claims-based version of this measure, SBIRT screening and intervention services are designed to prevent Oregon Health Plan members from developing a substance abuse disorder or for early detection. These services are not intended to treat members already diagnosed with a substance abuse disorder or those members already receiving substance abuse treatment services.

The exclusions for active diagnosis of alcohol or drug dependency, dementia or mental degeneration, limited life expectancy, and palliative care apply if they occur before the qualifying encounter (that is, before a visit that puts the patient in the denominator for Rate 1).

The exclusion for engagement in treatment applies if the patient was engaged in treatment before the qualifying visit and up to one year before the start of the measurement year.

Denominator Exceptions: Any of the following criteria also remove patients from the denominator.

Exception	Grouping Value Set

Patient Reason Patient refuses to participate	Patient Declined (2.16.840.1.113883.3.526.3.1582)
Medical Reason(s) Documentation of medical reason for not screening patient (e.g., cognitive, functional, or motivational limitations that may impact accuracy of results; patient is in an urgent or emergent situation where time is of the essence and to delay treatment would jeopardize the patient's health status)	Medical Reason(s) (2.16.840.1.113883.3.526.3.1007)

Note: For this SBIRT measure, these exception criteria may be captured using the SNOMED-CT codes in the value sets listed above *or* otherwise captured in a queryable field, such as a checkbox for noting patient refusal of screening. In other words, as the measure steward for this CCO SBIRT measure, OHA uses the same concepts but is less stringent than the measure steward for the depression screening and follow-up measure (NQF0418e/ CMS2) about how data is captured for these denominator exceptions.

Note: These exceptions could be applied at different points in the SBIRT process. For example, if the patient refuses screening at any point before the needed screening is completed, the patient would be excepted from Rate 1. Because a positive full screen is required for a patient to be counted in Rate 2, a patient who is an exception for Rate 1 would not be counted in Rate 2.

- Patient refuses brief screen. = Exception. Patient is not counted in rate 1.
- Patient completes brief screen, which is negative. = Process complete, and patient is numerator compliant for Rate 1.
- Patient completes brief screen, which is positive. Patient then completes full screen. = Process complete for rate 1, and patient is numerator compliant. (If full screen is positive, proceed to evaluate brief intervention or referral for rate 2.)
- Patient completes brief screen, which is positive. Patient then refuses full screen, either before starting or partway through. = Exception. Patient is not counted in rate 1.
- Patient completes full screen, which is positive. Patient then refuses brief intervention or referral to treatment. = Patient is numerator compliant for rate 1 but is not counted for rate 2.

Deviations from cited specifications for denominator: None.

Deviations from cited specifications for numerator: None.

What are the continuous enrollment criteria: For now, OHA does not use continuous enrollment criteria for EHR-based measures; the “eligible as of the last date of the reporting period” rule may be used to identify beneficiaries.

What are allowable gaps in enrollment: n/a

Define Anchor Date (if applicable): n/a

For more information:

- Educational materials and other resources related to EHR-sourced quality measurement can be accessed through the CMS/ ONC eCQI Resource Center: https://ecqi.healthit.gov/ep-ec-ecqms
- Value set content can be accessed through the Value Set Authority Center (VSAC) at the National Library of Medicine. https://vsac.nlm.nih.gov/
    - For more information about value sets and the code systems used, a guide can be found in the CMS Measure Management Blueprint: https://www.cms.gov/files/document/blueprint-codes-code-systems-value-sets.pdf
- Additional information on OHA reporting requirements will be available in the Year Nine (2021) Guidance Documentation, which will be posted at https://www.oregon.gov/oha/HPA/ANALYTICS/Pages/CCO-Metrics.aspx

Version Control

Initiation and Engagement of Substance Use Disorder Treatment (IET)

SUMMARY OF CHANGES TO HEDIS MY 2022

- Replaced “alcohol and other drug (AOD)” references with “substance use disorder (SUD).”
- Changed the start of the Intake Period to November 15 of the year prior to the measurement year.
- Changed from a member-based measure to an SUD diagnosis episode-based measure.
- Revised the age stratifications.
- Revised the negative diagnosis history from 60 days to 194 days.
- Added a Negative Medication History to the denominator.
- Revised the Continuous Enrollment criteria from 108 days to 242 days.
- Clarified that members in hospice or using hospice services any time during the measurement year are a required exclusion.
- Revised the numerator criteria for Initiation of SUD Treatment and Engagement of SUD Treatment.
- Added an *Other* section to the Rules for Allowable Adjustments.
- Clarified allowable adjustments to event/diagnosis criteria in the Rules for Allowable Adjustments.
- Added required exclusions to the Rules for Allowable Adjustments.

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 an outpatient, intensive outpatient, partial hospitalization, observation, telehealth, or ED visit (not resulting in an inpatient stay),* the SUD Episode Date is the date of service. *For an inpatient stay or for medically managed withdrawal event* (i.e., detoxification) that occurred during an inpatient stay, the SUD Episode Date is the date of discharge.

For medically managed withdrawal (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).

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 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 medically managed withdrawal (i.e., detoxification) 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. Exclude SUD episodes if there was an encounter in any setting other than an ED visit (ED Value Set) or a medically managed withdrawal (i.e., detoxification) 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. Exclude 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 Exclude 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 excluded 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 or 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 exclusion Members in hospice or using hospice services anytime during the measurement year. Refer to *General Guideline 17: Members in Hospice*.

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.

Exclude 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-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)

Rules for Allowable Adjustments of HEDIS

NCQA's Rules for Allowable Adjustments of HEDIS describe how NCQA's HEDIS measure specifications can be adjusted for non-health plan reporting. Refer to the *Guidelines for the Rules of Allowable Adjustments of HEDIS* for additional information.

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

Rules for Allowable Adjustments for 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 a population of interest such as gender, sociodemographic characteristic or geographic region.
CLINICAL COMPONENTS		
Eligible Population	**Adjustments Allowed (Yes/No)**	**Notes**
Event/Diagnosis	Yes, with limits	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. ***Note:*** *The measurement period may be adjusted. Modifying the determination dates in the eligible population can affect timing relationships. The order and relationship of events may not be changed.*
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
• Initiation of SUD Treatment • Engagement of SUD Treatment	No	Medication lists, value sets and logic may not be changed.

MEASURE CCW: CONTRACEPTIVE CARE – ALL WOMEN AGES 15–44

HHS Office of Population Affairs

A. DESCRIPTION

The Contraceptive Care – All Women measure (CCW) looks at women ages 15 to 44 at risk of unintended pregnancy, and among those, the percentage that:

1. Were provided a most effective or moderately effective method of contraception.
2. Were provided a long-acting reversible method of contraception (LARC).

The first rate is an intermediate outcome measure, and it is desirable to have a high percentage of women who are provided the most effective or moderately effective contraceptive methods. A state should exercise caution in using this measure for payment purposes, because performance on this measure is a function of a woman's preferences. The goal is to provide an indicator for states to assess the provision of most or moderately effective contraceptive methods within the state, and see where there is room for improvement. The second rate is an access measure, and the focus is on making sure that women have access to LARC methods.

