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

eCQM Title	**Adult Major Depressive Disorder (MDD): Suicide Risk Assessment**
eCQM Identifier (Measure Authoring Tool)	161
eCQM Version Number	9.2.000
NQF Number	0104e
GUID	60176fbf-bfdc-4892-9c9e-604f206553c8
Measurement Period	January 1, 20XX through December 31, 20XX
Measure Steward	PCPI(R) Foundation (PCPI[R])
Measure Developer	American Medical Association (AMA)
Measure Developer	PCPI(R) Foundation (PCPI[R])
Endorsed By	National Quality Forum
Description	All patient visits during which a new diagnosis of MDD or a new diagnosis of recurrent MDD was identified for patients aged 18 years and older with a suicide risk assessment completed during the visit
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Disclaimer	
Measure Scoring	Proportion
Measure Type	Process
Stratification	None
Risk Adjustment	None
Rate Aggregation	None
Rationale	This measure aims to improve rates of clinician assessment of suicide risk during an encounter where a new or recurrent episode of major depressive disorder is identified. In an epidemiologic study (2010) of mental illness in the United States with a large, representative sample, 69% of respondents with lifetime suicide attempts had also met diagnostic criteria for major depressive disorder. When considering other mood disorders related to depression, such as dysthymia and bipolar disorders, this rate increases to 74% (Bolton & Robinson, 2010). In a 2014 study conducted by Ahmedani et al., 50% of individuals who completed a suicide had been seen in a health care setting within four weeks prior. Better assessment and identification of suicide risk in the health care setting should lead to improved connection to treatment and reduction in suicide attempts and deaths by suicide.
Clinical Recommendation Statement	A careful and ongoing evaluation of suicide risk is necessary for all patients with major depressive disorder [I] (American Psychiatric Association, 2010a, reaffirmed 2015). Such an assessment includes specific inquiry about suicidal thoughts, intent, plans, means, and behaviors; identification of specific psychiatric symptoms (e.g., psychosis, severe anxiety, substance use) or general medical conditions that may increase the likelihood of acting on suicidal ideas; assessment of past and, particularly, recent suicidal behavior; delineation of current stressors and potential protective factors (e.g., positive reasons for living, strong social support); and identification of any family history of suicide or mental illness [I] (American Psychiatric Association, 2010a, reaffirmed 2015). As part of the assessment process, impulsivity and potential for risk to others should also be evaluated, including any history of violence or violent or homicidal ideas, plans, or intentions [I] (American Psychiatric Association, 2010a, reaffirmed 2015). The patient's risk of harm to him- or herself and to others should also be monitored as treatment proceeds [I] (American Psychiatric Association, 2010a, reaffirmed 2015). Guidelines for Selecting a Treatment Setting for Patients at Risk for Suicide or Suicidal Behaviors (from American Psychiatric Association's Practice Guideline for Assessment and Treatment of Patients With Suicidal Behaviors, 2010b): Admission generally indicated After a suicide attempt or aborted suicide attempt if: * Patient is psychotic * Attempt was violent, near-lethal, or premeditated * Precautions were taken to avoid rescue or discovery * Persistent plan and/or intent is present * Distress is increased or patient regrets surviving * Patient is male, older than age 45 years, especially with new onset of psychiatric illness or suicidal thinking * Patient has limited family and/or social support, including lack of stable living situation * Current impulsive behavior, severe agitation, poor judgment, or refusal of help is evident * Patient has change in mental status with a metabolic, toxic, infectious, or other etiology requiring further workup in a structured setting In the presence of suicidal ideation with: * Specific plan with high lethality * High suicidal intent Admission may be necessary After a suicide attempt or aborted suicide attempt, except in circumstances for which admission is generally indicated In the presence of suicidal ideation with:

	* Psychosis * Major psychiatric disorder * Past attempts, particularly if medically serious * Possibly contributing medical condition (e.g., acute neurological disorder, cancer, infection) * Lack of response to or inability to cooperate with partial hospital or outpatient treatment * Need for supervised setting for medication trial or ECT * Need for skilled observation, clinical tests, or diagnostic assessments that require a structured setting * Limited family and/or social support, including lack of stable living situation * Lack of an ongoing clinician-patient relationship or lack of access to timely outpatient follow-up * Evidence of putting one's affairs in order (e.g., giving away possessions, writing a will) In the absence of suicide attempts or reported suicidal ideation/plan/intent but evidence from the psychiatric evaluation and/or history from others suggests a high level of suicide risk and a recent acute increase in risk Release from emergency department with follow-up recommendations may be possible After a suicide attempt or in the presence of suicidal ideation/plan when: * Suicidality is a reaction to precipitating events (e.g., exam failure, relationship difficulties), particularly if the patient's view of situation has changed since coming to emergency department * Plan/method and intent have low lethality * Patient has stable and supportive living situation * Patient is able to cooperate with recommendations for follow-up, with treater contacted, if possible, if patient is currently in treatment Outpatient treatment may be more beneficial than hospitalization Patient has chronic suicidal ideation and/or self-injury without prior medically serious attempts, if a safe and supportive living situation is available and outpatient psychiatric care is ongoing.
Improvement Notation	Higher score indicates better quality
Reference	American Psychiatric Association. (2010a). Practice guideline for the treatment of patients with major depressive disorder. 3rd edition. Retrieved from http://psychiatryonline.org/pb/assets/raw/sitewide/practice_guidelines/guidelines/mdd.pdf (This guideline was reaffirmed in 2015.)
Reference	American Psychiatric Association. (2010b). Guidelines for selecting a treatment setting for patients at risk for suicide or suicidal behaviors. Retrieved from http://psychiatryonline.org/pb/assets/raw/sitewide/practice_guidelines/guidelines/suicide.pdf
Reference	Ahmedani, B. K., Simon, G. E., Stewart, C., Beck, A., Waitzfelder, B. E., Rossom, R.,… Solberg, L. I.(2014). Health care contacts in the year before suicide death. Journal of General Internal Medicine, 29(6), 870-877. doi:10.1007/s11606-014-2767-3
Reference	Bolton, J. M., & Robinson, J. (2010). Population-attributable fractions of Axis I and Axis II mental disorders for suicide attempts: Findings from a representative sample of the adult, noninstitutionalized U.S. population. American Journal of Public Health, 100(12), 2473-2480. doi:10.2105/ajph.2010.192252
Definition	The specific type and magnitude of the suicide risk assessment is intended to be at the discretion of the individual clinician and should be specific to the needs of the patient. At a minimum, suicide risk assessment should evaluate: 1) Suicidal ideation 2) Patient's intent of initiating a suicide attempt AND, if either is present, 3) Patient plans for a suicide attempt 4) Whether the patient has means for completing suicide Low burden tools to track suicidal ideation and behavior such as the Columbia-Suicide Severity Rating Scale (C-SSRS) and the Suicide Assessment Five-Step Evaluation and Triage (SAFE-T) can also be used. Because no validated assessment tool or instrument fully meets the aforementioned requirements for the suicide risk assessment, individual tools or instruments have not been explicitly included in coding.
Guidance	This eCQM is an episode-of-care measure and should be reported for each instance of a new or recurrent episode of major depressive disorder (MDD); every new or recurrent episode will count separately in the Initial Population. As the guidelines state, it is important to assess for additional factors which may increase or decrease suicide risk, such as presence of additional symptoms (e.g., psychosis, severe anxiety, hopelessness, severe chronic pain); presence of substance abuse, history and seriousness of previous attempts, particularly, recent suicidal behavior, current stressors and potential protective factors (e.g., positive reasons for living, strong social support), family history of suicide or mental illness or recent exposure to suicide, impulsivity and potential for risk to others, including history of violence or violent or homicidal ideas, plans, or intentions, and putting one's affairs in order (e.g., giving away possessions, writing a will). In addition, although the measure focuses on the initial visit, it is critical that suicide risk be monitored especially for the 90 days following the initial visit and throughout MDD treatment. It is expected that a suicide risk assessment will be completed at the visit during which a new diagnosis is made or at the visit during which a recurrent episode is first identified (i.e., at the initial evaluation). For the purposes of this measure, an episode of major depressive disorder (MDD) would be considered to be recurrent if a patient has not had an MDD-related encounter in the past 105 days. If there is a gap of 105 or more days between visits for major depressive disorder (MDD), that would imply a recurrent episode. The 105-day look-back period is an operational provision and not a clinical recommendation, or definition of relapse, remission, or recurrence. In recognition of the growing use of integrated and team-based care, the diagnosis of depression and the assessment for suicide risk need not be performed by the same provider or clinician. Suicide risk assessments completed via telehealth services can also meet numerator performance. Use of a standardized tool(s) or instrument(s) to assess suicide risk will meet numerator performance. Standardized tools can be mapped to the concept "Intervention, Performed": "Suicide risk assessment (procedure)" included in the numerator logic below. The logic statement for the age requirement, as written, captures patients who turn 18 years old during the measurement period so that these patients are included in the measure, so long as the minimum criteria noted above is evaluated. To ensure all patients with major depressive disorder (MDD) are assessed for suicide risk, there are two clinical quality measures addressing suicide risk assessment; CMS 177 covers children and adolescents aged 6 through 17, and CMS 161 covers the adult population aged 18 years and older, as no individual suicide risk assessment tool or instrument would satisfy the requirements alone. 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	Patient visits during which a new diagnosis of MDD, single or recurrent episode, was identified
Denominator	Equals Initial Population
Denominator Exclusions	None
Numerator	Patient visits during which a new diagnosis of MDD, single or recurrent episode, was identified and a suicide risk assessment was completed during the visit

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

```
"New or Recurrent Major Depressive Disorder Encounter" NewOrRecurrentMDDEncounter
  with ["Patient Characteristic Birthdate": "Birth date"] BirthDate
    such that Global."CalendarAgeInYearsAt" ( BirthDate.birthDatetime, start of "Measurement Period" ) >= 17
```

Denominator

```
"Initial Population"
```

Denominator Exclusions

None

Numerator

```
"New or Recurrent Major Depressive Disorder Encounter" NewOrRecurrentMDDEncounter
  with ["Intervention, Performed": "Suicide risk assessment (procedure)"] SuicideRiskAssessment
    such that SuicideRiskAssessment.relevantDatetime during NewOrRecurrentMDDEncounter.relevantPeriod
```

Numerator Exclusions

None

Denominator Exceptions

None

Stratification

None

Definitions

Denominator

```
"Initial Population"
```

Initial Population

```
"New or Recurrent Major Depressive Disorder Encounter" NewOrRecurrentMDDEncounter
  with ["Patient Characteristic Birthdate": "Birth date"] BirthDate
    such that Global."CalendarAgeInYearsAt" ( BirthDate.birthDatetime, start of "Measurement Period" ) >= 17
```

Major Depressive Disorder Encounter

```
( ["Encounter, Performed": "Psych Visit - Diagnostic Evaluation"]
  union ["Encounter, Performed": "Emergency Department Visit"]
  union ["Encounter, Performed": "Office Visit"]
  union ["Encounter, Performed": "Outpatient Consultation"]
  union ["Encounter, Performed": "Psych Visit - Psychotherapy"]
  union ["Encounter, Performed": "Psychoanalysis"]
  union ["Encounter, Performed": "Telehealth Services"] ) ValidEncounter
  where exists ( ValidEncounter.diagnoses EncounterDiagnosis
      where EncounterDiagnosis.code in "Major Depressive Disorder-Active"
  )
```

New or Recurrent Major Depressive Disorder Encounter

```
"Major Depressive Disorder Encounter" NewOrRecurrentMDDEncounter
  without "Major Depressive Disorder Encounter" PriorMDDEpisodeEncounter
    such that PriorMDDEpisodeEncounter !~ NewOrRecurrentMDDEncounter
      and PriorMDDEpisodeEncounter.relevantPeriod ends 104 days or less before day of start of NewOrRecurrentMDDEncounter.relevantPeriod
  where NewOrRecurrentMDDEncounter.relevantPeriod during "Measurement Period"
```

Numerator

```
"New or Recurrent Major Depressive Disorder Encounter" NewOrRecurrentMDDEncounter
  with ["Intervention, Performed": "Suicide risk assessment (procedure)"] SuicideRiskAssessment
    such that SuicideRiskAssessment.relevantDatetime during NewOrRecurrentMDDEncounter.relevantPeriod
```

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.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 "Suicide risk assessment (procedure)" ("SNOMEDCT Code (225337009)")
- valueset "Emergency Department Visit" (2.16.840.1.113883.3.464.1003.101.12.1010)
- valueset "Ethnicity" (2.16.840.1.114222.4.11.837)
- valueset "Major Depressive Disorder-Active" (2.16.840.1.113883.3.526.3.1491)
- valueset "Office Visit" (2.16.840.1.113883.3.464.1003.101.12.1001)
- valueset "ONC Administrative Sex" (2.16.840.1.113762.1.4.1)
- valueset "Outpatient Consultation" (2.16.840.1.113883.3.464.1003.101.12.1008)
- valueset "Payer" (2.16.840.1.114222.4.11.3591)
- valueset "Psych Visit - Diagnostic Evaluation" (2.16.840.1.113883.3.526.3.1492)
- valueset "Psych Visit - Psychotherapy" (2.16.840.1.113883.3.526.3.1496)
- valueset "Psychoanalysis" (2.16.840.1.113883.3.526.3.1141)
- valueset "Race" (2.16.840.1.114222.4.11.836)
- valueset "Telehealth Services" (2.16.840.1.113883.3.464.1003.101.12.1031)

Data Criteria (QDM Data Elements)

- "Encounter, Performed: Emergency Department Visit" using "Emergency Department Visit (2.16.840.1.113883.3.464.1003.101.12.1010)"
- "Encounter, Performed: Office Visit" using "Office Visit (2.16.840.1.113883.3.464.1003.101.12.1001)"
- "Encounter, Performed: Outpatient Consultation" using "Outpatient Consultation (2.16.840.1.113883.3.464.1003.101.12.1008)"
- "Encounter, Performed: Psych Visit - Diagnostic Evaluation" using "Psych Visit - Diagnostic Evaluation (2.16.840.1.113883.3.526.3.1492)"
- "Encounter, Performed: Psych Visit - Psychotherapy" using "Psych Visit - Psychotherapy (2.16.840.1.113883.3.526.3.1496)"
- "Encounter, Performed: Psychoanalysis" using "Psychoanalysis (2.16.840.1.113883.3.526.3.1141)"
- "Encounter, Performed: Telehealth Services" using "Telehealth Services (2.16.840.1.113883.3.464.1003.101.12.1031)"
- "Intervention, Performed: Suicide risk assessment (procedure)" using "Suicide risk assessment (procedure) (SNOMEDCT Code 225337009)"
- "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	None

Quality ID #47 (NQF 0326): Advance Care Plan
– National Quality Strategy Domain: Communication and Care Coordination
– Meaningful Measure Area: Care is Personalized and Aligned with Patient's Goals

2021 COLLECTION TYPE:
MIPS CLINICAL QUALITY MEASURES (CQMS)

MEASURE TYPE:
Process – High Priority

DESCRIPTION:
Percentage of patients aged 65 years and older who have an advance care plan or surrogate decision maker documented in the medical record or documentation in the medical record that an advance care plan was discussed but the patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan

INSTRUCTIONS:
This measure is to be submitted a minimum of **once per performance period** for patients seen during the performance period. 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.

***NOTE**: This measure is appropriate for use in all healthcare settings (e.g., inpatient, nursing home, ambulatory) except the emergency department. For each of these settings, there should be documentation in the medical record(s) that advance care planning was discussed or documented.*

***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 65 years and older

> ***DENOMINATOR NOTE:** MIPS eligible clinicians indicating the Place of Service as the emergency department will not be included in this measure.*
>
> **Denominator Criteria (Eligible Cases):**
> Patients aged ≥ 65 years on date of encounter
> **AND**
> **Patient encounter during the performance period (CPT or HCPCS):** 90791, 90832, 90834, 90837, 90845, 90846, 90847, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99218, 99219, 99220, 99221, 99222, 99223, 99231, 99232, 99233, 99234, 99235, 99236, 99291, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, G0402, G0438, G0439
> **WITHOUT**
> **Place of Service (POS):** 23

AND NOT
DENOMINATOR EXCLUSION:
Hospice services received by patient any time during the measurement period: G9692

NUMERATOR:
Patients who have an advance care plan or surrogate decision maker documented in the medical record or documentation in the medical record that an advance care plan was discussed but patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan

Definition:
Documentation that Patient did not Wish or was not able to Name a Surrogate Decision Maker or Provide an Advance Care Plan – May also include, as appropriate, the following:

- That the patient's cultural and/or spiritual beliefs preclude a discussion of advance care planning, as it would be viewed as harmful to the patient's beliefs and thus harmful to the physician-patient relationship.

Numerator Instruction:
If patient's cultural and/or spiritual beliefs preclude a discussion of advance care planning, submit **1124F**.

NUMERATOR NOTE: *The CPT Category II codes used for this measure indicate: Advance Care Planning was discussed and documented. The act of using the Category II codes on a claim indicates the provider confirmed that the Advance Care Plan was in the medical record (that is, at the point in time the code was assigned, the Advance Care Plan in the medical record was valid) or that advance care planning was discussed. The codes are required annually to ensure that the provider either confirms annually that the plan in the medical record is still appropriate or starts a new discussion.*

The provider does not need to review the Advance Care Plan annually with the patient to meet the numerator criteria; documentation of a previously developed advanced care plan that is still valid in the medical record meets numerator criteria.