Data Collection Method: Administrative

Guidance for Reporting:

- The Contraceptive Care – All Women measure is stratified into two age groups: ages 15 to 20 and ages 21 to 44.
- Two rates will be reported – one for the provision of most or moderately effective methods and one for provision of LARC.
- The measurement year is calendar year 2019. There is no lookback period for this measure to determine if there was a previous sterilization, LARC insertion, or other contraceptive method provided prior to the measurement year.
- Include all paid, suspended, pending, and denied claims.
- A secondary data source, such as the National Survey of Family Growth (NSFG) can be used to interpret the results of this measure. For more information, see Section E, "Additional Notes".

  The codes used to calculate this measure are available in Tables on OPA's website: https://opa.hhs.gov/claims-data-sas-program-instructions.
- Contraceptive surveillance codes can be used to document repeat prescriptions of contraceptives, contraceptive maintenance, or routine checking of a contraceptive device or system; in other words, contraceptive surveillance codes are not used for the initial prescription or provision of a contraceptive method. Contraceptive surveillance codes are included in the first rate for most or moderately effective contraceptive provision numerator because this measure is intended to capture both new and existing contraceptive users. The second rate for LARC provision is designed to capture new LARC insertions, so contraceptive surveillance codes are not included in the second rate.

The following coding systems are used in this measure: CPT, HCPCS, ICD-10-CM, ICD-10-PCS, and NDC. Refer to the Acknowledgments section for copyright information.

B. DEFINITIONS

Term	Definition
Provision of a most effective method of contraception	Provision of female sterilization, contraceptive implants, or intrauterine devices or systems (IUD/IUS).
Provision of a moderately effective method of contraception	Provision of injectables, oral pills, patch, ring or diaphragm.
Provision of a long-acting reversible method of contraception (LARC)	Provision of contraceptive implants or intrauterine devices or systems (IUD/IUS).
Measurement year	Calendar year 2019.

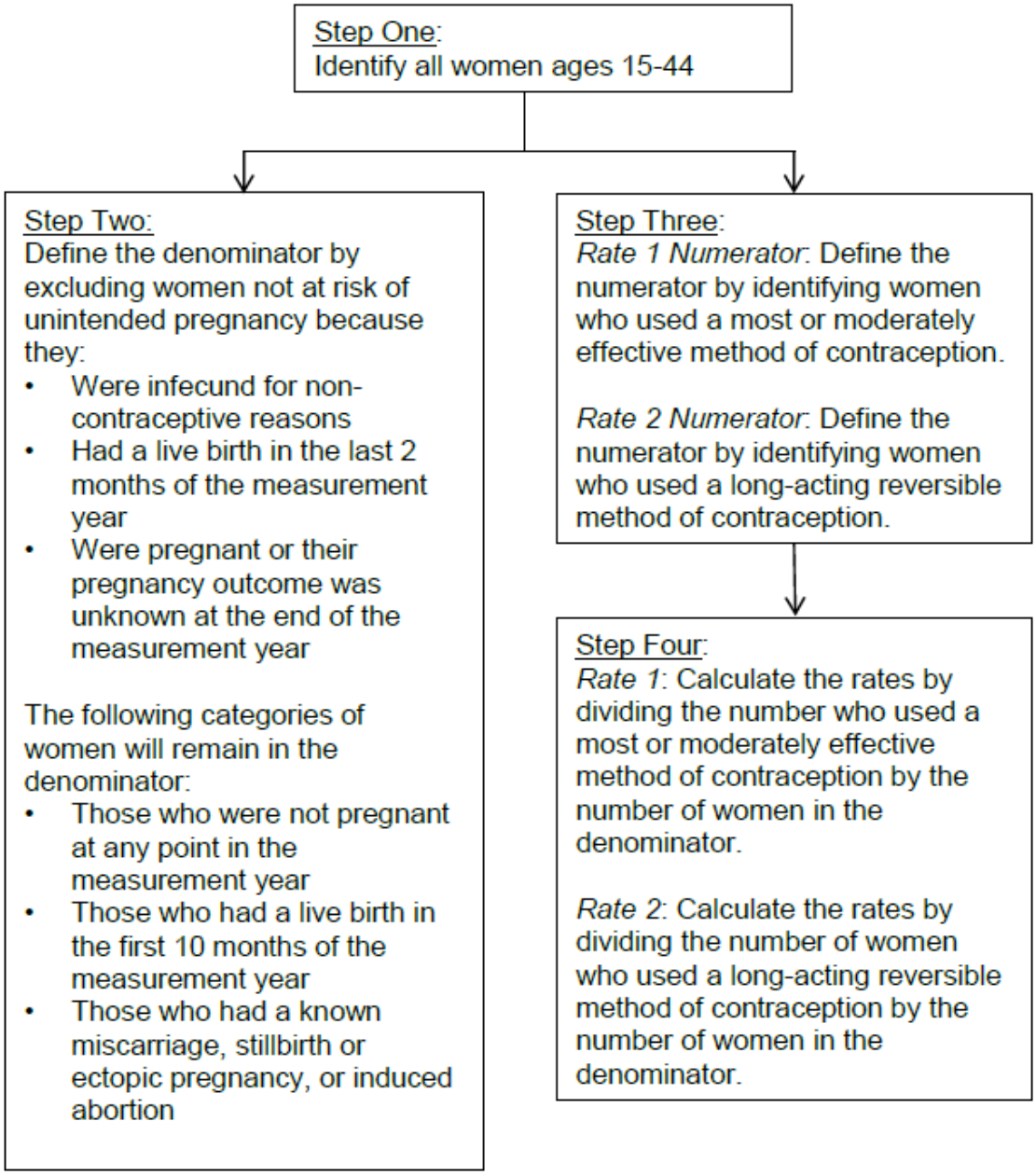
C. ELIGIBLE POPULATION

Population Characteristic	Criterion
Age	Women ages 15 to 44 as of December 31 of the measurement year.
Continuous enrollment period	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 beneficiary for whom enrollment is verified monthly, the beneficiary may not have more than a 1-month gap in coverage (i.e. a beneficiary whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).
Anchor date	December 31 of the measurement year.
Benefit	Medical or Family Planning Only Services.
Event/diagnosis	At risk of unintended pregnancy.

D. ADMINISTRATIVE SPECIFICATION

Figure A provides a flowchart for calculating CCW.

Figure A: CCW Measure Flowchart



Denominator

Follow the steps below to define the denominator:

Step 1

Identify all women ages 15 to 44.

Step 2

Define the denominator by excluding women not at risk of unintended pregnancy because they:

- Were infecund due to non-contraceptive reasons such as natural menopause or oophorectomy. To do this, use the codes listed in the Infecund table.
- Had a live birth in the last 2 months of the measurement year because there may not have been an opportunity to provide them with contraception. A two-month period was selected because the American College of Obstetricians and Gynecologists (ACOG) recommends having a postpartum visit by 6 weeks, and an additional 2 weeks was added to allow for reasonable delays in attending the postpartum visit. To identify live births, use the codes listed in the Live_birth table.
- Were still pregnant at the end of the year because they were pregnant (Pregnancy table) but did not have a pregnancy outcome code indicating a non-live birth (Non-live_birth table) or a live birth (Live_birth table).

Once the exclusions are applied, the denominator includes women who were:

- Not pregnant at any point in the measurement year.
- Pregnant during the measurement year but whose pregnancy ended in the first 10 months of the measurement year, since there was adequate time to provide contraception in the postpartum period.
- Pregnant during the measurement year but whose pregnancy ended in an ectopic pregnancy, stillbirth, miscarriage, or induced abortion.

All code tables used in the calculation of the denominator are available at: https://opa.hhs.gov/claims-data-sas-program-instructions

Numerator for Rate 1

Step 3

Define the numerator by identifying women who were provided a most (sterilization, IUD/IUS, implant) or moderately (injectables, oral pills, patch, ring, or diaphragm) effective method of contraception in the measurement year. To do this, use the codes in the Sterilization, IUD, Implant, Injectable, Oral_pill, Patch, Ring, Diaphragm tables.

Numerator for Rate 2

Step 3

Define the numerator by identifying women who were provided a LARC in the measurement year. To do this, use the codes in the LARC table.

Rate 1 Calculation

Step 4

Calculate the rates by dividing the number of women who were provided a most or moderately effective method of contraception by the number of women in the denominator.

All code tables used in the calculation of the numerator are available at: https://opa.hhs.gov/claims-data-sas-program-instructions.

Rate 2 Calculation

Step 4

Calculate the rates by dividing the number of women who were provided a LARC by the number of women in the denominator.

All code tables used in the calculation of the numerator are available at: https://opa.hhs.gov/claims-data-sas-program-instructions.

E. ADDITIONAL NOTES

Stratification of the results by category of Medicaid eligibility (e.g., family planning waiver vs. other Medicaid eligibility) is recommended for interpretation. A secondary data source, such as the National Survey of Family Growth[1] (NSFG) or the Behavioral Risk Factor Surveillance System[2] (BRFSS) should be used to interpret provision of most and moderately effective contraceptive methods. Secondary data sources may be used to interpret the results for the general Medicaid population. However, the results for the family planning waiver recipients do not need to be adjusted with secondary data as the vast majority of clients who receive services from these programs are seeking contraceptive services and should therefore be considered at risk of unintended pregnancy.

The ideal denominator for a clinical performance measure of contraceptive services is all women at risk of unintended pregnancy (i.e., who are fecund, are not pregnant or seeking pregnancy, and have ever had sex). However, it is not possible to identify this population with existing claims data because there are no codes for a woman's pregnancy intention or history of sexual activity. Further, both sterilization and LARC are long-lasting but there is no systematic record of receipt of sterilization or LARC in the year(s) preceding the measurement year. These limitations can be offset by using estimates from secondary survey data to help interpret the measure's results and to set better understand the limitations of claims data.

NSFG is a national survey that gathers information on family life, marriage and divorce, pregnancy, infertility, use of contraception, and men's and women's health. It is conducted

[1] National Center for Health Statistics. *NSFG – National Survey of Family Growth Homepage.* U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Health Statistics. https://www.cdc.gov/nchs/nsfg/index.htm

[2] National Center for Chronic Disease Prevention and Health Promotion, Division of Population Health. *CDC – BRFSS*. U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, Division of Population Health, National Center for Chronic Disease Prevention and Health Promotion. https://www.cdc.gov/brfss/

by CDC's National Center for Health Statistics and generates a nationally representative sample of women and men ages 15 to 49. Approximately 5,000 individuals are interviewed each year, and updated data files are released every two years. This survey can be used to identify the portion of beneficiaries that are not at risk of unintended pregnancy because they never had sex, are infecund, or are trying to get pregnant. This information can then help determine the population at risk for unintended pregnancy to provide context for measure performance.

BRFSS is a national telephone survey that collects data about health-related risk factors, chronic health conditions, and use of preventive health services.

Refer to "Interpreting Rates for the Contraceptive Care Measures - PDF," for examples of how to interpret performance results on this measure: https://opa.hhs.gov/sites/default/files/2020-07/interpreting-rates-for-contraceptive-care-measures.pdf

Acknowledgements

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The International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM) is published by the World Health Organization (WHO). ICD-10-CM is an official Health Insurance Portability and Accountability Act standard.

The International Classification of Diseases, 10th Revision, Procedure Coding System (ICD-10-PCS) is published by the World Health Organization (WHO). ICD-10-PCS is an official Health Insurance Portability and Accountability Act standard.

The National Drug Code (NDC) Directory is published by the U.S. Food and Drug Administration and is made available under the Open Database License: https://opendatacommons.org/licenses/dbcl/1-0/

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*Adult Immunization Status (AIS-E)**

***Developed with support from the Department of Health and Human Services (DHHS), Office of the Assistant Secretary for Health (OASH), National Vaccine Program Office (NVPO).**

SUMMARY OF CHANGES FOR HEDIS MY 2022

- Updated the logic for the measure to be expressed in FHIR.
- Removed the collection of the "Initial Population" data element by SSoR in the Data Elements for Reporting tables.
- Refer to the *Technical Release Notes* file in the Digital Measures Package for a comprehensive list of changes.

Description	The percentage of members 19 years of age and older who are up to date on recommended routine vaccines for influenza, tetanus and diphtheria (Td) or tetanus, diphtheria and acellular pertussis (Tdap), zoster and pneumococcal.
Measurement period	January 1–December 31.
Clinical recommendation statement	The Advisory Committee on Immunization Practices recommends annual influenza vaccination; and tetanus, diphtheria and acellular pertussis (Tdap) and/or tetanus and diphtheria (Td) vaccine; herpes zoster vaccine; and pneumococcal vaccination for adults at various ages.
Citations	Freedman M.S., P. Hunter, K. Ault, A. Kroger. 2020. "Advisory Committee on Immunization Practices Recommended Immunization Schedule for Adults Aged 19 Years or Older—United States, 2020." *MMWR Morb Mortal Wkly Rep* 69:133–5. DOI: http://dx.doi.org/10.15585/mmwr.mm6905a4.
Characteristics	
Scoring	Proportion.
Type	Process.
Stratification	1. Commercial 19–65 years. 2. Medicaid 19–65 years. 3. Medicare 66 years and older.
Risk adjustment	None.
Improvement notation	A higher rate indicates better performance.

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.
Initial Population	**Initial Population 1** Members 19 years and older at the start of the Measurement Period who also meet the criteria for Participation. **Initial Population 2** Same as the Initial Population 1. **Initial Population 3** Members 50 years and older at the start of Measurement Period who also meet the criteria for Participation. **Initial Population 4** Members 66 years and older at the start of the Measurement Period who also meet the criteria for Participation.
Exclusions	• Members with active chemotherapy any time during the Measurement Period. • Members with bone marrow transplant any time during the Measurement Period. • Members with history of immunocompromising conditions, cochlear implants, anatomic or functional asplenia, sickle cell anemia and HB-S disease or cerebrospinal fluid leaks 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.
Denominator	**Denominator 1** The Initial Population 1, minus Exclusions. **Denominator 2** Same as Denominator 1. **Denominator 3** The Initial Population 3, minus Exclusions. **Denominator 4** The Initial Population 4, minus Exclusions.