Services typically provided under CPT codes 99497 and 99498 satisfy the requirement of Advance Care Planning discussed and documented, minutes. If a patient received these types of services, submit CPT II ***1123F*** *or* ***1124F****.*

Numerator Options:

Performance Met:	Advance Care Planning discussed and documented; advance care plan or surrogate decision maker documented in the medical record **(1123F)**
OR	
Performance Met:	Advance Care Planning discussed and documented in the medical record; patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan **(1124F)**
OR	
Performance Not Met:	Advance Care Planning not documented, reason not otherwise specified **(1123F *with* 8P)**

RATIONALE:
It is essential that the patient's wishes regarding medical treatment be established as much as possible prior to incapacity. The Work Group has determined that the measure should remain as specified with no required timeframe based on a review of the literature. Studies have shown that people do change their preferences often with regard to advanced care planning, but it primarily occurs after a major medical event or other health status change. In the

stable patient, it would be very difficult to define the correct interval. It was felt by the Work Group that the error rate in simply not having addressed the issue at all is so much more substantial (Teno, 1997) than the risk that an established plan has become outdated that we should not define a specific timeframe at this time. As this measure is tested and reviewed, we will continue to evaluate if and when a specific timeframe should be included.

CLINICAL RECOMMENDATION STATEMENTS:

Advance directives are designed to respect patient's autonomy and determine his/her wishes about future life-sustaining medical treatment if unable to indicate wishes. Key interventions and treatment decisions to include in advance directives are: resuscitation procedures, mechanical respiration, chemotherapy, radiation therapy, dialysis, simple diagnostic tests, pain control, blood products, transfusions, and intentional deep sedation.

Oral statements:

- Conversations with relatives, friends, and clinicians are most common form; should be thoroughly documented in medical record for later reference.
- Properly verified oral statements carry same ethical and legal weight as those recorded in writing.

Instructional advance directives (DNR orders, living wills):

- Written instructions regarding the initiation, continuation, withholding, or withdrawal of particular forms of life-sustaining medical treatment.
- May be revoked or altered at any time by the patient.
- Clinicians who comply with such directives are provided legal immunity for such actions.

Durable power of attorney for health care or health care proxy:

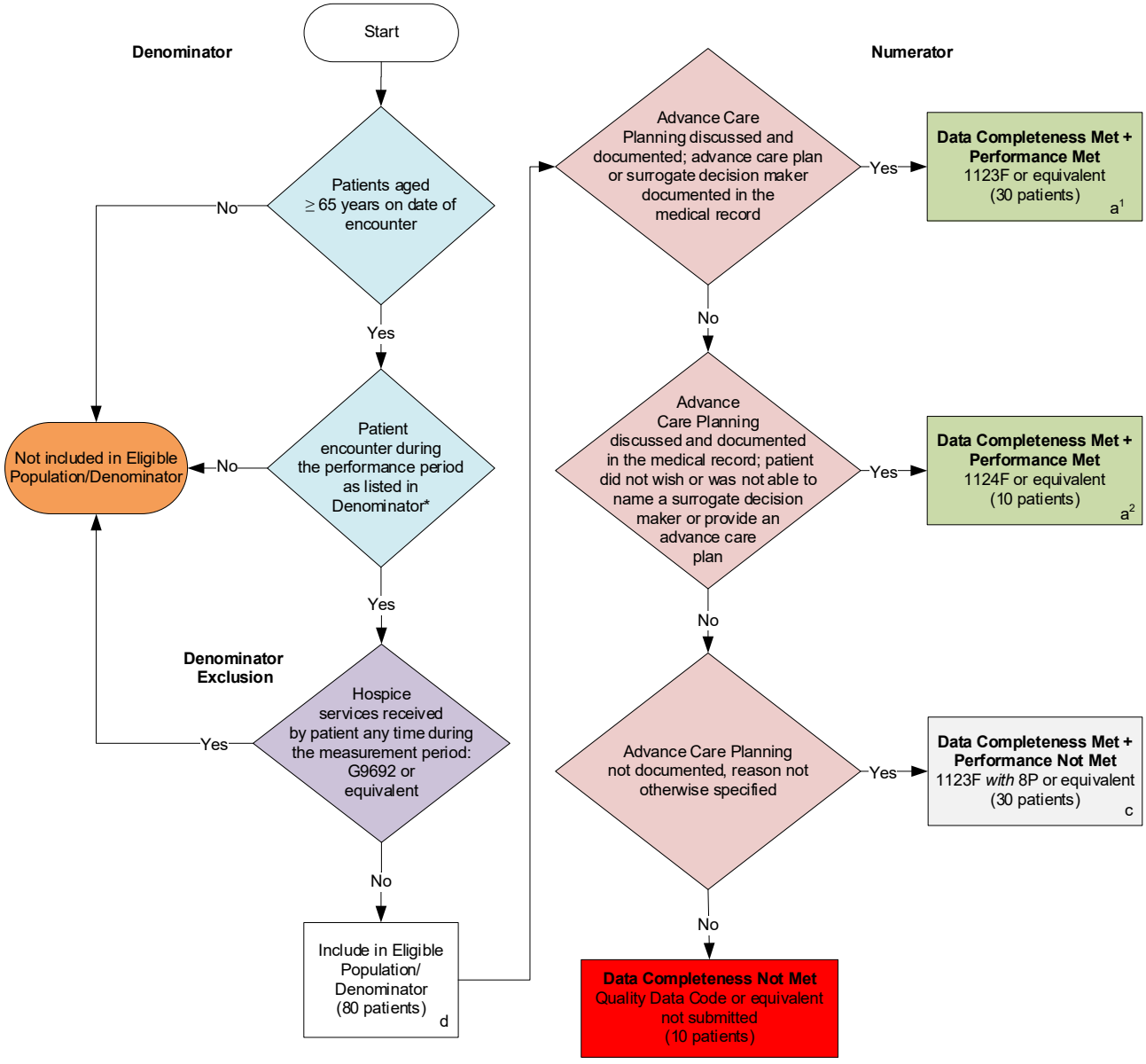
- A written document that enables a capable person to appoint someone else to make future medical treatment choices for him or her in the event of decisional incapacity. (AGS)

The National Hospice and Palliative Care Organization provides the Caring Connection web site, which provides resources and information on end-of-life care, including a national repository of state-by-state advance directives.

for use or accuracy of any third party codes contained in the specifications.

2021 Clinical Quality Measure Flow for Quality ID #47 (NQF 0326): Advance Care Plan

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 #047 (NQF 0326):
Advance Care Plan

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 65 years on date of encounter*:

    a. If *Patients aged greater than or equal to 65 years on date of encounter* equals No, do not include in *Eligible Population/Denominator*. Stop processing.

    b. If *Patients aged greater than or equal to 65 years on date of encounter* equals Yes, proceed to *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, proceed to *Hospice services received by patient any time during the measurement period*.

4. Check *Hospice services received by patient any time during the measurement period*:

    a. If *Hospice services received by patient any time during the measurement period* equals No, include in *Eligible Population/Denominator.*

    b. If *Hospice services received by patient any time during the measurement period* equals Yes, do not include in *Eligible Population/Denominator.* Stop processing.

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 equals 80 patients in the Sample Calculation.

6. Start Numerator

7. Check *Advance Care Planning discussed and documented; advance care plan or surrogate decision make documented in the medical record*:

    a. If *Advance Care Planning discussed and documented; advance care plan or surrogate decision make documented in the medical record* 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 30 patients in the Sample Calculation.

    b. If *Advance Care Planning discussed and documented; advance care plan or surrogate decision make documented in the medical record* equals No, proceed to *Advance Care Planning*

discussed and documented in the medical record; patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan.

8. Check *Advance Care Planning discussed and documented in the medical record; patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan*:

    a. *Advance Care Planning discussed and documented in the medical record; patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan* 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 10 patients in the Sample Calculation.

    b. If *Advance Care Planning discussed and documented in the medical record; patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan* equals No, proceed to *Advance Care Planning not documented, reason not otherwise specified*.

9. Check *Advance Care Planning not documented, reason not otherwise specified*:

    a. If *Advance Care Planning not documented, reason not otherwise specified* equals Yes, include in *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 *Advance Care Planning not documented, reason not otherwise specified* equals No, proceed to *Data Completeness Not Met*.

10. 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 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 87.5 percent.

Performance Rate equals Performance Met (a^1 plus a^2 equals 40) 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.

Behavioral Health Risk Assessment (for Pregnant Women) (BHRA-CH) - Maternal Care

NQF Endorsement Status	Not Endorsed
NQF ID	9999
Measure Type	Patient-Reported Outcome-Based Performance Measure (PRO-PM)
Measure Content Last Updated	2021-02-01
Info As Of	Not Available

Properties

Description	Percentage of women, regardless of age, who gave birth during a 12-month period seen at least once for prenatal care who received a behavioral health screening risk assessment that includes the following screenings at the first prenatal visit: depression screening, alcohol use screening, tobacco use screening, drug use screening (illicit and prescription, over the counter), and intimate partner violence screening.
Numerator	Patients who received the following behavioral health screening risk assessments at the first prenatal visit. Depression screening, Alcohol Use screening, Drug Use and Intimate Partner Violence
Denominator	All patients, regardless of age, who gave birth during a 12-month period seen at least once for prenatal care.
Denominator Exclusions	None
Rationale	Not Available
Evidence	Not Available

Developer/Steward

Steward	American Medical Association - Physician Consortium for Performance Improvement (AMA-PCPI)
Contact	Not Available

Behavioral Health Risk Assessment (for Pregnant Women) (BHRA-CH) - Maternal Care

Measure Developer	Not Available
Development Stage	Fully Developed

Characteristics

Measure Type	Patient-Reported Outcome-Based Performance Measure (PRO-PM)
Meaningful Measure Area	Not Available
Healthcare Priority	Person- and Family-Centered Care
eCQM Spec Available	Not Available
NQF Endorsement Status	Not Endorsed
NQF ID	9999
Last NQF Update	Not Available
Target Population Age	0+
Target Population Age (High)	Not Available
Target Population Age (Low)	0
Reporting Level	Clinician/Group
Conditions	Behavioral/Mental Health; Pregnancy
Subconditions	Not Available
Care Settings	Ambulatory Care: Clinican Office

Groups

Core Measure Set	Medicaid Child Core Set

Measure Group	Group Identifier

Behavioral Health Risk Assessment (for Pregnant Women) (BHRA-CH) - Maternal Care

Measure Group	Group Identifier
Child Core Set	
MC	03
CHIP Child Core Measure Set	
BHRA	CH
Medicaid Child Core Measures	

Measure Links

Measure Program: Medicaid

Info As Of	Not Available
Program / Model Notes	
Data Sources	Electronic Clinical Data (non-EHR)
Purposes	Not Available
Quality Domain	Maternal and Perinatal 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

Behavioral Health Risk Assessment (for Pregnant Women) (BHRA-CH) - Maternal Care

Measure Program Links

https://www.medicaid.gov/

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.

****NQF-ENDORSED VOLUNTARY CONSENSUS STANDARDS FOR HOSPITAL CARE****

Measure Information Form

Measure Set: Perinatal Care (PC)

Set Measure ID: PC-02

Performance Measure Name: Cesarean Birth

Description: Nulliparous women with a term, singleton baby in a vertex position delivered by cesarean birth

Rationale: The removal of any pressure to not perform a cesarean birth has led to a skyrocketing of hospital, state and national cesarean birth (CB) rates. Some hospitals now have CB rates over 50%. Hospitals with CB rates at 15-20% have infant outcomes that are just as good and better maternal outcomes (Gould et al., 2004). There are no data that higher rates improve any outcomes, yet the CB rates continue to rise. This measure seeks to focus attention on the most variable portion of the CB epidemic, the term labor CB in nulliparous women. This population segment accounts for the large majority of the variable portion of the CB rate, and is the area most affected by subjectivity.

As compared to other CB measures, what is different about NTSV CB rate (Low-risk Primary CB in first births) is that there are clear cut quality improvement activities that can be done to address the differences. Main et al. (2006) found that over 60% of the variation among hospitals can be attributed to first birth labor induction rates and first birth early labor admission rates. The results showed if labor was forced when the cervix was not ready the outcomes were poorer. Alfirevic et al. (2004) also showed that labor and delivery guidelines can make a difference in labor outcomes. Many authors have shown that physician factors, rather than patient characteristics or obstetric diagnoses are the major driver for the difference in rates within a hospital (Berkowitz, et al., 1989; Goyert et al., 1989; Luthy et al., 2003). The dramatic variation in NTSV rates seen in all populations studied is striking according to Menacker (2006). Hospitals within a state (Coonrod et al., 2008; California Office of Statewide Hospital Planning and Development [OSHPD], 2007) and physicians within a hospital (Main, 1999) have rates with a 3-5 fold variation.

Type Of Measure: Outcome

Improvement Noted As: Decrease in the rate

Numerator Statement: Patients with cesarean births

> **Included Populations:** *ICD-10-PCS Principal Procedure Code or ICD-10-PCS Other Procedure Codes* for cesarean birth as defined in Appendix A, Table 11.06
>
> **Excluded Populations:** None
>
> **Data Elements:**
>
> - *ICD-10-PCS Other Procedure Codes*

- *ICD-10-PCS Principal Procedure Code*

Denominator Statement: Nulliparous patients delivered of a live term singleton newborn in vertex presentation

Included Populations:

- *ICD-10-PCS Principal Procedure Code or ICD-10-PCS Other Procedure Codes* for delivery as defined in Appendix A, Table 11.01.1
- Nulliparous patients with *ICD-10-CM Principal Diagnosis Code or ICD-10-CM Other Diagnosis Codes* for outcome of delivery as defined in Appendix A, Table 11.08 and with a delivery of a newborn with 37 weeks or more of gestation completed

Excluded Populations:

- *ICD-10-CM Principal Diagnosis Code or ICD-10-CM Other Diagnosis Codes* for multiple gestations and other presentations as defined in Appendix A, Table 11.09
- Less than 8 years of age
- Greater than or equal to 65 years of age
- Length of Stay >120 days
- *Gestational Age* < 37 weeks or UTD

Data Elements:

- *Admission Date*
- *Birthdate*
- *Discharge Date*
- *Gestational Age*
- *ICD-10-CM Other Diagnosis Codes*
- *ICD-10-CM Principal Diagnosis Code*
- *Previous Live Births*

Risk Adjustment: No.

Data Collection Approach: Retrospective data sources for required data elements include administrative data and medical records.

Data Accuracy: Variation may exist in the assignment of ICD-10 codes; therefore, coding practices may require evaluation to ensure consistency.

Measure Analysis Suggestions: In order to identify areas for improvement, hospitals may want to review results based on specific ICD-10 codes or patient populations. Data could then be analyzed further determine specific patterns or trends to help reduce cesarean births.

Sampling: Yes. For additional information see the Sampling Section.

Data Reported As: Aggregate rate generated from count data reported as a proportion.

Selected References:

- Agency for Healthcare Research and Quality. (2002). *AHRQ Quality Indicators Guide to Inpatient Quality Indicators: Quality of Care in Hospitals Volume, Mortality, and Utilization*. Revision 4 (December 22, 2004). AHRQ Pub. No. 02-RO204.
- Alfirevic, Z., Edwards, G., & Platt, M.J. (2004). The impact of delivery suite guidelines on intrapartum care in "standard primigravida." *Eur J Obstet Gynecol Reprod Biol*.115:28-31.
- American College of Obstetricians and Gynecologists. (2000). *Task Force on Cesarean Delivery Rates. Evaluation of Cesarean Delivery*. (Developed under the direction of the Task Force on Cesarean Delivery Rates, Roger K. Freeman, MD, Chair, Arnold W. Cohen, MD, Richard Depp III, MD, Fredric D. Frigoletto Jr, MD, Gary D.V. Hankins, MD, Ellice Lieberman, MD, DrPH, M. Kathryn Menard, MD, David A. Nagey, MD, Carol W. Saffold, MD, Lisa Sams, RNC, MSN and ACOG Staff: Stanley Zinberg, MD, MS, Debra A. Hawks, MPH, and Elizabeth Steele).
- Bailit, J.L., Garrett, J.M., Miller, W.C., McMahon, M.J., & Cefalo, R.C. (2002). Hospital primary cesarean delivery rates and the risk of poor neonatal outcomes. *Am J Obstet Gynecol*. 187(3):721-7.
- Bailit, J. & Garrett, J. (2003). Comparison of risk-adjustment methodologies. *Am J Obstet Gynecol*.102:45-51.
- Bailit, J.L., Love, T.E., & Dawson, N.V. (2006). Quality of obstetric care and risk-adjusted primary cesarean delivery rates. *Am J Obstet Gynecol*.194:402.
- Bailit, J.L. (2007). Measuring the quality of inpatient obstetrical care. *Ob Gyn Sur*. 62:207-213.
- Berkowitz, G.S., Fiarman, G.S., Mojica, M.A., et al. (1989). Effect of physician characteristics on the cesarean birth rate. *Am J Obstet Gynecol*. 161:146-9.
- California Office of Statewide Hospital Planning and Development. (2017). Hospital Volume and Utilization Indicators for California, Retrieved from the Internet on February 22, 2018 at: https://www.oshpd.ca.gov/HID/AHRQ-Volume-Utilization.html
- Caughey, A.B., Cahill, A.G., Guise, JM., Rouse, D.J. (2019). Safe prevention of the primary cesarean delivery. American College of Obstetricians and Gynecologists, 123: 693-711. Retrieved from https://www.acog.org/Clinical-Guidance-and-Publications/Obstetric-Care-Consensus-Series/Safe-Prevention-of-the-Primary-Cesarean-Delivery.
- Cleary, R., Beard, R.W., Chapple, J., Coles, J., Griffin, M., & Joffe, M. (1996). The standard primipara as a basis for inter-unit comparisons of maternity care. *Br J Obstet Gynecol*. 103:223-9.
- Coonrod, D.V., Drachman, D., Hobson, P., & Manriquez, M. (2008). Nulliparous term singleton vertex cesarean delivery rates: institutional and individual level predictors. *Am J Obstet Gynecol*. 694-696.
- DiGiuseppe, D.L., Aron, D.C., Payne, S.M., Snow, R.J., Dieker, L., & Rosenthal, G.E. (2001). Risk adjusting cesarean delivery rates: a comparison of hospital profiles based on medical record and birth certificate data. *Health Serv Res*.36:959-77.
- Gould, J., Danielson, B., Korst, L., Phibbs, R., Chance, K.,& Main, E.K., et al. (2004). Cesarean delivery rate and neonatal morbidity in a low-risk population. *Am J Obstet Gynecol*, 104:11-19.
- Goyert, G.L., Bottoms, F.S., Treadwell, M.C., et al. (1989). The physician factor in cesarean birth rates. *N Engl J Med*.320:706-9.
- Le Ray, C., Carayol, M., Zeitlin, J., Berat, G., & Goffinet, F. (2006). Level of perinatal care of the maternity unit and rate of cesarean in low-risk nulliparas. *Am J Obstet Gynecol*. 107:1269-77.
- Luthy, D.A., Malmgren, J.A., Zingheim, R.W., & Leininger, C.J. (2003). Physician contribution to a cesarean delivery risk model. *Am J Obstet Gynecol*.188:1579-85.
- Main, E.K. (1999). Reducing cesarean birth rates with data-driven quality improvement activities. *Peds*. 103: 374-383.