Numerator	**Numerator 1—Immunization Status: Influenza** Members who received an influenza vaccine on or between July 1 of the year prior to the Measurement Period and June 30 of the Measurement Period. **Numerator 2—Immunization Status: Td/Tdap** • Members who received at least one Td vaccine or one Tdap vaccine between nine years prior to the start of the Measurement Period and the end of the Measurement Period, ***or*** • Members with a history of at least one of the following contraindications any time before or during the Measurement Period: – Anaphylaxis due to the diphtheria, tetanus or pertussis vaccine. – Encephalitis due to the diphtheria, tetanus or pertussis vaccine. **Numerator 3—Immunization Status: Zoster** Members who received at least one dose of the herpes zoster live vaccine or two doses of the herpes zoster recombinant vaccine at least 28 days apart, any time on or after the member's 50th birthday and before or during the Measurement Period. **Numerator 4—Immunization Status: Pneumococcal** Members who were administered the 23-valent pneumococcal polysaccharide vaccine on or after the member's 60th birthday and before or during the Measurement Period.
Data criteria (element level)	
Value Sets: • **AISE_HEDIS_MY2022-1.0.0** – Adult Influenza Immunization (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1913) – Adult Influenza Vaccine Procedure (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1914) – Anaphylaxis Due to Diphtheria, Tetanus or Pertussis Vaccine (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.2240) – Anatomic or Functional Asplenia (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1477) – Bone Marrow Transplant (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1325) – Cerebrospinal Fluid Leak (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1448) – Chemotherapy Encounter (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1519) – Chemotherapy Procedure (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1500) – Cochlear Implant (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1447) – Cochlear Implant Device (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1521) – Cochlear Implant Diagnosis (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1520)	
– Encephalitis Due to Diphtheria, Tetanus or Pertussis Vaccine (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.2241)	

- Herpes Zoster Live Immunization (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1915)
- Herpes Zoster Live Vaccine Procedure (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1917)
- Herpes Zoster Recombinant Immunization (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1916)
- Herpes Zoster Recombinant Vaccine Procedure (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1918)
- Immunocompromising Conditions (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1502)
- Influenza Virus LAIV Immunization (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1974)
- Influenza Virus LAIV Vaccine Procedure (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1973)
- Pneumococcal Polysaccharide 23 Immunization (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1921)
- Pneumococcal Polysaccharide 23 Vaccine Procedure (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1922)
- Sickle Cell Anemia and HB S Disease (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1373)
- Td Immunization (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1923)
- Td Vaccine Procedure (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1924)
- Tdap Immunization (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1791)
- Tdap Vaccine Procedure (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1792)

- **NCQA_Hospice-1.0.0**
  - 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:

- **AISE_HEDIS_MY2022-1.0.0**
  - codesystem "ICD-10": 'http://hl7.org/fhir/sid/icd-10-cm'
  - code "Encounter for antineoplastic chemotherapy": 'Z51.11' from "ICD-10" display 'Encounter for antineoplastic chemotherapy'
  - code "Encounter for antineoplastic immunotherapy": 'Z51.12' from "ICD-10" display 'Encounter for antineoplastic immunotherapy'
  - code "Encounter for antineoplastic radiation therapy": 'Z51.0' from "ICD-10" display 'Encounter for antineoplastic radiation therapy'
- **NCQA_Terminology-1.0.0**
  - codesystem "ConditionClinicalStatusCodes": 'http://terminology.hl7.org/CodeSystem/condition-clinical'
  - codesystem "coverage-type": 'http://terminology.hl7.org/CodeSystem/v3-ActCode’
  - code "active": 'active' from "ConditionClinicalStatusCodes"

- code "managed care policy": 'MCPOL' from "coverage-type"
- code "retiree health program": 'RETIRE' from "coverage-type"
- code "subsidized health program": 'SUBSIDIZ' from "coverage-type"

Data Elements for Reporting

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

Table AIS-E-: 1/2 Data Elements for Adult Immunizations Status

Metric	Data Element	Reporting Instructions
Influenza	InitialPopulation	For each Metric
TdTdap	ExclusionsByEHR	For each Metric
Zoster	ExclusionsByCaseManagement	For each Metric
	ExclusionsByHIERegistry	For each Metric
	ExclusionsByAdmin	For each Metric
	Exclusions	(Sum over SSoRs)
	Denominator	For each Metric
	NumeratorByEHR	For each Metric
	NumeratorByCaseManagement	For each Metric
	NumeratorByHIERegistry	For each Metric
	NumeratorByAdmin	For each Metric
	Numerator	(Sum over SSoRs)
	Rate	(Percent)

Table AIS-E:3 Data Elements for Adult Immunizations Status

Metric	Data Element	Reporting Instructions
Influenza	InitialPopulation	For each Metric
TdTdap	ExclusionsByEHR	For each Metric
Zoster	ExclusionsByCaseManagement	For each Metric
Pneumococcal	ExclusionsByHIERegistry	For each Metric
	ExclusionsByAdmin	For each Metric
	Exclusions	(Sum over SSoRs)
	Denominator	For each Metric
	NumeratorByEHR	For each Metric
	NumeratorByCaseManagement	For each Metric
	NumeratorByHIERegistry	For each Metric
	NumeratorByAdmin	For each Metric
	Numerator	(Sum over SSoRs)
	Rate	(Percent)

Rules for Allowable Adjustments of HEDIS

NCQA's Rules for Allowable Adjustments of HEDIS describe how NCQA's HEDIS measure specifications can be adjusted for non-health plan reporting. Refer to the *Guidelines for the Rules of Allowable Adjustments of HEDIS* for additional information.

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

Rules for Allowable Adjustments for Adult Immunizations Status

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 for each denominator. Organizations must consult ACIP guidelines when considering whether to expand the age range 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 a population of interest such as gender, 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	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**
• Influenza • Td/Tdap • Zoster • Pneumococcal • Composite	No	Value sets, Direct Reference Codes and logic may not be changed.

Quality ID #110 (NQF 0041): Preventive Care and Screening: Influenza Immunization
– National Quality Strategy Domain: Community/Population Health
– Meaningful Measure Area: Preventive Care

2021 COLLECTION TYPE:
MIPS CLINICAL QUALITY MEASURES (CQMS)

MEASURE TYPE:
Process

DESCRIPTION:
Percentage of patients aged 6 months and older seen for a visit between October 1 and March 31 who received an influenza immunization OR who reported previous receipt of an influenza immunization

INSTRUCTIONS:
This measure is to be submitted a minimum of **once for visits for patients seen** between January and March for the 2020-2021 influenza season AND a minimum of **once for visits for patients seen** between October and December for the 2021-2022 influenza season. This measure is intended to determine whether or not all patients aged 6 months and older received (either from the submitting Merit-based Incentive Payment System (MIPS) eligible clinician or from an alternate care provider) the influenza immunization during the flu season. There is no diagnosis associated with this measure. This measure may be submitted by MIPS eligible clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

- If submitting this measure between January 1, 2021 and March 31, 2021, quality-data code **G8482** should be submitted when the influenza immunization is administered to the patient during the months of August, September, October, November, and December of 2020 or January, February, and March of 2021 for the flu season ending March 31, 2021.
- If submitting this measure between October 1, 2021 and December 31, 2021, quality-data code **G8482** should be submitted when the influenza immunization is administered to the patient during the months of August, September, October, November, and December of 2021 for the flu season ending March 31, 2022.
- Influenza immunizations administered during the month of August or September of a given flu season (either 2020-2021 flu season OR 2021-2022 flu season) can be submitted when a visit occurs during the flu season (October 1 - March 31). In these cases, **G8482** should be submitted.