- Main E.K., Bloomfield, L., & Hunt, G. (2004). Development of a large-scale obstetric quality-improvement program that focused on the nulliparous patient at term. *Am J Obstet Gynecol*.190:1747-58.
- Main, E.K., Moore, D., Farrell, B., Schimmel, L.D., Altman, R.J., Abrahams, C., et al., (2006). Is there a useful cesarean birth measure? Assessment of the nulliparous term singleton vertex cesarean birth rate as a tool for obstetric quality improvement. *Am J Obstet Gynecol*. 194:1644-51.
- Main, E.K, Shen-Chih, C., Cape, V., Sakowski, C., Smith, H., Vasher, J. (2019). Safety assessment scale of a large-scale improvement collaborative to reduce nulliparous cesarean delivery rates. American College of Obstetricians and Gynecologists, 133 (4): 613-623.
- Menacker, F. (2005).Trends in cesarean rates for first births and repeat cesarean rates for low-risk women: United States, 1990-2003. *Nat Vital Stat Rep*. 54(4): 1-5.
- Romano, P.S., Yasmeen, S., Schembri, M.E., Keyzer, J.M., & Gilbert, W.M. (2005). Coding of perineal lacerations and other complications of obstetric care in hospital discharge data. *Am J Obstet Gynecol*.106:717-25.
- U.S. Department of Health and Human Services. (2000). *Healthy People 2010: Understanding and Improving Health*. 2nd ed. Washington, DC: U.S. Government Printing Office. Measure 16-9.
- Yasmeen, S., Romano, P.S., Schembri, M.E., Keyzer, J.M., & Gilbert, W.M. (2006). Accuracy of obstetric diagnoses and procedures in hospital discharge data. *Am J Obstet Gynecol*. 194:992-1001.

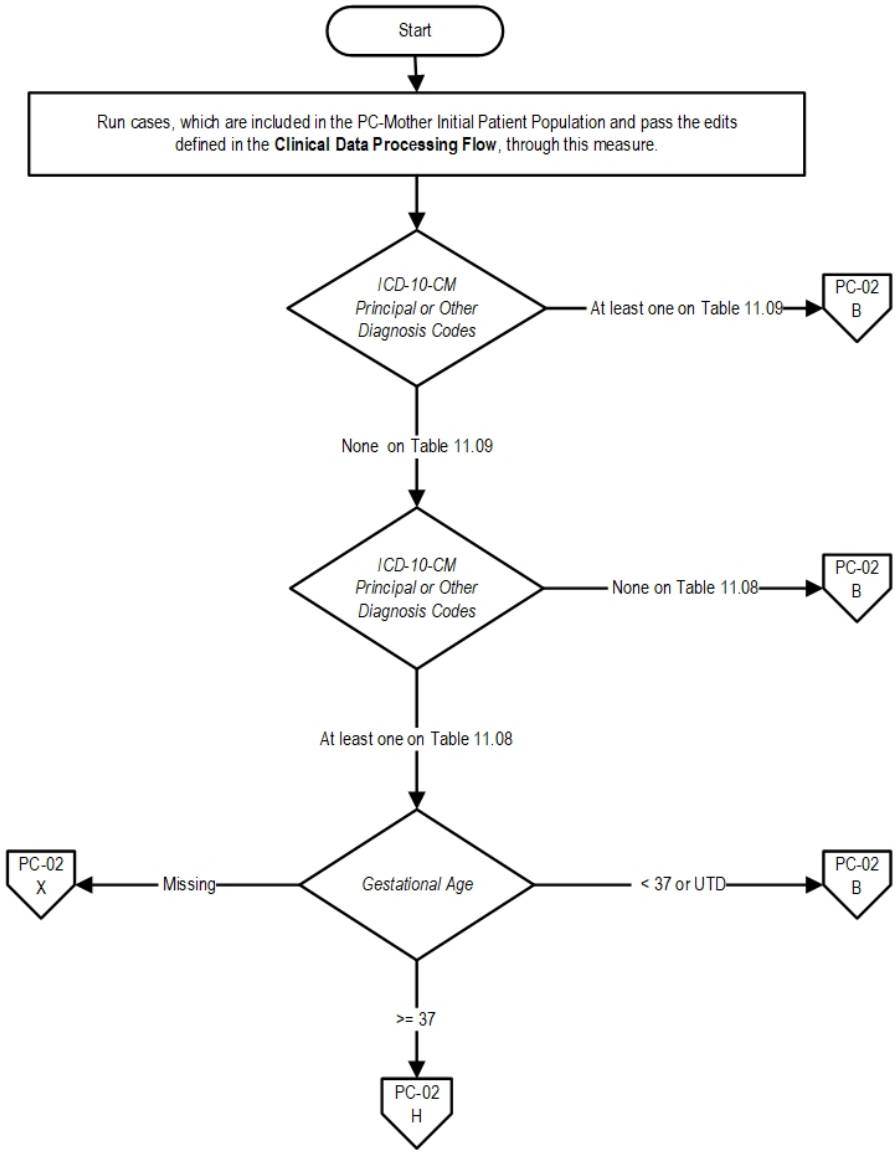
Original Performance Measure Source / Developer:
California Maternal Quality Care Collaborative

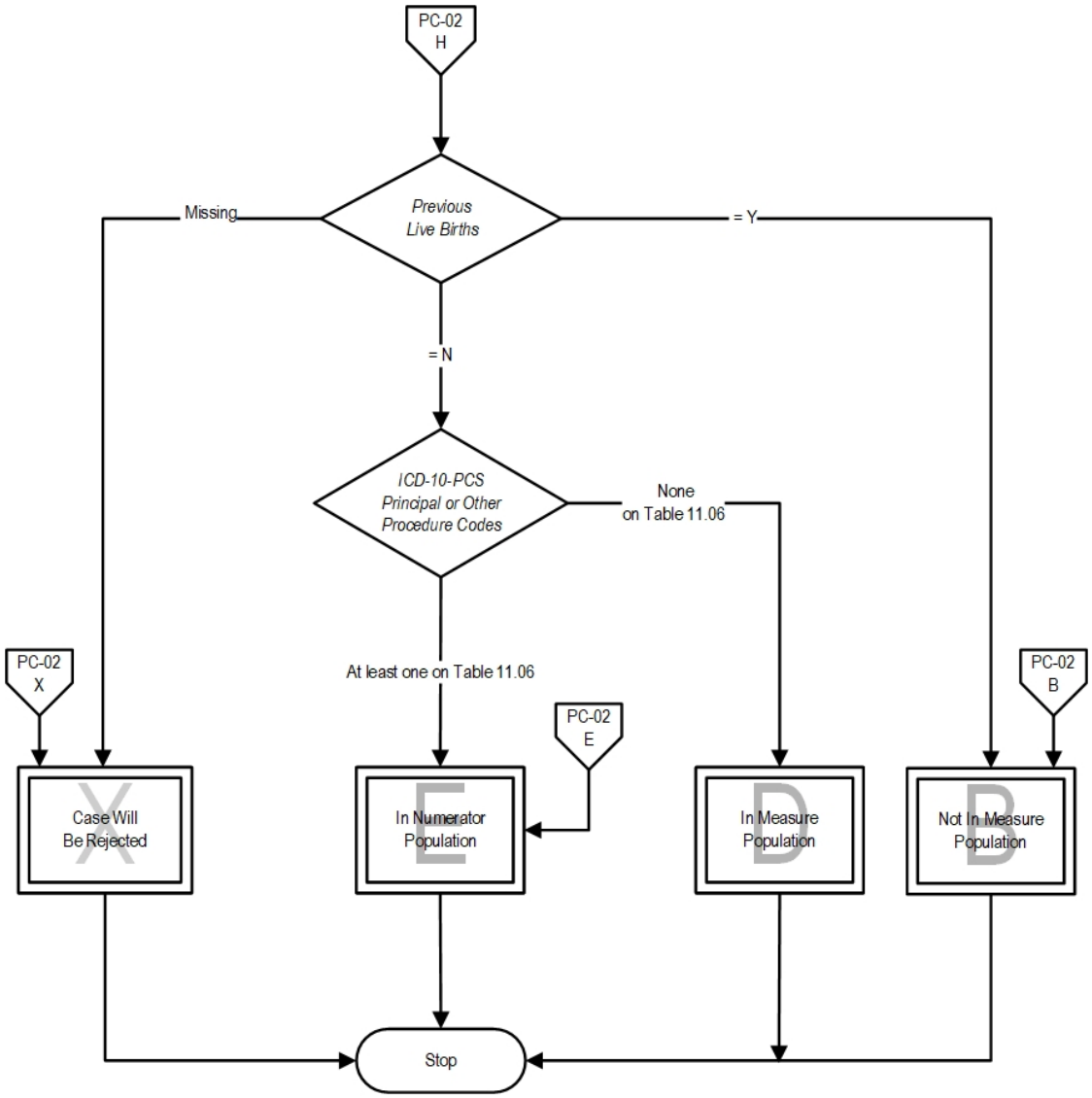
Measure Algorithm:

PC-02: Cesarean Birth

Numerator: Patients with cesarean births

Denominator: Nulliparous patients delivered of a live term singleton newborn in vertex presentation





eCQM Title	**Child and Adolescent Major Depressive Disorder (MDD): Suicide Risk Assessment**		
eCQM Identifier (Measure Authoring Tool)	177	**eCQM Version number**	8.1.000
NQF Number	1365e	**GUID**	848d09de-7e6b-43c4-bedd-5a2957ccffe3
Measurement Period	January 1, 20XX through December 31, 20XX		
Measure Steward	PCPI(R) Foundation (PCPI[R])		
Measure Developer	American Medical Association (AMA)		
Measure Developer	PCPI(R) Foundation (PCPI[R])		
Endorsed By	National Quality Forum		
Description	Percentage of patient visits for those patients aged 6 through 17 years with a diagnosis of major depressive disorder with an assessment for suicide risk		
Copyright	Copyright 2019 PCPI(R) Foundation and American Medical Association. All Rights Reserved.		
Disclaimer	The Measure is not a clinical guideline, does not establish a standard of medical care, and has not been tested for all potential applications. The Measure, while copyrighted, can be reproduced and distributed, without modification, for noncommercial purposes, e.g., use by health care providers in connection with their practices. Commercial use is defined as the sale, license, or distribution of the Measure for commercial gain, or incorporation of the Measure into a product or service that is sold, licensed or distributed for commercial gain. Commercial uses of the Measure require a license agreement between the user and the PCPI(R) Foundation (PCPI[R]) or the American Medical Association (AMA). Neither the AMA, nor the former AMA-convened Physician Consortium for Performance Improvement(R) (AMA-PCPI), nor PCPI, nor their members shall be responsible for any use of the Measure. AMA and PCPI encourage use of the Measure by other health care professionals, where appropriate. THE MEASURE AND SPECIFICATIONS ARE PROVIDED "AS IS" WITHOUT WARRANTY OF ANY KIND. Limited proprietary coding is contained in the Measure specifications for convenience. Users of the proprietary code sets should obtain all necessary licenses from the owners of these code sets. The AMA, the PCPI and its members and former members of the AMA-PCPI disclaim all liability for use or accuracy of any Current Procedural Terminology (CPT[R]) or other coding contained in the specifications. CPT(R) contained in the Measure specifications is copyright 2004-2018 American Medical Association. LOINC(R) is copyright 2004-2018 Regenstrief Institute, Inc. This material contains SNOMED Clinical Terms(R) (SNOMED CT[R]) copyright 2004-2018 International Health Terminology Standards Development Organisation. ICD-10 is copyright 2018 World Health Organization. All Rights Reserved. Due to technical limitations, registered trademarks are indicated by (R) or [R].		
Measure Scoring	Proportion		
Measure Type	Process		
Stratification	None		
Risk Adjustment	None		
Rate Aggregation	None		
Rationale	Research has shown that patients with major depressive disorder are at a high risk for suicide attempts and completion - among the most significant and devastating sequelae of the disease. Suicide risk is a critical consideration in children and adolescents with MDD and an important aspect of care that should be assessed at each visit and subsequently managed to minimize that risk. Additionally, the importance of the assessments is underscored by research that indicates that many individuals who die by suicide do make contact with primary care providers and mental health services beforehand. More specifically, approximately 15% of suicide victims aged 35 years or younger had seen a mental health professional within 1 month of suicide while approximately 23% had seen a primary care provider within 1 month of suicide.		
Clinical Recommendation Statement	The evaluation must include assessment for the presence of harm to self or others (MS) (American Academy of Child and Adolescent Psychiatry, 2007). Suicidal behavior exists along a continuum from passive thoughts of death to a clearly developed plan and intent to carry out that plan. Because depression is closely associated with suicidal thoughts and behavior, it is imperative to evaluate these symptoms at the initial and subsequent assessments. For this purpose, low burden tools to track suicidal ideation and behavior such as the Columbia-Suicidal Severity Rating Scale can be used. Also, it is crucial to evaluate the risk (e.g., age, sex, stressors, comorbid conditions, hopelessness, impulsivity) and protective factors (e.g., religious belief, concern not to hurt family) that might influence the desire to attempt suicide. The risk for suicidal behavior increases if there is a history of suicide attempts, comorbid psychiatric disorders (e.g., disruptive disorders, substance abuse), impulsivity and aggression, availability of lethal agents (e.g., firearms), exposure to negative events (e.g., physical or sexual abuse, violence), and a family history of suicidal behavior (American Academy of Child and Adolescent Psychiatry, 2007). A careful and ongoing evaluation of suicide risk is necessary for all patients with major depressive disorder (Category I). Such an assessment includes specific inquiry about suicidal thoughts, intent, plans, means, and behaviors; identification of specific psychiatric symptoms (e.g., psychosis, severe anxiety, substance use) or general medical conditions that may increase the likelihood of acting on suicidal ideas; assessment of past and, particularly, recent suicidal behavior; delineation of current stressors and potential protective factors (e.g., positive reasons for living, strong social support); and identification of any family history of suicide or mental illness (Category I) (American Psychiatric Association, 2010, reaffirmed 2015).		
Improvement Notation	Higher score indicates better quality		
Reference	American Academy of Child and Adolescent Psychiatry. (2007). Practice parameter for the assessment and treatment of children and adolescents with depressive disorders. Journal of the American Academy of Child and Adolescent Psychiatry, 46(11), 1503-1526. Retrieved from https://www.jaacap.org/article/S0890-8567(09)62053-0/fulltext		
Reference	American Psychiatric Association Work Group on Major Depressive Disorder. (2010, October). Practice guideline for the treatment of patients with major depressive disorder. 3rd edition. Retrieved from http://psychiatryonline.org/pb/assets/raw/sitewide/practice_guidelines/guidelines/mdd.pdf (This guideline was reaffirmed in October 2015.)		
Reference	Luoma, J. B., Martin, C. E., & Pearson, J. L. (2002). Contact with mental health and primary care providers before suicide: A review of the evidence. American Journal of Psychiatry, 159(6), 909-916.		
Definition	Numerator Definition: The specific type and magnitude of the suicide risk assessment is intended to be at the discretion of the individual clinician and should be specific to the needs of the patient. At a minimum, suicide risk assessment should evaluate: 1. Risk (e.g., age, sex, stressors, comorbid conditions, hopelessness, impulsivity) and protective factors (e.g.,		

	religious belief, concern not to hurt family) that may influence the desire to attempt suicide. 2. Current severity of suicidality. 3. Most severe point of suicidality in episode and lifetime. Low burden tools to track suicidal ideation and behavior such as the Columbia-Suicidal Severity Rating Scale can also be used. Because no validated assessment tool or instrument fully meets the aforementioned requirements for the suicide risk assessment, individual tools or instruments have not been explicitly included in coding.
Guidance	A suicide risk assessment should be performed at every visit for major depressive disorder during the measurement period. Suicide risk assessments completed via telehealth services can also meet numerator performance. This measure is an episode-of-care measure; the level of analysis for this measure is every visit for major depressive disorder during the measurement period. For example, at every visit for MDD, the patient should have a suicide risk assessment. Use of a standardized tool(s) or instrument(s) to assess suicide risk will meet numerator performance, so long as the minimum criteria noted above is evaluated. Standardized tools can be mapped to the concept "Intervention, Performed": "Suicide risk assessment (procedure)" included in the numerator logic below, as no individual suicide risk assessment tool or instrument would satisfy the requirements alone.
Transmission Format	TBD
Initial Population	All patient visits for those patients aged 6 through 17 years with a diagnosis of major depressive disorder
Denominator	Equals Initial Population
Denominator Exclusions	None
Numerator	Patient visits with an assessment for suicide risk
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

```
"Major Depressive Disorder Encounter" MDDEncounter
    with ["Patient Characteristic Birthdate": "Birth date"] BirthDate
        such that Global."CalendarAgeInYearsAt"(BirthDate.birthDatetime, start of "Measurement Period")>= 6
            and Global."CalendarAgeInYearsAt"(BirthDate.birthDatetime, start of "Measurement Period")< 17
```