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

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

DENOMINATOR:
All patients aged 6 months and older seen for a visit during the measurement period

DENOMINATOR NOTE: *For the purposes of the program, in order to submit on the flu season 2020-2021, the patient must have a qualifying encounter between January 1 and March 31, 2021. In order to submit on the flu season 2021-2022, the patient must have a qualifying encounter between October 1 and December 31, 2021. A qualifying encounter needs to occur within the flu season that is being submitted; any additional encounter(s) may occur at any time within the measurement period.*

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

Denominator Criteria (Eligible Cases):
Patients aged ≥ 6 months

AND
Patient encounter during January thru March and/or October thru December (CPT or HCPCS): 90945, 90947, 90951, 90952, 90953, 90954, 90955, 90956, 90957, 90958, 90959, 90960, 90961, 90962, 90963, 90964, 90965, 90966, 90967, 90968, 90969, 90970, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99241*, 99242*, 99243*, 99244*, 99245*, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99315, 99316, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, 99381*, 99382*, 99383*, 99384*, 99385*, 99386*, 99387*, 99391*, 99392*, 99393*, 99394*, 99395*, 99396*, 99397*, 99401*, 99402*, 99403*, 99404*, 99411*, 99412*, 99429*, 99512*, G0438, G0439

NUMERATOR:
Patients who received an influenza immunization OR who reported previous receipt of an influenza immunization

Definition:
Previous Receipt – Receipt of the current season's influenza immunization from another provider OR from same provider prior to the visit to which the measure is applied (typically, prior vaccination would include influenza vaccine given since August 1st).

Numerator Instruction:
The numerator for this measure can be met by submitting either administration of an influenza vaccination or that the patient reported previous receipt of the current season's influenza immunization. If the performance of the numerator is not met, a MIPS eligible clinician can submit a valid denominator exception for having not administered an influenza vaccination. For MIPS eligible clinicians submitting a denominator exception for this measure, there should be a clear rationale and documented reason for not administering an influenza immunization if the patient did not indicate previous receipt, which could include a medical reason (e.g., patient allergy), patient reason (e.g., patient declined), or system reason (e.g., vaccination not available). The system reason should be indicated only for cases of disruption or shortage of influenza vaccination supply.

Due to the changing nature of the CDC/ACIP recommendations regarding the live attenuated influenza vaccine (LAIV) for a particular flu season, this measure will not include the administration of this specific formulation of the flu vaccination. Given the variance of the timeframes for the annual update cycles, program implementation, and publication of revised recommendations from the CDC/ACIP, it has been determined that the coding for this measure will specifically exclude this formulation, so as not to inappropriately include this form of the vaccine for flu seasons when CDC/ACIP explicitly advise against it. However, it is recommended that all eligible professionals or eligible clinicians review the guidelines for each flu season to determine appropriateness of the LAIV and other formulations of the flu vaccine. Should the LAIV be recommended for administration for a particular flu season, an eligible professional or clinician may consider one of the following options: 1) satisfy the numerator by reporting previous

receipt, 2) report a denominator exception, either as a patient reason (e.g., for patient preference) or a system reason (e.g., the institution only carries LAIV).

NUMERATOR NOTE: *Denominator Exception(s) are determined at the time of the denominator eligible encounter during the current flu season.*

Numerator Options:

Performance Met:	Influenza immunization administered or previously received **(G8482)**
OR	
Denominator Exception:	Influenza immunization was not administered for reasons documented by clinician (e.g., patient allergy or other medical reasons, patient declined or other patient reasons, vaccine not available or other system reasons) **(G8483)**
OR	
Performance Not Met:	Influenza immunization was not administered, reason not given **(G8484)**

RATIONALE:

Influenza vaccination is the most effective protection against influenza virus infection (Centers for Disease Control and Prevention [CDC], 2018). Influenza may lead to serious complications including hospitalization or death (CDC, 2018). Influenza vaccine is recommended for all persons aged >= 6 months who do not have contraindications to vaccination. However, data indicate that less than half of all eligible individuals receive an influenza vaccination (CDC, 2015). This measure promotes annual influenza vaccination for all persons aged >= 6 months.

CLINICAL RECOMMENDATION STATEMENTS:

The following evidence statements are quoted verbatim from the referenced clinical guidelines.

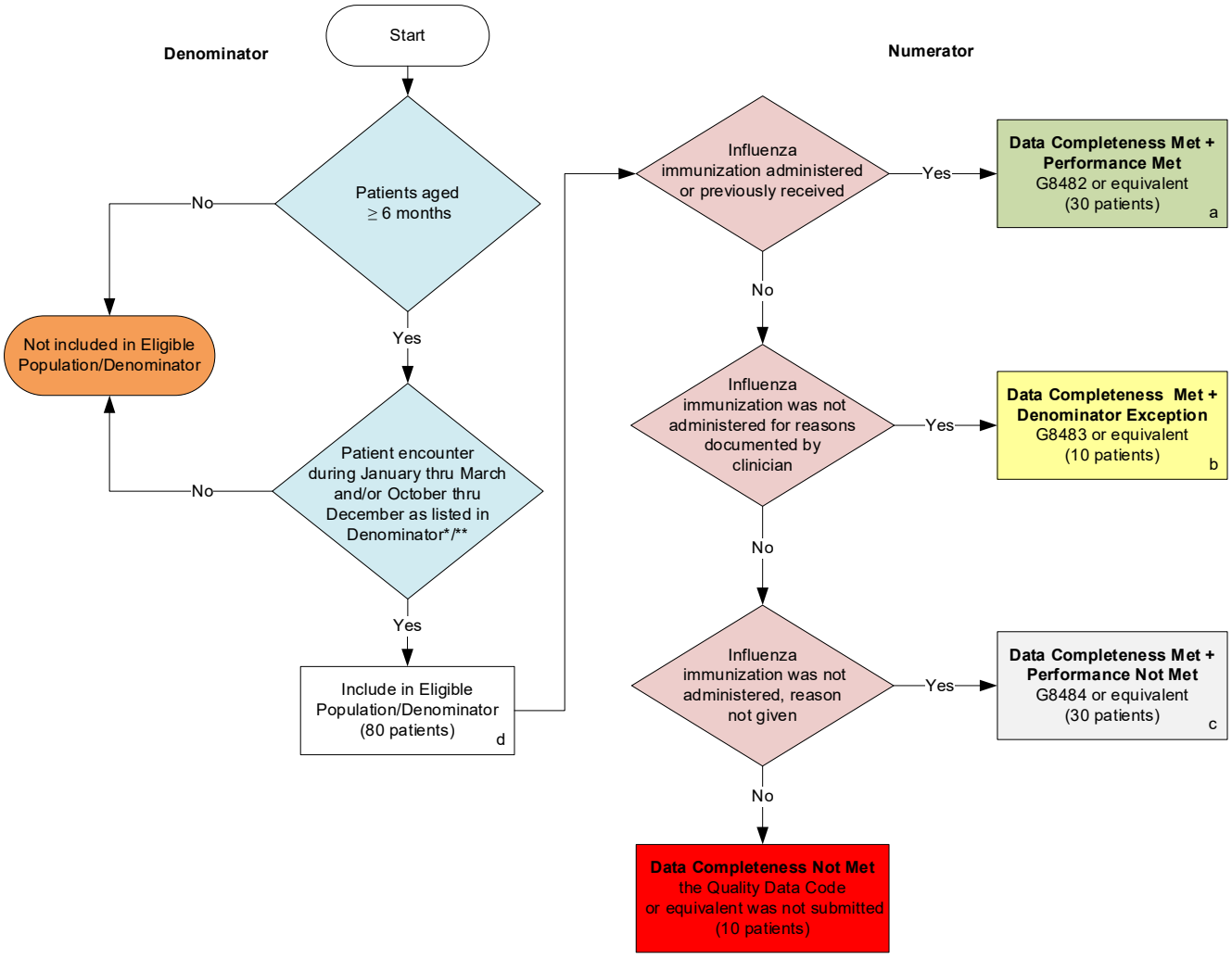
Routine annual influenza vaccination is recommended for all persons aged >= 6 months who do not have contraindications. Optimally, vaccination should occur before onset of influenza activity in the community. Although vaccination by the end of October is recommended, vaccine administered in December or later, even if influenza activity has already begun, is likely to be beneficial in the majority of influenza seasons (CDC/Advisory Committee on Immunization Practices [ACIP], 2019).