Denominator

```
"Initial Population"
```

Denominator Exclusions

None

Numerator

```
"Major Depressive Disorder Encounter" MDDEncounter
    with ["Intervention, Performed": "Suicide risk assessment (procedure)"] SuicideRiskAssessment
        such that SuicideRiskAssessment.relevantPeriod during MDDEncounter.relevantPeriod
```

Numerator Exclusions

None

Denominator Exceptions

None

Stratification

None

Definitions

Denominator

```
"Initial Population"
```

Initial Population

```
"Major Depressive Disorder Encounter" MDDEncounter
    with ["Patient Characteristic Birthdate": "Birth date"] BirthDate
        such that Global."CalendarAgeInYearsAt"(BirthDate.birthDatetime, start of "Measurement Period")>= 6
            and Global."CalendarAgeInYearsAt"(BirthDate.birthDatetime, start of "Measurement Period")< 17
```

Major Depressive Disorder Encounter

```
( ["Encounter, Performed": "Office Visit"]
    union ["Encounter, Performed": "Outpatient Consultation"]
    union ["Encounter, Performed": "Psych Visit - Diagnostic Evaluation"]
    union ["Encounter, Performed": "Psych Visit - Family Psychotherapy"]
    union ["Encounter, Performed": "Psych Visit - Psychotherapy"]
```

```
union ["Encounter, Performed": "Psychoanalysis"]
union ["Encounter, Performed": "Group Psychotherapy"]
union ["Encounter, Performed": "Telehealth Services"] ) ValidEncounter
where exists ( ValidEncounter.diagnoses EncounterDiagnosis
            where EncounterDiagnosis in "Major Depressive Disorder-Active"
)
      and ValidEncounter.relevantPeriod during "Measurement Period"
```

Numerator

```
"Major Depressive Disorder Encounter" MDDEncounter
      with ["Intervention, Performed": "Suicide risk assessment (procedure)"] SuicideRiskAssessment
            such that SuicideRiskAssessment.relevantPeriod during MDDEncounter.relevantPeriod
```