modification must be approved by NCQA and are subject to a license at the discretion of NCQA. The PCPI's and AMA's significant past efforts and contributions to the development and updating of the measure are acknowledged.

Limited proprietary coding is contained in the Measure specifications for user convenience. Users of proprietary code sets should obtain all necessary licenses from the owners of the code sets. NCQA disclaims all liability for use or accuracy of any third party codes contained in the specifications.

2021 Clinical Quality Measure Flow for Quality ID #110 (NQF 0041): Preventive Care and Screening: Influenza Immunization

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



SAMPLE CALCULATIONS

Data Completeness=

Performance Met (a=30 patients) + Denominator Exception (b=10 patients) + Performance Not Met (c=30 patients) = 70 patients = **87.50%**

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

Performance Rate=

Performance Met (a=30 patients) = 30 patients = **50.00%**

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

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

**This measure is only to be submitted once for visits occurring between January 1, 2021 and March 31, 2021 for the 2020-2021 influenza season AND once for visits occurring between October 1, 2021 and December 31, 2021 for the 2021-2022 influenza season for patients seen during the performance period. If the patient is seen during both flu seasons, the provider should report the measure for each flu season the patient is seen, cycling through this flow diagram for each flu season during which the patient was seen for a visit.

NOTE: Submission Frequency: Patient-Periodic

2021 Clinical Quality Measure Flow Narrative for Quality ID #110 (NQF 0041): Preventive Care and Screening: Influenza Immunization

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

1. Start with Denominator
2. Check *Patients aged greater than or equal to 6 months*:
    a. If *Patients aged greater than or equal to 6 months* equals No, do not include in *Eligible Population/Denominator*. Stop processing.
    b. If *Patients aged greater than or equal to 6 months* equals Yes, proceed to check *Patient encounter during January thru March and/or October thru December as listed in Denominator*/***.
3. Check *Patient encounter during January thru March and/or October thru December as listed in Denominator*/***:
    a. If *Patient encounter during January thru March and/or October thru December as listed in Denominator*/*** equals No, do not include in *Eligible Population/Denominator*. Stop processing.
    b. If *Patient encounter during January thru March and/or October thru December as listed in Denominator*/*** equals Yes, include in *Eligible Population/Denominator*.
4. Denominator Population:
    a. Denominator Population is all Eligible Patients in Denominator. Denominator is represented as Denominator in the Sample Calculation listed at the end of this document. Letter d equals 80 patients in the Sample Calculation.
5. Start Numerator
6. Check *Influenza immunization administered or previously received*:
    a. If *Influenza immunization administered or previously received* equals Yes, include in *Data Completeness Met and Performance Met*.
        - *Data Completeness Met and Performance Met* letter is represented in the Data Completeness and Performance Rate in the Sample Calculation listed at the end of this document. Letter a equals 30 patients in the Sample Calculation.
    b. If *Influenza immunization administered or previously received* equals No, proceed to check *Influenza immunization was not administered for reasons documented by clinician*.
7. Check *Influenza immunization was not administered for reasons documented by clinician*:
    a. If *Influenza immunization was not administered for reasons documented by clinician* equals Yes, include in *Data Completeness Met and Denominator Exception*.
        - *Completeness Met and Denominator Exception* letter is represented in the Data Completeness and Performance Rate in the Sample Calculation listed at the end of this document. Letter b equals 10 patients in the Sample Calculation.
    b. If *Influenza immunization was not administered for reasons documented by clinician* equals No, proceed to check *Influenza immunization was not administered, reason not given*.
8. Check *Influenza immunization was not administered, reason not given*:

a. If *Influenza immunization was not administered, reason not given* equals Yes, include in the *Data Completeness Met and Performance Not Met*.

   - *Data Completeness Met and Performance Not Met* letter is represented in the Data Completeness in the Sample Calculation listed at the end of this document. Letter c equals 30 patients in the Sample Calculation.

b. If *Influenza immunization was not administered, reason not given* equals No, proceed to check *Data Completeness Not Met*.

9. Check *Data Completeness Not Met*:

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

Sample Calculations

Data Completeness equals Performance Met (a equals 30 patients) plus Denominator Exception (b equals 10 patients) plus Performance Not Met (c equals 30 patients) divided by Eligible Population/Denominator (d equals 80 patients). All equals 70 patients divided by 80 patients. All equals 87.5 percent.

Performance Rate equals Performance Met (a equals 30 patients) divided by Data Completeness Numerator (70 patients) minus Denominator Exception (b equals 10 patients). All equals 30 patients divided by 60 patients. All equals 50 percent.

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

**This measure is only to be submitted once for visits occurring between January 1, 2021 and March 31, 2021 for the 2020-2021 influenza season AND once for visits occurring between October 1, 2021 and December 31, 2021 for the 2021-2022 influenza season for patients seen during the performance period. If the patient is seen during both flu seasons, the provider should report the measure for each flu season the patient is seen, cycling through this flow diagram for each flu season during which the patient was seen for a visit.