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.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, timezone from Value)
```

Terminology

- code "Birth date" ("LOINC Code (21112-8)")
- code "Suicide risk assessment (procedure)" ("SNOMEDCT Code (225337009)")
- valueset "Ethnicity" (2.16.840.1.114222.4.11.837)
- valueset "Group Psychotherapy" (2.16.840.1.113883.3.526.3.1187)
- valueset "Major Depressive Disorder-Active" (2.16.840.1.113883.3.526.3.1491)
- valueset "Office Visit" (2.16.840.1.113883.3.464.1003.101.12.1001)
- valueset "ONC Administrative Sex" (2.16.840.1.113762.1.4.1)
- valueset "Outpatient Consultation" (2.16.840.1.113883.3.464.1003.101.12.1008)
- valueset "Payer" (2.16.840.1.114222.4.11.3591)
- valueset "Psych Visit - Diagnostic Evaluation" (2.16.840.1.113883.3.526.3.1492)
- valueset "Psych Visit - Family Psychotherapy" (2.16.840.1.113883.3.526.3.1018)
- valueset "Psych Visit - Psychotherapy" (2.16.840.1.113883.3.526.3.1496)
- valueset "Psychoanalysis" (2.16.840.1.113883.3.526.3.1141)
- valueset "Race" (2.16.840.1.114222.4.11.836)
- valueset "Telehealth Services" (2.16.840.1.113883.3.464.1003.101.12.1031)

Data Criteria (QDM Data Elements)

- "Encounter, Performed: Group Psychotherapy" using "Group Psychotherapy (2.16.840.1.113883.3.526.3.1187)"
- "Encounter, Performed: Office Visit" using "Office Visit (2.16.840.1.113883.3.464.1003.101.12.1001)"
- "Encounter, Performed: Outpatient Consultation" using "Outpatient Consultation (2.16.840.1.113883.3.464.1003.101.12.1008)"
- "Encounter, Performed: Psych Visit - Diagnostic Evaluation" using "Psych Visit - Diagnostic Evaluation (2.16.840.1.113883.3.526.3.1492)"
- "Encounter, Performed: Psych Visit - Family Psychotherapy" using "Psych Visit - Family Psychotherapy (2.16.840.1.113883.3.526.3.1018)"
- "Encounter, Performed: Psych Visit - Psychotherapy" using "Psych Visit - Psychotherapy (2.16.840.1.113883.3.526.3.1496)"
- "Encounter, Performed: Psychoanalysis" using "Psychoanalysis (2.16.840.1.113883.3.526.3.1141)"
- "Encounter, Performed: Telehealth Services" using "Telehealth Services (2.16.840.1.113883.3.464.1003.101.12.1031)"
- "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)"
- "Intervention, Performed: Suicide risk assessment (procedure)" using "Suicide risk assessment (procedure) (SNOMEDCT Code 225337009)"
- "Patient Characteristic Birthdate: Birth date" using "Birth date (LOINC Code 21112-8)"

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	None

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

[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>

	Duke Anxiety-Depression Scale (DUKE-AD)®[2]	Total Score ≥30
	Geriatric Depression Scale Short Form (GDS)[1]	Total Score ≥5
	Geriatric Depression Scale Long Form (GDS)	Total Score ≥10
	Edinburgh Postnatal Depression Scale (EPDS)	Total Score ≥10
	My Mood Monitor (M-3)®	Total Score ≥5
	PROMIS Depression	Total Score (T Score) ≥60
	Clinically Useful Depression Outcome Scale (CUDOS)	Total Score ≥31
	[1]Brief screening instrument. All other instruments are full-length. [2]Proprietary; may be cost or licensing requirement associated with use.	
Initial Population	Members 12 years of age and older at the start of the Measurement Period who also meet criteria for Participation.	
Exclusions	• 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.	
Denominator	**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.	
Numerator	**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.	

	• 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.

****NQF-ENDORSED VOLUNTARY CONSENSUS STANDARDS FOR HOSPITAL CARE****

Measure Information Form

Measure Set: Perinatal Care (PC)

Set Measure ID: PC-01

Performance Measure Name: Elective Delivery

Description: Patients with elective vaginal deliveries or elective cesarean births at >= 37 and < 39 weeks of gestation completed

Rationale: For almost 3 decades, the American College of Obstetricians and Gynecologists (ACOG) and the American Academy of Pediatrics (AAP) have had in place a standard requiring 39 completed weeks gestation prior to ELECTIVE delivery, either vaginal or operative (ACOG, 1996). A survey conducted in 2007 of almost 20,000 births in HCA hospitals throughout the U.S. carried out in conjunction with the March of Dimes at the request of ACOG revealed that almost 1/3 of all babies delivered in the United States are electively delivered with 5% of all deliveries in the U.S. delivered in a manner violating ACOG/AAP guidelines. Most of these are for convenience, and result in significant short term neonatal morbidity (neonatal intensive care unit admission rates of 13- 21%) (Clark et al., 2009).

According to Glantz (2005), compared to spontaneous labor, elective inductions result in more cesarean births and longer maternal length of stay. The American Academy of Family Physicians (2000) also notes that elective induction doubles the cesarean delivery rate. Repeat elective cesarean births before 39 weeks gestation also result in higher rates of adverse respiratory outcomes, mechanical ventilation, sepsis and hypoglycemia for the newborns (Tita et al., 2009).

Type Of Measure: Process

Improvement Noted As: Decrease in the rate

Numerator Statement: Patients with elective deliveries

> **Included Populations:** *ICD-10-PCS Principal Procedure Code or ICD-10-PCS Other Procedure Codes* for one or more of the following:
>
> - Medical induction of labor as defined in Appendix A, Table 11.05 while not in *Labor* prior to the procedure
> - Cesarean birth as defined in Appendix A, Table 11.06 and all of the following:
>   - not in *Labor*
>   - no history of a *Prior Uterine Surgery*
>
> **Excluded Populations:** None
>
> **Data Elements:**

- *ICD-10-PCS Other Procedure Codes*
- *ICD-10-PCS Principal Procedure Code*
- *Labor*
- *Prior Uterine Surgery*

Denominator Statement: Patients delivering newborns with >= 37 and < 39 weeks of gestation completed

Included Populations:

- *ICD-10-PCS Principal Procedure Code or ICD-10-PCS Other Procedure Codes* for delivery as defined in Appendix A, Table 11.01.1

- *ICD-10-CM Principal Diagnosis Code or ICD-10-CM Other Diagnosis Codes* for planned cesarean birth in labor as defined in Appendix A, Table 11.06.1

Excluded Populations:

- *ICD-10-CM Principal Diagnosis Code or ICD-10-CM Other Diagnosis Codes* for conditions possibly justifying elective delivery prior to 39 weeks gestation as defined in Appendix A, Table 11.07
- History of prior stillbirth
- Less than 8 years of age
- Greater than or equal to 65 years of age
- Length of stay > 120 days
- *Gestational Age* < 37 or >= 39 weeks or UTD

Data Elements:

- *Admission Date*
- *Birthdate*
- *Discharge Date*
- *Gestational Age*
- *History of Stillbirth*
- *ICD-10-CM Other Diagnosis Codes*
- *ICD-10-CM Principal Diagnosis Code*

Risk Adjustment: No.

Data Collection Approach: Retrospective data sources for required data elements include administrative data and medical records.

Data Accuracy: Variation may exist in the assignment of ICD-10 codes; therefore, coding practices may require evaluation to ensure consistency.

Measure Analysis Suggestions: In order to identify areas for improvement, hospitals may want to review results based on specific ICD-10 codes or patient populations. Data could be analyzed further to determine specific patterns or trends to help reduce elective deliveries.

Sampling: Yes. For additional information see the Sampling Section.

Data Reported As: Aggregate rate generated from count data reported as a proportion.

Selected References:

- American Academy of Family Physicians. (2000). Tips from Other Journals: Elective induction doubles cesarean delivery rate, 61, 4.Retrieved December 29, 2008 at: http://www.aafp.org/afp/20000215/tips/39.html.
- American College of Obstetricians and Gynecologists. (November 1996). ACOG Educational Bulletin.
- Borders, E.B., Birsner, M.L., Gyanmfi-Bannerbaum, C. (2019). Avoidance of nonmedically indicated early-term deliveries and associated neonatal morbidities. American College of Obstetricians and Gynecologists Committee Opinion, 133:2, e156-163.
- Clark, S., Miller, D., Belfort, M., Dildy, G., Frye, D., & Meyers, J. (2009). Neonatal and maternal outcomes associated with elective delivery. [Electronic Version]. *Am J Obstet Gynecol*. 200:156.e1-156.e4.
- Glantz, J. (Apr.2005). Elective induction vs. spontaneous labor associations and outcomes. [Electronic Version]. *J Reprod Med*. 50(4):235-40.
- Tita, A., Landon, M., Spong, C., Lai, Y., Leveno, K., Varner, M, et al. (2009). Timing of elective repeat cesarean delivery at term and neonatal outcomes. [Electronic Version]. *NEJM*. 360:2, 111-120.

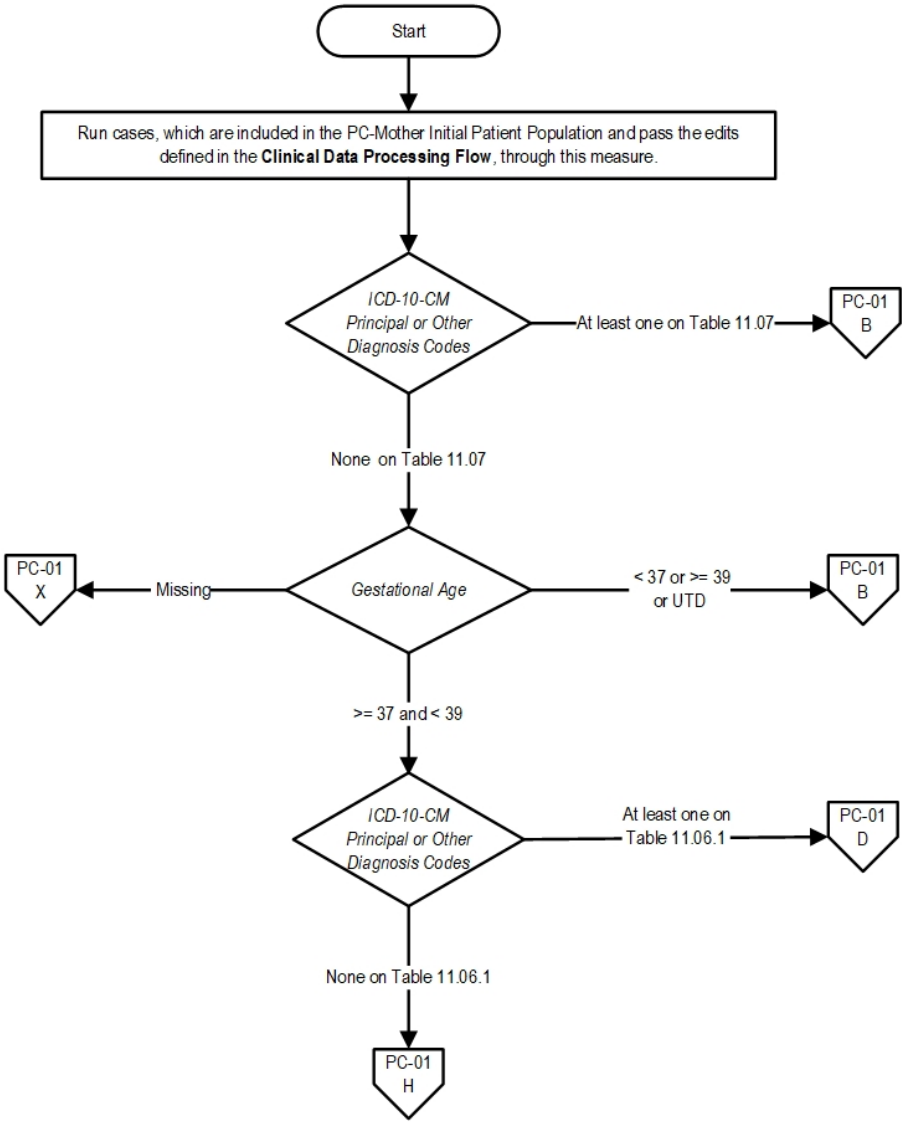
Original Performance Measure Source / Developer:
Hospital Corporation of America-Women's and Children's Clinical Services

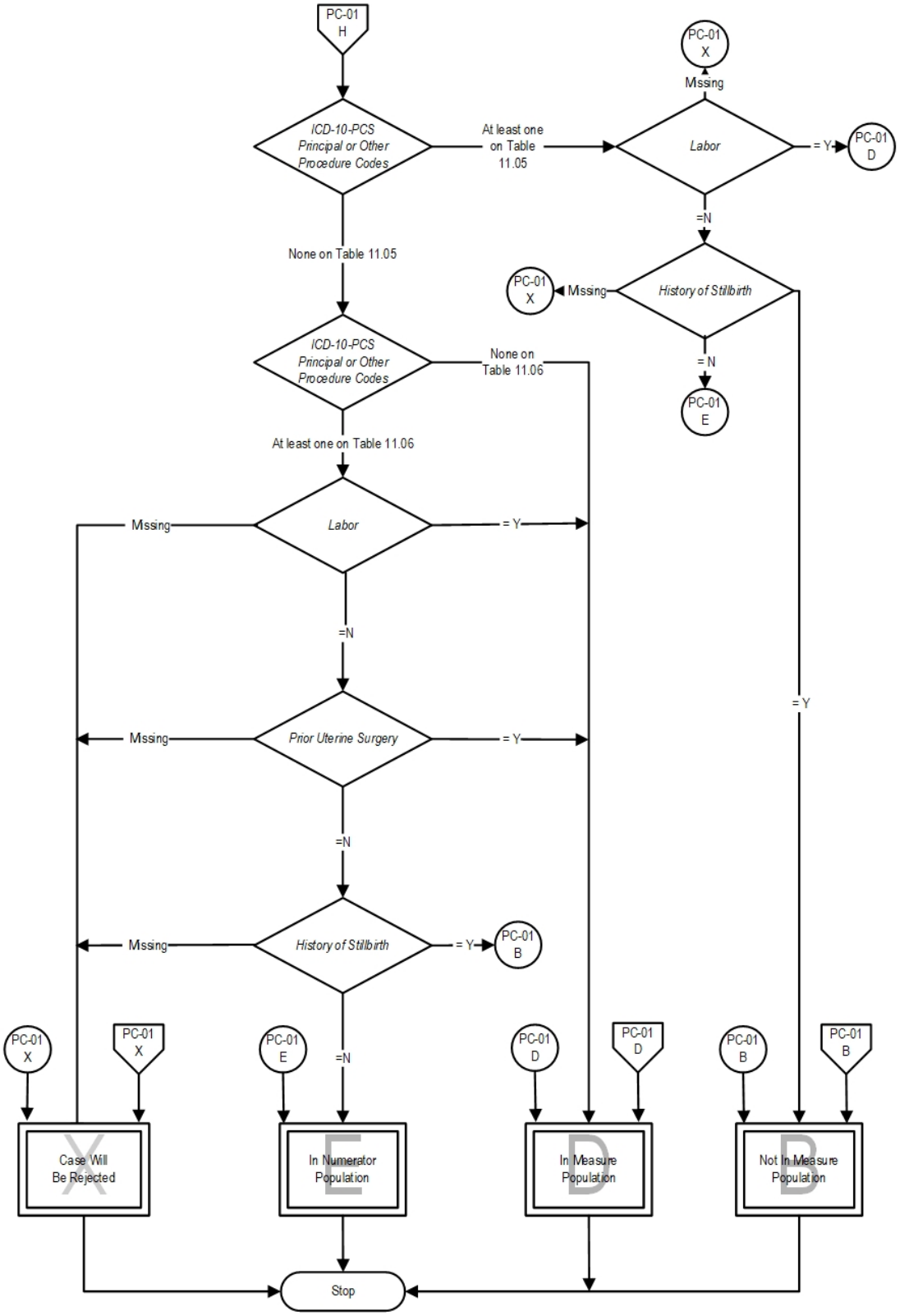
Measure Algorithm:

PC-01: Elective Delivery

Numerator: Patients with elective deliveries

Denominator: Patients delivering newborns with >= 37 and < 39 weeks of gestation completed





****NQF-ENDORSED VOLUNTARY CONSENSUS STANDARDS FOR HOSPITAL CARE****

Measure Information Form

Measure Set: Perinatal Care (PC)

Set Measure ID: PC-05

Performance Measure Name: Exclusive Breast Milk Feeding

Description: Exclusive breast milk feeding during the newborn's entire hospitalization

The measure is reported as an overall rate which includes all newborns that were exclusively fed breast milk during the entire hospitalization.

Rationale: Exclusive breast milk feeding for the first 6 months of neonatal life has long been the expressed goal of World Health Organization (WHO), Department of Health and Human Services (DHHS), American Academy of Pediatrics (AAP) and American College of Obstetricians and Gynecologists (ACOG). ACOG has recently reiterated its position (ACOG, 2007). A recent Cochrane review substantiates the benefits (Kramer et al., 2002). Much evidence has now focused on the prenatal and intrapartum period as critical for the success of exclusive (or any) BF (Centers for Disease Control and Prevention [CDC], 2007; Petrova et al., 2007; Shealy et al., 2005; Taveras et al., 2004). Exclusive breast milk feeding rate during birth hospital stay has been calculated by the California Department of Public Health for the last several years using newborn genetic disease testing data. Healthy People 2010 and the CDC have also been active in promoting this goal.

Type Of Measure: Process

Improvement Noted As: Increase in the rate

Numerator Statement: Newborns that were fed breast milk only since birth

> **Included Populations:** Not applicable
>
> **Excluded Populations:** None
>
> **Data Elements:**
>
> - *Exclusive Breast Milk Feeding*

Denominator Statement: Single term newborns discharged alive from the hospital

> **Included Populations:** Liveborn newborns with *ICD-10-CM Principal Diagnosis Code* for single liveborn newborn as defined in Appendix A, Table 11.20.1
>
> **Excluded Populations:**

- Admitted to the Neonatal Intensive Care Unit (NICU) at this hospital during the hospitalization
- *ICD-10-CM Other Diagnosis Codes* for galactosemia as defined in Appendix A, Table 11.21
- *ICD-10-PCS Principal Procedure Code or ICD-10-PCS Other Procedure Codes* for parenteral nutrition as defined in Appendix A, Table 11.22
- Experienced death
- Length of Stay >120 days
- Patients transferred to another hospital
- Patients who are not term or with < 37 weeks gestation completed

Data Elements:

- *Admission Date*
- *Admission to NICU*
- *Birthdate*
- *Discharge Date*
- *Discharge Disposition*
- *ICD-10-CM Other Diagnosis Codes*
- *ICD-10-CM Principal Diagnosis Code*
- *ICD-10-PCS Other Procedure Codes*
- *ICD-10-PCS Principal Procedure Code*
- *Term Newborn*

Risk Adjustment: No.

Data Collection Approach: Retrospective data sources for required data elements include administrative data and medical records.

Data Accuracy: Variation may exist in the assignment of ICD-10 codes; therefore, coding practices may require evaluation to ensure consistency.

Measure Analysis Suggestions: In order to identify areas for improvement in breast milk feeding rates, hospitals may wish to review documentation for reasons. Education efforts can be targeted based on the specific reasons identified.

Sampling: Yes. For additional information see the Sampling Section.

Data Reported As: Aggregate rate generated from count data reported as a proportion.

Selected References:

- American Academy of Pediatrics. Section on Breastfeeding. Policy Statement. Breastfeeding and the Use of Human Milk. *Pediatrics* 2012 Mar; 129 (3): e827-841.
- American College of Obstetricians and Gynecologists. (Feb. 2007). Committee on Obstetric Practice and Committee on Health Care for Underserved Women.Breastfeeding: Maternal and Infant Aspects. ACOG Committee Opinion 361.

- California Department of Public Health. (2017). Division of Maternal, Child and Adolescent Health, Breastfeeding Initiative, In-Hospital Breastfeeding Initiation Data, Hospital of Occurrence: Available at: https://www.cdph.ca.gov/Programs/CFH/DMCAH/Breastfeeding/Pages/In-Hospital-Breastfeeding-Initiation-Data.aspx
- Centers for Disease Control and Prevention. (Aug 3, 2007). Breastfeeding trends and updated national health objectives for exclusive breastfeeding--United States birth years 2000-2004. *MMWR - Morbidity & Mortality Weekly Report*. 56(30):760-3.
- Centers for Disease Control and Prevention. (2017). Division of Nutrition, Physical Activity and Obesity. Breastfeeding Report Card. Available at: https://www.cdc.gov/breastfeeding/data/reportcard.htm
- Ip, S., Chung, M., Raman, G., et al. (2007). Breastfeeding and maternal and infant health outcomes in developed countries. Rockville, MD: *US Department of Health and Human Services*. Available at: https://archive.ahrq.gov/downloads/pub/evidence/pdf/brfout/brfout.pdf
- Kramer, M.S. & Kakuma, R. (2002).Optimal duration of exclusive breastfeeding. [107 refs] Cochrane Database of Systematic Reviews. (1):CD003517.
- Petrova, A., Hegyi, T., & Mehta, R. (2007). Maternal race/ethnicity and one-month exclusive breastfeeding in association with the in-hospital feeding modality. *Breastfeeding Medicine*. 2(2):92-8.
- Shealy, K.R., Li, R., Benton-Davis, S., & Grummer-Strawn, L.M. (2005).The CDC guide to breastfeeding interventions. Atlanta, GA: US Department of Health and Human Services, CDC. Available at: http://www.cdc.gov/breastfeeding/pdf/breastfeeding_interventions.pdf.
- Taveras, E.M., Li, R., Grummer-Strawn, L., Richardson, M., Marshall, R., Rego, V.H., Miroshnik, I., & Lieu, T.A. (2004). Opinions and practices of clinicians associated with continuation of exclusive breastfeeding. *Pediatrics*. 113(4):e283-90.
- US Department of Health and Human Services. (2007). Healthy People 2010 Midcourse Review. Washington, DC: US Department of Health and Human Services. Available at: https://www.healthypeople.gov/2010/data/midcourse/html/default.htm?visit=1
- World Health Organization. (2007). Indicators for assessing infant and young child feeding practices. Washington, DC, USA: World Health Organization. Available at: http://apps.who.int/iris/bitstream/10665/43895/1/9789241596664_eng.pdf

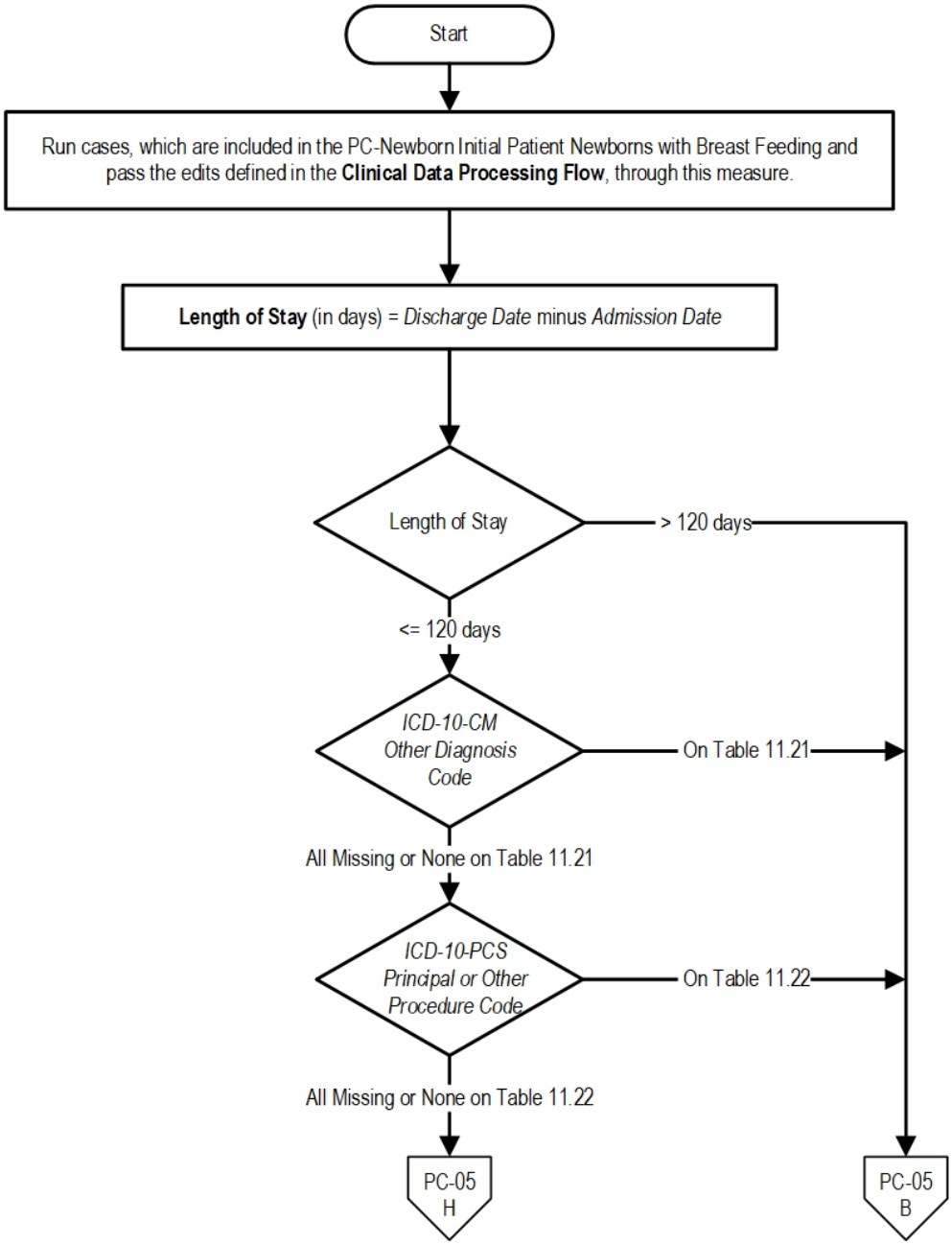
Original Performance Measure Source / Developer:
California Maternal Quality Care Collaborative

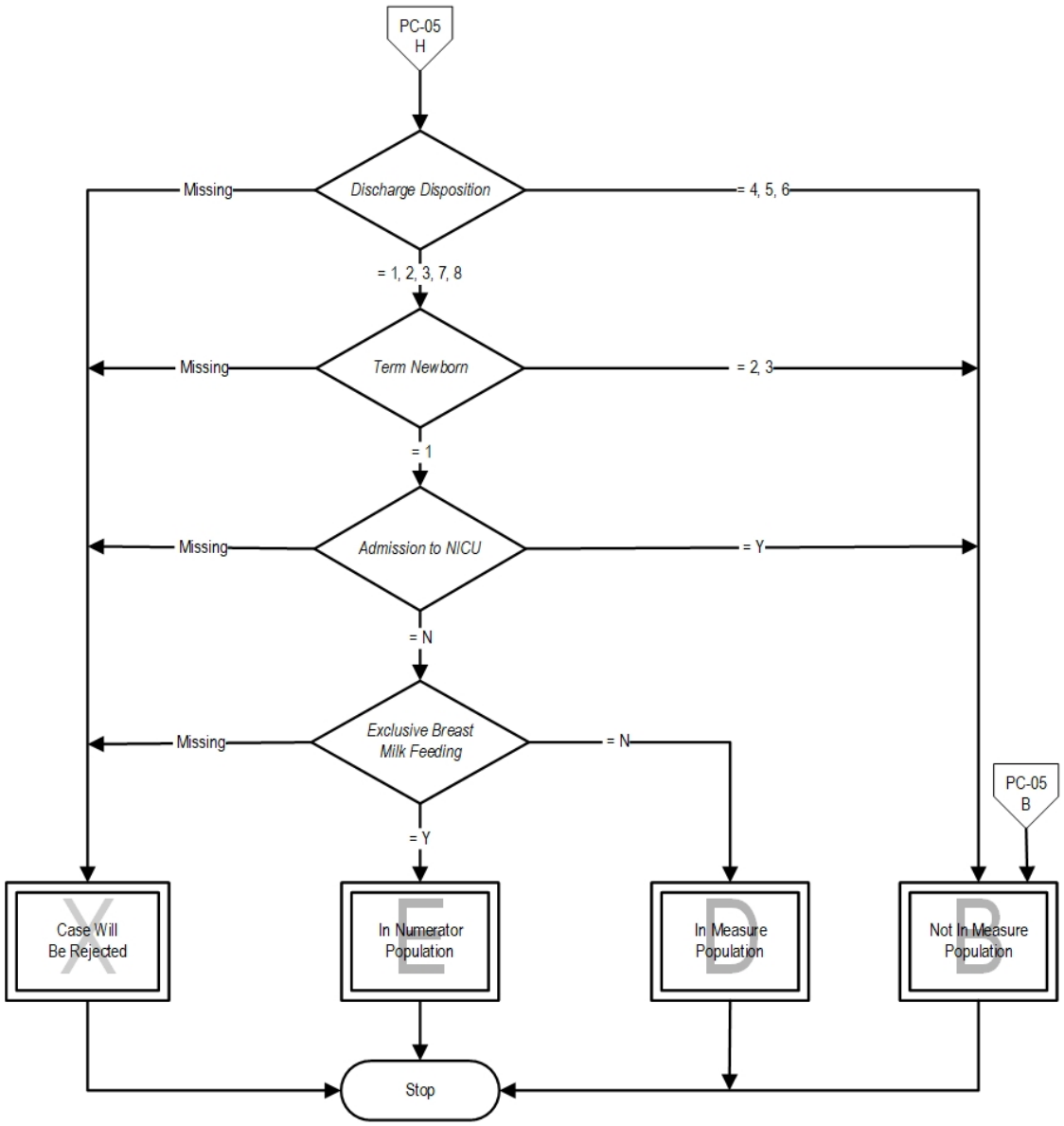
Measure Algorithm:

PC-05: Exclusive Breast Milk Feeding

Numerator: Newborns that were fed breast milk only since birth

Denominator: Single term newborns discharged alive from the hospital





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.

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

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

SUMMARY OF CHANGES TO HEDIS MY 2022

- Revised the measure name from *Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence* to *Follow-Up After Emergency Department Visit for Substance Use.*
- Revised terminology from "alcohol or other drug abuse or dependence (AOD)" to "substance use" or substance use disorder (SUD)."
- Clarified that members in hospice or using hospice services anytime during the measurement year are a required exclusion.
- Added a pharmacy benefit requirement.
- Added ED visits with a diagnosis of unintentional and undetermined drug overdose to the denominator.
- Revised and restructured the numerator logic and value sets.
- Added required exclusions in the Rules for Allowable Adjustments.

Description

The percentage of emergency department (ED) visits among members age 13 years and older with a principal diagnosis of substance use disorder (SUD), or any diagnosis of drug overdose, for which there was follow-up. Two rates are reported:

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

Eligible Population

Product lines	Commercial, Medicaid, Medicare (report each product line separately).
Ages	13 years and older as of the ED visit. Report two age stratifications and a total rate: • 13–17 years. • 18 and older. • Total. The total is the sum of the age stratifications.
Continuous enrollment	The date of the ED visit through 30 days after the ED visit (31 total days).
Allowable gap	None.
Anchor date	None.

Benefit

Medical, chemical dependency and pharmacy.

Note: *Members with detoxification-only chemical dependency benefits do not meet these criteria.*

Event/diagnosis

An ED visit (ED Value Set) with a principal diagnosis of SUD (AOD Abuse and Dependence Value Set) ***or*** any diagnosis of drug overdose (Unintentional Drug Overdose Value Set) on or between January 1 and December 1 of the measurement year, where the member was 13 years or older on the date of the visit.

The denominator for this measure is based on ED visits, not on members. If a member has more than one ED visit, identify all eligible ED visits between January 1 and December 1 of the measurement year and do not include more than one visit per 31-day period, as described below.

Multiple visits in a 31-day period

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

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

ED visits followed by inpatient admission

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

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

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

Required 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

30-Day Follow-Up

A follow-up visit or a pharmacotherapy dispensing event within 30 days after the ED visit (31 total days). Include visits and pharmacotherapy events that occur on the date of the ED visit.

7-Day Follow-Up

A follow-up visit or a pharmacotherapy dispensing event within 7 days after the ED visit (8 total days). Include visits and pharmacotherapy events that occur on the date of the ED visit.

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

- An outpatient visit (Visit Setting Unspecified Value Set) ***with*** (Outpatient POS Value Set) ***with*** any diagnosis of SUD (AOD Abuse and Dependence Value Set), substance use (Substance Induced Disorders Value Set) or drug overdose (Unintentional Drug Overdose Value Set).
- An outpatient visit (Visit Setting Unspecified Value Set) ***with*** (Outpatient POS Value Set) ***with*** a mental health provider.
- An outpatient visit (BH Outpatient Value Set) ***with*** any diagnosis of SUD (AOD Abuse and Dependence Value Set), substance use (Substance Induced Disorders Value Set) or drug overdose (Unintentional Drug Overdose Value Set).
- An outpatient visit (BH Outpatient Value Set) ***with*** a mental health provider.
- An intensive outpatient encounter or partial hospitalization (Visit Setting Unspecified Value Set) ***with*** (Partial Hospitalization POS Value Set) ***with*** any diagnosis of SUD (AOD Abuse and Dependence Value Set), substance use (Substance Induced Disorders Value Set) or drug overdose (Unintentional Drug Overdose Value Set).
- An intensive outpatient encounter or partial hospitalization (Visit Setting Unspecified Value Set) ***with*** (Partial Hospitalization POS Value Set) ***with*** a mental health provider.
- An intensive outpatient encounter or partial hospitalization (Partial Hospitalization or Intensive Outpatient Value Set) ***with*** any diagnosis of SUD (AOD Abuse and Dependence Value Set), substance use (Substance Induced Disorders Value Set) or drug overdose (Unintentional Drug Overdose Value Set).
- An intensive outpatient encounter or partial hospitalization (Partial Hospitalization or Intensive Outpatient Value Set) ***with*** a mental health provider.
- A non-residential substance abuse treatment facility visit (Visit Setting Unspecified Value Set) ***with*** (Non-residential Substance Abuse Treatment Facility POS Value Set) ***with*** any diagnosis of SUD (AOD Abuse and Dependence Value Set), substance use (Substance Induced Disorders Value Set) or drug overdose (Unintentional Drug Overdose Value Set).
- A non-residential substance abuse treatment facility visit (Visit Setting Unspecified Value Set) ***with*** (Non-residential Substance Abuse Treatment Facility POS Value Set) ***with*** a mental health provider.
- A community mental health center visit (Visit Setting Unspecified Value Set) ***with*** (Community Mental Health Center POS Value Set) ***with*** any diagnosis of SUD (AOD Abuse and Dependence Value Set), substance use (Substance Induced Disorders Value Set) or drug overdose (Unintentional Drug Overdose Value Set).
- A community mental health center visit (Visit Setting Unspecified Value Set) ***with*** (Community Mental Health Center POS Value Set) ***with*** a mental health provider.
- An observation visit (Observation Value Set) ***with*** any diagnosis of SUD (AOD Abuse and Dependence Value Set), substance use (Substance Induced Disorders Value Set) or drug overdose (Unintentional Drug Overdose Value Set).

- An observation visit (Observation Value Set) ***with*** a mental health provider.
- A peer support service (Peer Support Services Value Set) ***with*** any diagnosis of SUD (AOD Abuse and Dependence Value Set), substance use (Substance Induced Disorders Value Set) or drug overdose (Unintentional Drug Overdose Value Set).
- An opioid treatment service that bills monthly or weekly (OUD Weekly Non Drug Service Value Set; OUD Monthly Office Based Treatment Value Set) ***with*** any diagnosis of SUD (AOD Abuse and Dependence Value Set), substance use (Substance Induced Disorders Value Set) or drug overdose (Unintentional Drug Overdose Value Set).
- A telehealth visit (Visit Setting Unspecified Value Set) ***with*** (Telehealth POS Value Set) ***with*** any diagnosis of SUD (AOD Abuse and Dependence Value Set), substance use (Substance Induced Disorders Value Set) or drug overdose (Unintentional Drug Overdose Value Set).
- A telehealth visit (Visit Setting Unspecified Value Set) ***with*** (Telehealth POS Value Set) ***with*** a mental health provider.
- A telephone visit (Telephone Visits Value Set), ***with*** any diagnosis of SUD (AOD Abuse and Dependence Value Set), substance use (Substance Induced Disorders Value Set) or drug overdose (Unintentional Drug Overdose Value Set).
- A telephone visit (Telephone Visits Value Set), ***with*** a mental health provider.
- An e-visit or virtual check-in (Online Assessments Value Set), ***with*** any diagnosis of SUD (AOD Abuse and Dependence Value Set), substance use (Substance Induced Disorders Value Set) or drug overdose (Unintentional Drug Overdose Value Set).
- An e-visit or virtual check-in (Online Assessments Value Set), ***with*** a mental health provider.
- A substance use disorder service (Substance Use Disorder Services Value Set).
- A behavioral health screening or assessment for SUD or mental health disorders (Behavioral Health Assessment Value Set).
- A substance use service (Substance Use Services Value Set).
- A pharmacotherapy dispensing event (Alcohol Use Disorder Treatment Medications List; Opioid Use Disorder Treatment Medications List) or medication treatment event (AOD Medication Treatment Value Set; OUD Weekly Drug Treatment Service Value Set).

Note

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

Data Elements for Reporting

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

Table FUA-1/2/3: Data Elements for Follow-Up After Emergency Department Visit for Substance Use

Metric	Age	Data Element	Reporting Instructions
FollowUp30Day	13-17	Benefit	Metadata
FollowUp7Day	18+	EligiblePopulation	For each Stratification, repeat per Metric
	Total	ExclusionAdminRequired	For each Stratification, repeat per Metric
		NumeratorByAdmin	For each Metric and Stratification
		NumeratorBySupplemental	For each Metric and Stratification
		Rate	(Percent)

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 Follow-Up After Emergency Department Visit for Substance Use

NONCLINICAL COMPONENTS		
Eligible Population	**Adjustments Allowed (Yes/No)**	**Notes**
Product Lines	Yes	Organizations are not required to use product line criteria; product lines may be combined and all (or no) product line criteria may be used.
Ages	Yes	The age determination date(s) may be changed (i.e., age 13 as of ED visit). Changing denominator age range is allowed.
Continuous enrollment, Allowable gap, Anchor Date	Yes	Organizations are not required to use enrollment criteria; adjustments are allowed.
Benefits	Yes	Organizations are not required to use a benefit; adjustments are allowed.
Other	Yes	Organizations may use additional eligible population criteria to focus on 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 and diagnoses that contain (or map to) codes in the value sets may be used to identify visits with a diagnosis. Value sets and logic may not be changed. ***Note:*** *Organizations may assess at the member level by applying measure logic appropriately (i.e., percentage of members with documentation of an emergency department visit with a principal diagnosis of SUD or any diagnosis of unintentional drug overdose, who had a follow-up visit).*
Denominator Exclusions	**Adjustments Allowed (Yes/No)**	**Notes**
Required Exclusions	Yes	The hospice exclusion is not required. Refer to *Exclusions* in the *Guidelines for the Rules for Allowable Adjustments*.
Numerator Criteria	**Adjustments Allowed (Yes/No)**	**Notes**
• 30-Day Follow-Up • 7-Day Follow-Up	No	Value sets and logic may not be changed.

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

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

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

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

Eligible Population

Product lines	Commercial, Medicaid, Medicare (report each product line separately).
Ages	6 years and older as of the date of the ED visit. Report three age stratifications and total rate: • 6–17 years. • 18–64 years. • 65 years and older. • Total. The total is the sum of the age stratifications.
Continuous enrollment	Date of the ED visit through 30 days after the ED visit (31 total days).
Allowable gap	None.
Anchor date	None.
Benefit	Medical and mental health.
Event/diagnosis	An ED visit (ED Value Set) with a principal diagnosis of mental illness or intentional self-harm (Mental Illness Value Set; Intentional Self-Harm Value Set) on or between January 1 and December 1 of the measurement year where the member was 6 years or older on the date of the visit. The denominator for this measure is based on ED visits, not on members. If a member has more than one ED visit, identify all eligible ED visits between January 1 and December 1 of the measurement year and do not include more than one visit per 31-day period as described below.

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

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

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

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

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

Required 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

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

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

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

- An outpatient visit (Visit Setting Unspecified Value Set ***with*** Outpatient POS Value Set) ***with*** a principal diagnosis of a mental health disorder (Mental Health Diagnosis Value Set).
- An outpatient visit (BH Outpatient Value Set) ***with*** a principal diagnosis of a mental health disorder (Mental Health Diagnosis Value Set).
- An intensive outpatient encounter or partial hospitalization (Visit Setting Unspecified Value Set ***with*** Partial Hospitalization POS Value Set), ***with*** a principal diagnosis of a mental health disorder (Mental Health Diagnosis Value Set).

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

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

Note

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

Data Elements for Reporting

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

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

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

Rules for Allowable Adjustments of HEDIS

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 Follow-Up After Emergency Department Visit for Mental Illness

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

Follow-Up After Hospitalization for Mental Illness (FUH)

SUMMARY OF CHANGES TO HEDIS MY 2022

- Updated the steps for identifying acute readmission or direct transfer in the event/diagnosis.
- Clarified that members in hospice or using hospice services anytime during the measurement year are a required exclusion.
- Added psychiatric collaborative care management to the numerator.
- Added required exclusions to the Rules for Allowable Adjustments.

Description

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

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

Eligible Population

Product lines	Commercial, Medicaid, Medicare (report each product line separately).
Ages	6 years and older as of the date of discharge. Report three age stratifications and total rate: • 6–17 years. • 18–64 years. • 65 years and older. • Total.
Continuous enrollment	The total is the sum of the age stratifications. Date of discharge through 30 days after discharge.
Allowable gap	None.
Anchor date	None.
Benefits	Medical and mental health (inpatient and outpatient).
Event/diagnosis	An acute inpatient discharge with a principal diagnosis of mental illness or intentional self-harm (Mental Illness Value Set; Intentional Self-Harm Value Set) on the discharge claim on or between January 1 and December 1 of the measurement year. To identify acute inpatient discharges: 1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set). 2. Exclude nonacute inpatient stays (Nonacute Inpatient Stay Value Set). 3. Identify the discharge date for the stay. The denominator for this measure is based on discharges, not on members. If members have more than one discharge, include all discharges on or between January 1 and December 1 of the measurement year.

Acute readmission or direct transfer

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

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

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

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

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

Nonacute readmission or direct transfer

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

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

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

Required 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

30-Day Follow-Up

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

7-Day Follow-Up

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

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

- An outpatient visit (Visit Setting Unspecified Value Set) ***with*** (Outpatient POS Value Set) ***with*** a mental health provider.
- An outpatient visit (BH Outpatient Value Set) ***with*** a mental health provider.
- An intensive outpatient encounter or partial hospitalization (Visit Setting Unspecified Value Set) ***with*** (Partial Hospitalization POS Value Set).

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

Note

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

Data Elements for Reporting

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

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

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

Rules for Allowable Adjustments of HEDIS

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 Follow-Up After Hospitalization for Mental Illness

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

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

Properties

Description

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

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

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

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

Numerator

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

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

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

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

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

Denominator

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

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

Admission includes at least one overnight stay in the hospital

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

Non-psychiatric MS-DRG/principal diagnosis at discharge

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

Alive at the time of discharge

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

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

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

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

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

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

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

Patients who are excluded because of state regulations

Patients discharged to nursing homes and skilled nursing facilities

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

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

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

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

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

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

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

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

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

03 Skilled nursing facility

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

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Developer/Steward

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

Characteristics

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

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Groups

Core Measure Set	Not Available

Measure Group	**Group Identifier**
HCAHPS	

Measure Links

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

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

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Measure Program Links

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

Milestones

Milestone: Implemented

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

Milestone: Finalized

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

Milestone: Proposed

Effective Date	2013-05-10
Comments	Not Available

Milestone: Reference

Effective Date	1900-01-01
Comments	Not Available

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

Measure Program: Hospital Inpatient Quality Reporting

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

Measure Program Links

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

Milestones

Milestone: Implemented

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

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

Milestone: Finalized

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

Measure Program: Hospital Value-Based Purchasing

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

Measure Program Links

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

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Programs/HVBP/Hospital-Value-Based-Purchasing

Milestones

Milestone: Implemented

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

Milestone: Finalized

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

Measure Program: Hospital Compare

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

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Measure Program Links

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

Milestones

Milestone: Implemented

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

Milestone: Finalized

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

Milestone: Proposed

Effective Date	2013-05-10
Comments	Not Available

Milestone: Reference

Effective Date	1900-01-01
Comments	Not Available

Hospital Consumer Assessment of Healthcare Providers and Systems

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

Hospital-Wide, 30-day All-Cause Unplanned Readmission (HWR) Rate for MIPS Eligible Clinician

NQF Endorsement Status	Not Endorsed
NQF ID	9999
Measure Type	Outcome
Measure Content Last Updated	2021-02-01
Info As Of	Not Available

Properties

Description	This measure is a re-specified version of the measure, “Risk-adjusted readmission rate (RARR) of unplanned readmission within 30 days of hospital discharge for any condition” (NQF 1789), which was developed for patients 65 years and older using Medicare claims. This re-specified measure attributes outcomes to MIPS participating clinician groups and assesses each group’s readmission rate. The measure comprises a single summary score, derived from the results of five models, one for each of the following specialty cohorts (groups of discharge condition categories or procedure categories): medicine, surgery/gynecology, cardio-respiratory, cardiovascular, and neurology.
Numerator	The outcome for this measure is unplanned all-cause 30-day readmission. Readmission is defined as a subsequent inpatient admission to any acute care facility which occurs within 30 days of the discharge date of an eligible index admission. Any readmission is eligible to be counted as an outcome, except those that are considered planned. To align with data years used, the planned readmission algorithm version 4.0 was used to classify readmissions as planned or unplanned
Denominator	Patients eligible for inclusion in the measure have an index admission hospitalization to which the readmission outcome is attributed and includes admissions for patients: Enrolled in Medicare Fee-For-Service (FFS) Part A for the 12 months prior to the date of admission; Aged 65 or over; Discharged alive from a non-federal short-

Hospital-Wide, 30-day All-Cause Unplanned Readmission (HWR) Rate for MIPS Eligible Clinician

	term acute care hospital; and, Not transferred to another acute care facility.
Denominator Exclusions	1. Patients discharged against medical advice (AMA) are excluded. 2. Admissions for patients to a PPS-exempt cancer hospital are excluded. 3. Admissions primarily for medical treatment of cancer are excluded. 4. Admissions primarily for psychiatric disease are excluded. 5. Admissions for “rehabilitation care; fitting of prostheses and adjustment devices” (CCS 254) are excluded. 6. Admissions where patient cannot be attributed to a clinician group.
Rationale	This risk-adjusted administrative claims measure was proposed to address unplanned readmissions at the physician group level of Medicare aged > 65 patients. This measure is a re-specified version of the hospital-level measure, “Hospital-Wide All-Cause, Unplanned Readmission Measure” (NQF #1789), which has been in the MIPS program since 2017. In the event we did not finalize this measure, we would have maintained the current measure Q458: All-Cause Hospital Readmission. The respecification of this measure promotes a systems-level approach by clinicians and focus on high-risk conditions, such as COPD and heart failure. The measure was evaluated by the MAP and was conditionally supported pending NQF endorsement. While we agreed with the MAP that NQF endorsement of measures is preferred, NQF endorsement is not a requirement for measures to be considered for MIPS if the measure has an evidence-based focus as required in section 1848(q)(2)(D)(v) of the Act. A riskadjusted readmission rate of 15.3 percent at the physician group level was provided by the measure developer. The readmission rate indicates a substantial need to reduce the expected rate and variation of rates across eligible physician groups. Physician groups have the capability to influence unplanned readmission outcomes by appropriate medication reconciliation at discharge, reduction of infection risk, and ensuring proper outpatient follow-up. As an administrative claims measure, there is no separate reporting burden. To maintain continuity with the existing measure Q458: All-

Hospital-Wide, 30-day All-Cause Unplanned Readmission (HWR) Rate for MIPS Eligible Clinician

	Cause Hospital Readmission, the case minimum will remain at 200 cases for consistency in implementation. For 2023 payment determination, the performance period will include administrative claims from January 1, 2021 to December 31, 2021. For further information regarding the implementation of this measure, please see section IV.A.3.c.(1)(e)(i) of this final rule.
Evidence	Not Available

Developer/Steward

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

Characteristics

Measure Type	Outcome
Meaningful Measure Area	Admissions and Readmissions to Hospitals
Healthcare Priority	Promote Effective Communication & Coordination of Care
eCQM Spec Available	No
NQF Endorsement Status	Not Endorsed
NQF ID	9999
Last NQF Update	Not Available
Target Population Age	65+
Target Population Age (High)	Not Available

Hospital-Wide, 30-day All-Cause Unplanned Readmission (HWR) Rate for MIPS Eligible Clinician

Target Population Age (Low)	65
Reporting Level	Accountable Care Organization
Conditions	Not Available
Subconditions	Not Available
Care Settings	Hospital/Acute Care Facility

Groups

Core Measure Set	Not Available

Measure Group	Group Identifier
qpp quality id	479
ACO	8

Measure Links

Measure Program: Medicare Shared Savings Program

Info As Of	Not Available
Program / Model Notes	
Data Sources	Claims Data
Purposes	Not Available
Quality Domain	Communication and Care Coordination
Reporting Frequency	Not Available

Hospital-Wide, 30-day All-Cause Unplanned Readmission (HWR) Rate for MIPS Eligible Clinician

Impacts Payment	No
Reporting Status	Active
Data Reporting Begin Date	2021-01-01
Data Reporting End Date	Not Available

Measure Program Links

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/about

Milestones

Milestone: Implemented

Effective Date	2012-04-01
Comments	Not Available
Milestone Links	https://www.govinfo.gov/content/pkg/FR-2011-11-02/pdf/2011-27461.pdf

Milestone: Finalized

Effective Date	2011-11-02
Comments	Not Available
Milestone Links	https://www.govinfo.gov/content/pkg/FR-2011-11-02/pdf/2011-27461.pdf

*Immunizations for Adolescents (IMA)**

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

SUMMARY OF CHANGES TO HEDIS MY 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.

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.

*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

Plan All-Cause Readmissions (PCR)

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 Rules for Allowable Adjustments of HEDIS.

Description

For members 18 years of age and older, the number of acute inpatient and observation stays during the measurement year that were followed by an unplanned acute readmission for any diagnosis within 30 days and the predicted probability of an acute readmission.

Note: *For commercial and Medicaid, report only members 18–64 years of age.*

Definitions

IHS	Index hospital stay. An acute inpatient or observation stay with a discharge on or between January 1 and December 1 of the measurement year, as identified in the denominator.
Index Admission Date	The IHS admission date.
Index Discharge Date	The IHS discharge date. The index discharge date must occur on or between January 1 and December 1 of the measurement year.
Index Readmission Stay	An acute inpatient or observation stay for any diagnosis with an admission date within 30 days of a previous Index Discharge Date.
Index Readmission Date	The admission date associated with the Index Readmission Stay.
Planned hospital stay	A hospital stay is considered planned if it meets criteria as described in step 3 (required exclusions) of the numerator.