NOTE: Submission Frequency: Patient-Periodic

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

eCQM Title	**Children Who Have Dental Decay or Cavities**		
eCQM Identifier (Measure Authoring Tool)	75	**eCQM Version Number**	9.2.000
NQF Number	Not Applicable	**GUID**	61947125-4376-4a7b-ab7a-ac2be9bd9138
Measurement Period	January 1, 20XX through December 31, 20XX		
Measure Steward	Centers for Medicare & Medicaid Services (CMS)		
Measure Developer	National Committee for Quality Assurance		
Endorsed By	None		
Description	Percentage of children, 6 months - 20 years of age, who have had tooth decay or cavities during the measurement period		
Copyright	This Physician Performance Measure (Measure) and related data specifications are owned and stewarded by the Centers for Medicare & Medicaid Services (CMS). CMS contracted (Contract HHSP23320095627WC; HHSP23337008T) with the National Committee for Quality Assurance (NCQA) to develop this electronic measure. NCQA is not responsible for any use of the Measure. NCQA makes no representations, warranties, or endorsement about the quality of any organization or physician that uses or reports performance measures and NCQA has no liability to anyone who relies on such measures or specifications. Limited proprietary coding is contained in the Measure specifications for user convenience. Users of proprietary code sets should obtain all necessary licenses from the owners of the code sets. NCQA disclaims all liability for use or accuracy of any third party codes contained in the specifications. CPT(R) contained in the Measure specifications is copyright 2004-2019 American Medical Association. LOINC(R) copyright 2004-2019 Regenstrief Institute, Inc. This material contains SNOMED Clinical Terms(R) (SNOMED CT[R]) copyright 2004-2019 International Health Terminology Standards Development Organisation. ICD-10 copyright 2019 World Health Organization. All Rights Reserved.		
Disclaimer	The performance Measure is not a clinical guideline and does not establish a standard of medical care, and has not been tested for all potential applications. THE MEASURE AND SPECIFICATIONS ARE PROVIDED "AS IS" WITHOUT WARRANTY OF ANY KIND. Due to technical limitations, registered trademarks are indicated by (R) or [R] and unregistered trademarks are indicated by (TM) or [TM].		
Measure Scoring	Proportion		
Measure Type	Outcome		
Stratification	None		
Risk Adjustment	None		
Rate Aggregation	None		
Rationale	Dental caries is the most chronic disease among youth aged 6-19 years. Data from the National Health and Nutrition Examination Survey from 2015-2016 showed that approximately 45.8% of children and youth aged 2-19 years had total caries (untreated and treated). Prevalence of total dental caries (untreated and treated) in primary or permanent teeth increases with age, going from 21.4%, 50.5%, and 53.8% among ages 2-5, 6-11, and 12-19, respectively. Total dental caries was highest in Hispanic youths aged 2-19 at 57.1% compared to 48.1% for non-Hispanic black, 44.6% for non-Asian, and 40.4% for non-Hispanic white youth. Monitoring prevalence of untreated and total caries is vital to preventing and controlling oral disease (Fleming & Afful, 2018). Children who have dental decay or cavities are less likely to be in very good or excellent overall health than children without decay or cavities (Edelstein & Chinn, 2009). Children with decay are also more likely to have other oral health problems such as toothaches, broken teeth, and bleeding gums (Data Resource Center for Child and Adolescent Health, 2007).		
Clinical Recommendation Statement	This is an outcome measure. As such, no clinical recommendations are included.		
Improvement Notation	A lower score indicates better quality		
Reference	Data Resource Center for Child and Adolescent Health, Child and Adolescent Health Measurement Initiative. (2007). 2007 National Survey of Children's Health. Baltimore, MD: Author.		
Reference	Edelstein, B. L., & Chinn, C. H. (2009). Update on disparities in oral health and access to dental care for America's children. Academic Pediatrics, 9(6), 415-419.		
Reference	Fleming, E., & Afful, J. (2018). Prevalence of total and untreated dental carries among youth: United States, 2015-2016. NCHS Data Brief No. 307. Hyattsville, MD: National Center for Health Statistics.		
Definition	None		
Guidance	This eCQM is a patient-based measure. This version of the eCQM uses QDM version 5.5. Please refer to the eCQI resource center (https://ecqi.healthit.gov/qdm) for more information on the QDM.		
Transmission Format	TBD		
Initial Population	Children, 6 months - 20 years of age, with a clinical oral evaluation during the measurement period		
Denominator	Equals Initial Population		
Denominator Exclusions	Exclude patients whose hospice care overlaps the measurement period		
Numerator	Children who had a diagnosis of cavities or decayed teeth overlapping the measurement period		
Numerator Exclusions	Not applicable		
Denominator Exceptions	None		
Supplemental Data Elements	For every patient evaluated by this measure also identify payer, race, ethnicity and sex		

Table of Contents

Population Criteria

Initial Population

```
exists ( ["Patient Characteristic Birthdate": "Birth date"] BirthDate
    where Global."CalendarAgeInMonthsAt" ( BirthDate.birthDatetime, start of "Measurement Period" ) >= 6
      and Global."CalendarAgeInYearsAt" ( BirthDate.birthDatetime, start of "Measurement Period" ) < 20
)
  and exists ( "Qualifying Encounters" )
```

Denominator

```
"Initial Population"
```

Denominator Exclusions

```
Hospice."Has Hospice"
```

Numerator

```
exists ( ["Diagnosis": "Dental Caries"] DentalCaries
    where DentalCaries.prevalencePeriod overlaps "Measurement Period"
)
```

Numerator Exclusions

None

Denominator Exceptions

None

Stratification

None

Definitions

Denominator

```
"Initial Population"
```

Denominator Exclusions

```
Hospice."Has Hospice"
```

Hospice.Has Hospice

```
exists ( ["Encounter, Performed": "Encounter Inpatient"] DischargeHospice
    where ( DischargeHospice.dischargeDisposition ~ "Discharge to home for hospice care (procedure)"
      or DischargeHospice.dischargeDisposition ~ "Discharge to healthcare facility for hospice care (procedure)"
    )
      and DischargeHospice.relevantPeriod ends during "Measurement Period"
)
  or exists ( ["Intervention, Order": "Hospice care ambulatory"] HospiceOrder
    where HospiceOrder.authorDatetime during "Measurement Period"
  )
  or exists ( ["Intervention, Performed": "Hospice care ambulatory"] HospicePerformed
    where HospicePerformed.relevantPeriod overlaps "Measurement Period"
  )
```

Initial Population

```
exists ( ["Patient Characteristic Birthdate": "Birth date"] BirthDate
    where Global."CalendarAgeInMonthsAt" ( BirthDate.birthDatetime, start of "Measurement Period" ) >= 6
      and Global."CalendarAgeInYearsAt" ( BirthDate.birthDatetime, start of "Measurement Period" ) < 20
)
  and exists ( "Qualifying Encounters" )
```

Numerator

```
exists ( ["Diagnosis": "Dental Caries"] DentalCaries
    where DentalCaries.prevalencePeriod overlaps "Measurement Period"
)
```

Qualifying Encounters

```
["Encounter, Performed": "Clinical Oral Evaluation"] ValidEncounter
  where ValidEncounter.relevantPeriod during "Measurement Period"
```

SDE Ethnicity

```
["Patient Characteristic Ethnicity": "Ethnicity"]
```

SDE Payer

["Patient Characteristic Payer": "Payer"]

SDE Race

["Patient Characteristic Race": "Race"]

SDE Sex

["Patient Characteristic Sex": "ONC Administrative Sex"]