Plan population	Members in the eligible population prior to exclusion of outliers (denominator steps 1–5). The plan population is only used as a denominator for the Outlier Rate. Members must be 18 and older as of the earliest Index Discharge Date. The plan population is based on members, not discharges. Count members only once in the plan population. Assign members to the product/product line in which they are enrolled at the start of the continuous enrollment period of their earliest Index Hospital Stay. If the member has a gap at the beginning of this continuous enrollment period, assign the member to the product/product line in which they were enrolled as of their first enrollment segment during this continuous enrollment period.

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

Eligible Population

Refer to General Guideline 10: Reporting for small denominator limits.

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

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

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

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

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

Administrative Specification

Denominator The eligible population.

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

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

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

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

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

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

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

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

Step 4 Exclude hospital stays for the following reasons:

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

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

Step 5 Calculate continuous enrollment.

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

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

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

Risk Adjustment Determination

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

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

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

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

Exclude diagnoses that cannot be mapped to Table CC_Mapping.

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

Risk Adjustment Weighting

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

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

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

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

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

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

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

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

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

OR

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

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

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

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

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

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

Example: If the Estimated Readmission Risk is 0.1518450741 for an IHS, then the variance for this IHS is 0.1518450741 x 0.8481549259 = 0.1287881476.

Note: *When calculating variance at the IHS level, do not round. Organizations must sum the variances for each stratification and age when populating the Variance cells in the reporting tables. When reporting, round the variance to 4 decimal places using the .5 rule.*

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

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

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

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

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

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

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

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

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

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

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

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

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

Reporting: Number of Members in Plan Population

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

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

Reporting: Number of Outliers

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

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

Calculated: Outlier Rate

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

Reporting: Denominator

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

Reporting: SES Stratification (Medicare only)

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

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

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

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

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

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

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

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

Reporting: Numerator

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

Calculated: Observed Readmission Rate

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

Reporting: Count of Expected 30-Day Readmissions

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

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

Calculated: Expected Readmission Rate

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

Reporting: Variance

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

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

Calculated: O/E Ratio

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

Note

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

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

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

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

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

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

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

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

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

Rules for Allowable Adjustments of HEDIS

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.

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

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

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

Rules for Allowable Adjustments of HEDIS

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.

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

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

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

Prenatal and Postpartum Care (PPC)

SUMMARY OF CHANGES TO HEDIS MY 2022

- Added instructions to report rates stratified by race and ethnicity for each product line.
- Removed the definition of *last enrollment segment* and clarified continuous enrollment requirements for steps 1 and 2 of the Timeliness of Prenatal Care numerator.
- Clarified that members in hospice or using hospice services anytime during the measurement year are a required exclusion.
- Clarified that services provided during a telephone visit, e-visit or virtual check-in may be used for Administrative and Hybrid collection methods.
- Added required exclusions to the Rules for Allowable Adjustments.
- Added new data elements tables for race and ethnicity stratification reporting.

Description

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

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

Definitions

First trimester 280–176 days prior to delivery (or EDD).

Eligible Population

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

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

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

Age None specified.

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

Allowable gap None.

Anchor date Date of delivery.

Benefit Medical.

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

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

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

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

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

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

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

Required 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

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

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

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

Step 2 Identify women who were not continuously enrolled (with no gaps) from at least 219 days before delivery (or EDD) through 60 days after delivery.

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

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

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

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

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

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

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

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

Hybrid Specification

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

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

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

Numerator

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

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

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

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

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

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

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

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

- Pelvic exam.

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

Note

- *Criteria for identifying prenatal care for women who were not enrolled during the first trimester allow more flexibility than criteria for women who were enrolled.*
  - *For women who were enrolled at least 219 days before delivery, the organization has sufficient opportunity to provide prenatal care by the end of the first trimester.*
  - *For women who were not enrolled at least 219 days before delivery, the organization has sufficient opportunity to provide prenatal care within 42 days after enrollment.*
- *Services that occur over multiple visits count toward this measure if all services are within the time frame established in the measure. Ultrasound and lab results alone are not considered a visit; they must be combined with an office visit with an appropriate practitioner in order to count for this measure.*
- *For each member, the organization must use one date (date of delivery or EDD) to define the start and end of the first trimester. If multiple EDDs are documented, the organization must define a method to determine which EDD to use, and use that date consistently. If the organization elects to use EDD, and the EDD is not on or between October 8 of the year prior to the measurement year and October 7 of the measurement year, the member is excluded as a valid data error and replaced by the next member of the oversample. The LMP may not be used to determine the first trimester.*
- *The organization may use EDD to identify the first trimester for the Timeliness of Prenatal Care rate and use the date of delivery for the Postpartum Care rate.*
- *A Pap test does not count as a prenatal care visit for the administrative and hybrid specification of the Timeliness of Prenatal Care rate, but is acceptable for the Postpartum Care rate as evidence of a pelvic exam. A colposcopy alone is not numerator compliant for either rate.*
- *The intent is that a prenatal visit is with a PCP or OB/GYN or other prenatal care practitioner. Ancillary services (lab, ultrasound) may be delivered by an ancillary provider. Nonancillary services (e.g., fetal heart tone, prenatal risk assessment) must be delivered by the required provider type.*
- *The intent is to assess whether prenatal and preventive care was rendered on a routine, outpatient basis rather than assessing treatment for emergent events.*
- *Refer to Appendix 3 for the definition of* PCP *and* OB/GYN and other prenatal care practitioner.

- *For both rates and for both Administrative and Hybrid data collection methods, services provided during a telephone visit, e-visit or virtual check-in are eligible for use in reporting.*

Data Elements for Reporting

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

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

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

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

Metric
TimelinessPrenatalCare
PostpartumCare

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

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

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

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

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

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 Prenatal and Postpartum Care

NONCLINICAL COMPONENTS		
Eligible Population	**Adjustments Allowed (Yes/No)**	**Notes**
Product Lines	Yes	Organizations are not required to use product line criteria; product lines may be combined and all (or no) product line criteria may be used.
Ages	NA	There are no ages specified in this measure.
Continuous enrollment, Allowable gap, Anchor Date	Yes	Organizations are not required to use enrollment criteria; adjustments are allowed.
Benefits	Yes	Organizations are not required to use a benefit; adjustments are allowed.
Other	Yes	Organizations may use additional eligible population criteria to focus on 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 value sets may be used to identify visits. The value sets and logic may not be changed. Organizations may not change the logic but may change the delivery date and account for the impact on other date-dependent events. ***Note:*** *Organizations may assess at the member level (vs. discharge level) by applying measure logic appropriately (i.e., percentage of members with deliveries).*
Denominator Exclusions	**Adjustments Allowed (Yes/No)**	**Notes**
Required Exclusions	Yes	The hospice exclusion is not required. Refer to *Exclusions* in the *Guidelines for the Rules for Allowable Adjustments*.
Numerator Criteria	**Adjustments Allowed (Yes/No)**	**Notes**
• Timeliness of Prenatal Care • Postpartum Care	No	Value sets and logic may not be changed. If the delivery-date range is changed, all numerator events must be measured in relation to the new range.

SDOH Screening Measure Specifications

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

Measure #3: Timely Transmission of Transition Record

(Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)

(facility-level measure; included in bundled measure set: Measures 1, 2, & 3)

Care Transitions

Measure Description

Percentage of patients, regardless of age, discharged from an inpatient facility (eg, hospital inpatient or observation, skilled nursing facility, or rehabilitation facility) to home or any other site of care for whom a transition record was transmitted to the facility or primary physician or other health care professional designated for follow-up care within 24 hours of discharge

Measure Components

Numerator Statement ➢ **See "Additional Information" for clarification on the bundling of measures 1, 2, & 3**	Patients for whom a transition record[a] was transmitted[b] to the facility or primary physician or other health care professional designated for follow-up care[c] within 24 hours of discharge Numerator Element Definitions: a. Transition record: a core, standardized set of data elements related to patient's diagnosis, treatment, and care plan that is discussed with and provided to patient in printed or electronic format at each transition of care, and transmitted to the facility/physician/other health care professional providing follow-up care. Electronic format may be provided only if acceptable to patient. b. Transmitted: transition record may be transmitted to the facility or physician or other health care professional designated for follow-up care via fax, secure e-mail, or mutual access to an electronic health record (EHR) *c.* Primary physician or other health care professional designated for follow-up care: may be designated primary care physician (PCP), medical specialist, or other physician or health care professional
Denominator Statement	All patients, regardless of age, discharged from an inpatient facility (eg, hospital inpatient or observation, skilled nursing facility, or rehabilitation facility) to home/self care or any other site of care
Denominator Exclusions	Patients who died Patients who left against medical advice (AMA) or discontinued care
Supporting Guideline & Other References	The following evidence statements are quoted verbatim from the referenced clinical guidelines. **Coordinating Clinicians** Communication and information exchange between the Medical Home and the receiving provider should occur in an amount of time that will allow the receiving provider to effectively treat the patient. This communication should ideally occur whenever patients are at a transition of care; eg, at discharge from the inpatient setting. The timeliness of this communication should be consistent with the patient's clinical presentation and, in the case of a patient being discharged, the urgency of the follow-up required. Communication and information exchange between the MH and the physician may be in the form of a call, voicemail, fax, or other secure, private, and accessible means, including mutual access to an EHR. (TOCCC, 2008)[21] **Standard PC.02.02.01** The [organization] coordinates the [patient]'s care, treatment, and services based on the [patient]'s needs.

1. The hospital has a process to receive or share patient information when the patient is referred to other internal or external providers of care, treatment, and services. (See also PC.04.02.01, EP 1) (The Joint Commission, 2009)[23]

Standard PC.04.02.01
When a [patient] is discharged or transferred, the [organization] gives information about the care, treatment, and services provided to the [patient] to other service providers who will provide the [patient] with care, treatment, or services.

1. At the time of the patient's discharge or transfer, the hospital informs other service providers who will provide care, treatment, or services to the patient about the following:
   - The reason for the patient's discharge or transfer
   - The patient's physical and psychosocial status
   - A summary of care, treatment, and services it provided to the patient
   - The patient's progress toward goals
   - A list of community resources or referrals made or provided to the patient
   (See also PC.02.02.01, EP 1) (Joint Commission, 2009)

Safe Practice #8: Communication of Critical Information
Ensure that care information is transmitted and appropriately documented in a timely manner and in a clearly understandable form to patients and to all of the patient's healthcare providers/professionals, within and between care settings, who need that information to provide continued care. (National Quality Forum Safe Practices, 2006)[26]

Safe Practice #11: Discharge Systems
A "discharge plan" must be prepared for each patient at the time of hospital discharge, and a concise discharge summary must be prepared for and relayed to the clinical caregiver accepting responsibility for postdischarge care in a timely manner.

Organizations must ensure that there is confirmation of the receipt of the discharge information by the independent licensed practitioner who will assume the responsibility for care after discharge.

- A discharge summary must be provided to the clinical provider who accepts the patient's care after hospital discharge. At a minimum, the discharge summary should include the following:
  - the reason for hospitalization;
  - significant findings;
  - procedures performed and care, treatment, and services provided to the patient
  - the patient's condition at discharge
  - information provided to the patient and family
  - a comprehensive and reconciled medication list; and
  - a list of acute medical issues and tests and studies for which confirmed results were unavailable at the time of discharge that require follow-up

The organization should ensure and document the receipt of the discharge information by caregivers who assume responsibility for postdischarge care. This confirmation may occur via telephone, fax, e-mail response, or other electronic response using health information technologies. (National Quality Forum Safe Practices, 2006)[26]

Measure Importance

Relationship to	The availability of the patient's discharge information at the first post-discharge physician visit

desired outcome	improves the continuity of care and may be associated with a decreased risk of rehospitalization.[18]
Opportunity for Improvement	A recent literature summary found that direct communication between hospital physicians and primary care physicians occurred infrequently (in 3-20% of cases studied) and that the availability of a discharge summary at the first post-discharge visit was low (12-34%) and did not improve greatly even after 4 weeks (51-77%), affecting the quality of care in approximately 25% of follow-up visits.[17]
IOM Domains of Health Care Quality Addressed[25]	• Safe • Patient-centered • Timely • Efficient • Equitable
Exclusion Justification	Exclusions arise when patients who are included in the initial patient or eligible population for a measure do not meet the denominator criteria specific to the intervention required by the numerator. Exclusions are absolute and apply to all patients and therefore are not part of clinical judgment within a measure. Patients who expired and patients who left against medical advice (AMA) are categorized by inpatient facilities as having been "discharged" (with specific discharge status codes) and must therefore be excluded from the denominators for these measures. The Care Transitions Work Group acknowledges that it may be feasible to provide patients who leave AMA with a medication list and transition record (and to transmit this information to the facility/physician providing follow-up care), but not necessarily with the level of detail specified in these measures.
Harmonization with Existing Measures	Harmonization with existing measures was not applicable to this measure.