Functions

Global.CalendarAgeInMonthsAt(BirthDateTime DateTime, AsOf DateTime)

months between ToDate(BirthDateTime)and ToDate(AsOf)

Global.CalendarAgeInYearsAt(BirthDateTime DateTime, AsOf DateTime)

years between ToDate(BirthDateTime)and ToDate(AsOf)

Global.ToDate(Value DateTime)

DateTime(year from Value, month from Value, day from Value, 0, 0, 0, 0, timezoneoffset from Value)

Terminology

- code "Birth date" ("LOINC Code (21112-8)")
- code "Discharge to healthcare facility for hospice care (procedure)" ("SNOMEDCT Code (428371000124100)")
- code "Discharge to home for hospice care (procedure)" ("SNOMEDCT Code (428361000124107)")
- valueset "Clinical Oral Evaluation" (2.16.840.1.113883.3.464.1003.125.12.1003)
- valueset "Dental Caries" (2.16.840.1.113883.3.464.1003.125.12.1004)
- valueset "Encounter Inpatient" (2.16.840.1.113883.3.666.5.307)
- valueset "Ethnicity" (2.16.840.1.114222.4.11.837)
- valueset "Hospice care ambulatory" (2.16.840.1.113762.1.4.1108.15)
- valueset "ONC Administrative Sex" (2.16.840.1.113762.1.4.1)
- valueset "Payer" (2.16.840.1.114222.4.11.3591)
- valueset "Race" (2.16.840.1.114222.4.11.836)

Data Criteria (QDM Data Elements)

- "Diagnosis: Dental Caries" using "Dental Caries (2.16.840.1.113883.3.464.1003.125.12.1004)"
- "Encounter, Performed: Clinical Oral Evaluation" using "Clinical Oral Evaluation (2.16.840.1.113883.3.464.1003.125.12.1003)"
- "Encounter, Performed: Encounter Inpatient" using "Encounter Inpatient (2.16.840.1.113883.3.666.5.307)"
- "Intervention, Order: Hospice care ambulatory" using "Hospice care ambulatory (2.16.840.1.113762.1.4.1108.15)"
- "Intervention, Performed: Hospice care ambulatory" using "Hospice care ambulatory (2.16.840.1.113762.1.4.1108.15)"
- "Patient Characteristic Birthdate: Birth date" using "Birth date (LOINC Code 21112-8)"
- "Patient Characteristic Ethnicity: Ethnicity" using "Ethnicity (2.16.840.1.114222.4.11.837)"
- "Patient Characteristic Payer: Payer" using "Payer (2.16.840.1.114222.4.11.3591)"
- "Patient Characteristic Race: Race" using "Race (2.16.840.1.114222.4.11.836)"
- "Patient Characteristic Sex: ONC Administrative Sex" using "ONC Administrative Sex (2.16.840.1.113762.1.4.1)"

Supplemental Data Elements

SDE Ethnicity

["Patient Characteristic Ethnicity": "Ethnicity"]

SDE Payer

["Patient Characteristic Payer": "Payer"]

SDE Race

["Patient Characteristic Race": "Race"]

SDE Sex

["Patient Characteristic Sex": "ONC Administrative Sex"]

Risk Adjustment Variables

None

Measure Set	Not applicable

MEASURE PDENT-CH: PERCENTAGE OF ELIGIBLES WHO RECEIVED PREVENTIVE DENTAL SERVICES

Centers for Medicare & Medicaid Services

A. DESCRIPTION

Percentage of individuals ages 1 to 20 who are enrolled in Medicaid or CHIP Medicaid Expansion programs for at least 90 continuous days, are eligible for Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services, and who received at least one preventive dental service during the reporting period.

Data Collection Method: Administrative (Form CMS-416)

Guidance for Reporting:

- CMS will calculate this measure for states based on data submitted as part of the annual EPSDT report (Form CMS-416). States are not asked, and will not be able to provide data for this measure.
- The denominator for this measure includes only individuals enrolled in a Medicaid program or a CHIP Medicaid expansion program for at least 90 continuous days during the federal fiscal year and eligible for EPSDT services.
- States with a separate CHIP program should report dental data in Section III.G of the CHIP Annual Report Template System (CARTS) report.
- Instructions for the Form CMS-416, including for the dental lines of the report, are available at https://www.medicaid.gov/medicaid/benefits/downloads/cms-416-instructions.pdf. The instructions for each dental line specify the provider type(s) relevant to that line. It is important to report only services delivered by the type(s) of providers specified for that line. Line 12b collects information on dental services (not oral health services), and this distinction relates to the type of provider who delivered the service (see Section B. Definitions).
- Report dental services provided to eligible children in all places of service, such as dental offices, federally qualified health centers, and schools.
- Include all paid, unpaid, and denied claims.

The following coding systems are used in this measure: CDT, CPT, and HCPCS. Refer to the Acknowledgments section at the beginning of the manual for copyright information.

B. DEFINITIONS

Unduplicated	An individual may only be counted once.
Dental services	Services provided by or under the supervision of a dentist. Supervision is a spectrum and includes, for example, direct, indirect, general, collaborative or public health supervision as provided in the state's dental practice act. The most common examples of this are dentists themselves, and dental hygienists who are working under the supervision of dentists.
Oral health services	Services provided by any qualified health care practitioner or by a dental professional who is neither a dentist nor providing services under the supervision of a dentist. The most common examples of this are primary care medical providers and dental hygienists or dental therapists who are not working under the supervision of a dentist.

C. ELIGIBLE POPULATION

Age	Individuals ages 1 to 20 as of September 30 of the federal fiscal year.
Continuous enrollment	Eligible for EPSDT services for at least 90 continuous days during the federal fiscal year.

D. ADMINISTRATIVE SPECIFICATION

Denominator

The total unduplicated number of individuals ages 1 to 20 who have been continuously enrolled in Medicaid or CHIP Medicaid Expansion programs for at least 90 days during the federal fiscal year and are eligible to receive EPSDT services.

Numerator

The unduplicated number of individuals receiving at least one preventive dental service by or under the supervision of a dentist as defined by HCPCS codes D1000 - D1999 (or equivalent CDT codes D1000 - D1999 or equivalent CPT codes, that is, only those CPT codes that are for preventive dental services and only if provided by or under the supervision of a dentist), based on an unduplicated paid, unpaid, or denied claim.

The numerator should be inclusive of services reimbursed directly by the state under fee-for-service, managed care, prospective payment, or any other payment arrangements, or through any other health or dental plans that contract with the state to provide services to Medicaid or CHIP Medicaid expansion beneficiaries, based on an unduplicated paid, unpaid, or denied claim.

Exclusions

Do not include in this count the following groups of individuals:

- Medically needy individuals ages 1 to 20 if your state does not provide EPSDT services for the medically needy population
- Individuals eligible for Medicaid only under a §1115 waiver as part of an expanded population for which the full complement of EPSDT services is not available
- Undocumented aliens who are eligible only for emergency Medicaid services
- Children in separate state CHIP programs
- Groups of individuals ages 1 to 20 who are eligible only for limited services as part of their Medicaid eligibility (for example, pregnancy-related services).