Measure Designation

Measure purpose	• Quality Improvement • Accountability
Type of measure	• Process
Level of Measurement	• Facility
Care setting	• Discharge from an inpatient facility (eg, hospital inpatient or observation, skilled nursing facility, or rehabilitation facility)
Data source	• Administrative data • Medical record • Electronic health record system • Retrospective data collection flowsheet

Technical Specifications: Administrative Data

Administrative claims data collection requires users to identify the eligible population (denominator) and numerator using medical record abstraction (electronic or paper). Users report a rate based on all patients in a given practice for whom data are available and who meet the eligible population/denominator criteria.
The specifications listed below are those needed for performance calculation.
Note: Facilities are responsible for determining the appropriate use of codes.

	Facility Level Specifications
Denominator (Eligible Population)	Identify patients discharged from inpatient facility using the following: UB-04 (Form Locator 04 - Type of Bill): • 0111 (Hospital Inpatient (Including Medicare Part A), Admit through Discharge Claim) • 0114 (Hospital Inpatient (Including Medicare Part A), Interim - Last Claim) • 0121 (Hospital, Inpatient (Medicare Part B only), Admit through Discharge Claim)

- 0124 (Hospital, Inpatient (Medicare Part B only), Interim - Last Claim)
- 0181 (Hospital - Swing Beds, Admit through Discharge Claim)
- 0184 (Hospital - Swing Beds, Interim - Last Claim)
- 0211 (Skilled Nursing-Inpatient (Including Medicare Part A), Admit through Discharge Claim)
- 0214 (Skilled Nursing-Inpatient (Including Medicare Part A), Interim - Last Claim)
- 0221 (Skilled Nursing-Inpatient (Medicare Part B only), Admit through Discharge Claim)
- 0224 (Skilled Nursing- Inpatient (Medicare Part B only), Interim - Last Claim)
- 0281 (Skilled Nursing-Swing Beds, Admit through Discharge Claim)
- 0284 (Skilled Nursing-Swing Beds, Interim - Last Claim)

AND

Discharge Status (Form Locator 17)

- 01 (Discharged to home or self care (routine discharge)
- 02 (Discharged/transferred to a short term general hospital for inpatient care)
- 03 (Discharged/transferred to skilled nursing facility (SNF) with Medicare certification in anticipation of skilled care)
- 04 (Discharged/transferred to a facility that provides custodial or supportive care)
- 05 (Discharged/transferred to a designated cancer center or children's hospital)
- 06 (Discharged/transferred to home under care of an organized home health service organization in anticipation of covered skilled care)
- 21 (Discharged/transferred to court/law enforcement)
- 43 (Discharged/transferred to a federal health care facility)
- 50 (Hospice – home)
- 51 (Hospice - medical facility (certified) providing hospice level of care)
- 61 (Discharged/transferred to hospital-based Medicare approved swing bed)
- 62 (Discharged/transferred to an inpatient rehabilitation facility (IRF) including rehabilitation distinct part units of a hospital)
- 63 (Discharged/transferred to a Medicare certified long term care hospital (LTCH))
- 64 (Discharged/transferred to a nursing facility certified under Medicaid but not certified under Medicare)
- 65 (Discharged/transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital)
- 66 (Discharged/transferred to a Critical Access Hospital (CAH))
- 69 (Discharged/transferred to a designated disaster alternative care site)
- 70 (Discharged/transferred to another type of health care institution not defined elsewhere in this code list)
- 81 (Discharged to home or self care with a planned acute care hospital inpatient readmission)
- 82 (Discharged/transferred to a short term general hospital for inpatient care with a planned acute care hospital inpatient readmission)
- 83 (Discharged/transferred to a skilled nursing facility (SNF) with Medicare certification with a planned acute care hospital inpatient readmission)
- 84 (Discharged/transferred to a facility that provides custodial or supportive care with a planned acute care hospital inpatient readmission)
- 85 (Discharged/transferred to a designated cancer center or children's hospital with a planned acute care hospital inpatient readmission)
- 86 (Discharged/transferred to home under care of organized home health service organization with a planned acute care hospital inpatient readmission)
- 87 (Discharged/transferred to court/law enforcement with a planned acute care hospital inpatient readmission)
- 88 (Discharged/transferred to a federal health care facility with a planned acute

care hospital inpatient readmission
- 89 (Discharged/transferred to a hospital-based Medicare approved swing bed with a planned acute care hospital inpatient readmission)
- 90 (Discharged/transferred to an inpatient rehabilitation facility (IRF) including rehabilitation distinct part units of a hospital with a planned acute care hospital inpatient readmission)
- 91 (Discharged/transferred to a Medicare certified long term care hospital (LTCH) with a planned acute care hospital inpatient readmission)
- 92 (Discharged/transferred to nursing facility certified under Medicaid but not certified under Medicare with a planned acute care hospital inpatient readmission)
- 93 (Discharged/transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital with a planned acute care hospital inpatient readmission)
- 94 (Discharged/transferred to a critical access hospital (CAH) with a planned acute care hospital inpatient readmission)
- 95 (Discharged/transferred to another type of health care institution not defined elsewhere in this code list with a planned acute care hospital inpatient readmission)

OR

UB-04 (Form Locator 04 - Type of Bill):
- 0131 (Hospital Outpatient, Admit through Discharge Claim)
- 0134 (Hospital Outpatient, Interim - Last Claim)

AND

UB-04 (Form Locator 42 - Revenue Code):
- 0762 (Hospital Observation)
- 0490 (Ambulatory Surgery)
- 0499 (Other Ambulatory Surgery)

AND

Discharge Status (Form Locator 17)
- 01 (Discharged to home or self care (routine discharge)
- 02 (Discharged/transferred to a short term general hospital for inpatient care)
- 03 (Discharged/transferred to skilled nursing facility (SNF) with Medicare certification in anticipation of skilled care)
- 04 (Discharged/transferred to a facility that provides custodial or supportive care)
- 05 (Discharged/transferred to a designated cancer center or children's hospital)
- 06 (Discharged/transferred to home under care of an organized home health service organization in anticipation of covered skilled care)
- 21 (Discharged/transferred to court/law enforcement)
- 43 (Discharged/transferred to a federal health care facility)
- 50 (Hospice – home)
- 51 (Hospice - medical facility (certified) providing hospice level of care)
- 61 (Discharged/transferred to hospital-based Medicare approved swing bed)
- 62 (Discharged/transferred to an inpatient rehabilitation facility (IRF) including rehabilitation distinct part units of a hospital)
- 63 (Discharged/transferred to a Medicare certified long term care hospital (LTCH))
- 64 (Discharged/transferred to a nursing facility certified under Medicaid but not certified under Medicare)
- 65 (Discharged/transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital)
- 66 (Discharged/transferred to a Critical Access Hospital (CAH))
- 69 (Discharged/transferred to a designated disaster alternative care site)
- 70 (Discharged/transferred to another type of health care institution not defined

	elsewhere in this code list) • 81 (Discharged to home or self care with a planned acute care hospital inpatient readmission) • 82 (Discharged/transferred to a short term general hospital for inpatient care with a planned acute care hospital inpatient readmission) • 83 (Discharged/transferred to a skilled nursing facility (SNF) with Medicare certification with a planned acute care hospital inpatient readmission) • 84 (Discharged/transferred to a facility that provides custodial or supportive care with a planned acute care hospital inpatient readmission) • 85 (Discharged/transferred to a designated cancer center or children's hospital with a planned acute care hospital inpatient readmission) • 86 (Discharged/transferred to home under care of organized home health service organization with a planned acute care hospital inpatient readmission) • 87 (Discharged/transferred to court/law enforcement with a planned acute care hospital inpatient readmission) • 88 (Discharged/transferred to a federal health care facility with a planned acute care hospital inpatient readmission • 89 (Discharged/transferred to a hospital-based Medicare approved swing bed with a planned acute care hospital inpatient readmission) • 90 (Discharged/transferred to an inpatient rehabilitation facility (IRF) including rehabilitation distinct part units of a hospital with a planned acute care hospital inpatient readmission) • 91 (Discharged/transferred to a Medicare certified long term care hospital (LTCH) with a planned acute care hospital inpatient readmission) • 92 (Discharged/transferred to nursing facility certified under Medicaid but not certified under Medicare with a planned acute care hospital inpatient readmission) • 93 (Discharged/transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital with a planned acute care hospital inpatient readmission) • 94 (Discharged/transferred to a critical access hospital (CAH) with a planned acute care hospital inpatient readmission) • 95 (Discharged/transferred to another type of health care institution not defined elsewhere in this code list with a planned acute care hospital inpatient readmission)
Numerator	**Numerator Elements to be identified through medical record abstraction:** See Sample Data Collection Tool (included in tool for Measure #2 above).
Denominator Exclusions	UB-04 (Form Locator 17 - Discharge Status): • 07 (Left against medical advice or discontinued care) • 20 (Expired) • 40 (Expired at home) • 41 (Expired in a medical facility (e.g. hospital, SNF, ICF, or free standing hospice)) • 42 (Expired-place unknown)

Technical Specifications: Electronic Health Record System

The PCPI seeks to facilitate the integration of its measures into electronic health record (EHR) systems, registries, and applications used by physicians and other health care professionals that improve health care quality and prevent medical

errors. In particular, it is valuable to have data for measurement and improvement available at the point of care and for practice-wide or facility-wide analysis as well as for external reporting.

The Care Transitions measures do not lend themselves to a "traditional specification" for EHR reporting, where data elements, logic and clinical coding are identified to calculate the measure, due to the fact that every facility may have a different template for a transition record and the information required for this measure is based on individualized patient information unique to one episode of care (ie, inpatient stay). We have provided guidance on how a facility should query the electronic health record for the information required for this measure.

Transmitting the Transition Record with Specified Elements
The Transition Record should be transmitted to the next provider(s) of care in accordance with established approved standards for interoperability. The ONC Health IT Standards Committee (HITSC) has recommended that certain vocabulary standards are used for quality measure reporting, in accordance with the Quality Data Model (https://ecqi.healthit.gov/qdm). The use of recognized interoperability standards for the transmission of the Transition Record information will ensure that the information can be received into the destination EHR.

Systematic External Reporting that the Transition Record was transmitted within 24 hours of discharge
To systematically identify the transition records that were transmitted within 24 hours of discharge, a discrete data field and code may be needed in the EHR. This discrete data field will facilitate external reporting of the information.

Technical Specifications: Retrospective Data Collection Flowsheet

See Measure #2: Transition Record with Specified Elements Received by Discharged Patients (above)

Additional Information

By requiring the completion and prompt transmission of a detailed "transition record" for discharged patients, these measures are promoting a significant enhancement to the customary use of the "discharge summary," the traditional means of information transfer for which existing standards require completion within 30 days. Numerous studies have documented the prevalence of communication gaps and discontinuities in care for patients after discharge,[9-11] and the significant effect of these lapses on hospital readmissions and other indicators of the quality of transitional care.[17-20] Current information and communication technology can facilitate the routine completion and transmission of a transition record within 24 hours of discharge, which could greatly reduce communication gaps and may have a positive downstream effect on patient outcomes.

Measures 1, 2, & 3 address closely related, interdependent aspects of the transition in care for patients discharged from an inpatient facility and are therefore proposed as a bundled set of measures. The intent of this proposal is that the measures always be used together when assessing performance; no one of these measures should be selected for use independently. The bundling of the measures is *not* intended to suggest the use of any particular scoring methodology (ie, a composite score), nor does it imply either equality or difference in the relative "weights" of the three measures. A performance score for each of the three measures should be reported individually.

This rationale and methodology for a measure bundle are consistent with the definitions for "bundle" and "composite" provided by the Institute for Healthcare Improvement (IHI):

> Bundle – a series of interventions related to a specific condition that, when implemented together, will achieve significantly better outcomes than when implemented individually.
>
> Composite measure – a combination of two or more individual measures into a single measure that results in a single score. (www.ihi.org)

Measure #2: Transition Record with Specified Elements Received by Discharged Patients

(Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)

(facility-level measure; included in bundled measure set: Measures 1, 2, & 3)

Care Transitions

Measure Description

Percentage of patients, regardless of age, discharged from an inpatient facility (eg, hospital inpatient or observation, skilled nursing facility, or rehabilitation facility) to home or any other site of care, or their caregiver(s), who received a transition record (and with whom a review of all included information was documented) at the time of discharge including, at a minimum, *all* of the specified elements

Measure Components

Numerator Statement

- **See "Additional Information" for clarification of numerator elements and the bundling of measures 1, 2, & 3**

Patients or their caregiver(s) who received a transition record[a] (and with whom a review of all included information was documented) at the time of discharge including, at a minimum, *all* of the following elements:

Inpatient Care

- Reason for inpatient admission, AND
- Major procedures and tests performed during inpatient stay and summary of results, AND
- Principal diagnosis at discharge

Post-Discharge/ Patient Self-Management

- Current medication list,[b] AND
- Studies pending at discharge (eg, laboratory, radiological) , AND
- Patient instructions

Advance Care Plan

- Advance directives[c] or surrogate decision maker documented **OR** Documented reason for not providing advance care plan[d]

Contact Information/ Plan for Follow-up Care[e]

- 24-hour/7-day contact information including physician for emergencies related to inpatient stay, AND
- Contact information for obtaining results of studies pending at discharge, AND
- Plan for follow-up care,[f] AND
- Primary physician, other health care professional, or site designated for follow-up care[g]

Numerator Element Definitions*:*

a. Transition record: a core, standardized set of data elements related to patient's diagnosis, treatment, and care plan that is discussed with and provided to patient in printed or electronic format at each transition of care, and transmitted to the facility/physician/other health care professional providing follow-up care. Electronic format may be provided only if acceptable to patient.
b. Current medication list: all medications to be taken by patient after discharge, including all continued and new medications
c. Advance directives: eg, written statement of patient wishes regarding future use of life-

	sustaining medical treatment d. Documented reason for not providing advance care plan: documentation that advance care plan was discussed but patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan, OR documentation as appropriate that the patient's cultural and/or spiritual beliefs preclude a discussion of advance care planning as it would be viewed as harmful to the patient's beliefs and thus harmful to the physician-patient relationship e. Contact information/ plan for follow-up care: For patients discharged to an inpatient facility, the transition record may indicate that these four elements are to be discussed between the discharging and the "receiving" facilities. f. Plan for follow-up care: may include any post-discharge therapy needed (eg, oxygen therapy, physical therapy, occupational therapy), any durable medical equipment needed, family/psychosocial resources available for patient support, etc. g. Primary physician or other health care professional designated for follow-up care: may be designated primary care physician (PCP), medical specialist, or other physician or health care professional
Denominator Statement	All patients, regardless of age, discharged from an inpatient facility (eg, hospital inpatient or observation, skilled nursing facility, or rehabilitation facility) to home/self care or any other site of care
Denominator Exclusions	Patients who died Patients who left against medical advice (AMA) or discontinued care
Supporting Guideline & Other References	The following evidence statements are quoted verbatim from the referenced clinical guidelines. ***Transition record*** All transitions must include a transition record. There is a minimal set of data elements that should always be part of the transition record: – Principal diagnosis and problem list – Medication list (reconciliation) including OTC/ herbals, allergies and drug interactions – Clearly identifies the medical home/transferring coordinating physician/institution and their contact information – Patient's cognitive status – Test results/pending results (TOCCC, 2008) [21] Patients and/or their family/caregivers must receive, understand and be encouraged to participate in the development of their transition record which should take into consideration the patient's health literacy, insurance status and be culturally sensitive. (TOCCC, 2008) **Standard PC.04.02.01** When a [patient] is discharged or transferred, the [organization] gives information about the care, treatment, and services provided to the [patient] to other service providers who will provide the [patient] with care, treatment, or services. • At the time of the patient's discharge or transfer, the hospital informs other service providers who will provide care, treatment, or services to the patient about the following: - The reason for the patient's discharge or transfer - The patient's physical and psychosocial status - A summary of care, treatment, and services it provided to the patient - The patient's progress toward goals - A list of community resources or referrals made or provided to the patient (See also PC.02.02.01, EP 1) (Joint Commission, 2009)[23]

	Standard PC.04.01.05 Before the [organization] discharges or transfers a [patient], it informs and educates the [patient] about his or her follow-up care, treatment, and services. 1. When the hospital determines the patient's discharge or transfer needs, it promptly shares this information with the patient. 2. Before the patient is discharged, the hospital informs the patient of the kinds of continuing care, treatment, and services he or she will need. 3. When the patient is discharged or transferred, the hospital provides the patient with information about why he or she is being discharged or transferred. 5. Before the patient is transferred, the hospital provides the patient with information about any alternatives to the transfer. 7. The hospital educates the patient about how to obtain any continuing care, treatment, and services that he or she will need. 8. The hospital provides written discharge instructions in a manner that the patient and/or the patient's family or caregiver can understand. (See also RI.01.01.03, EP 1) (Joint Commission, 2009) [23]

Measure Importance

Relationship to desired outcome	Providing detailed discharge information enhances patients' preparation to self-manage post-discharge care and comply with treatment plans. Additionally, randomized trials have shown that many hospital readmissions can be prevented by patient education, predischarge assessment, and domiciliary aftercare.[20] One recent study found that patients participating in a hospital program providing detailed, personalized instructions at discharge, including a review of medication routines and assistance with arranging follow-up appointments, had 30% fewer subsequent emergency visits and hospital readmissions than patients who received usual care at discharge.[5]
Opportunity for Improvement	A prospective, cross-sectional study of discharged patients found that approximately 40% have pending test results at the time of discharge and that 10% of these require some action; yet outpatient physicians and patients are unaware of these results.[11] A more recent literature summary found that discharge summaries often lacked information important for follow-up care, including diagnostic test results (missing in 33-63% of summaries), treatment or hospital course (7-22%), discharge medications (2-40%), test results pending at discharge (65%), and follow-up plans (2-43%).[17]
IOM Domains of Health Care Quality Addressed [25]	• Safe • Patient-centered • Efficient • Equitable
Exclusion Justification	Exclusions arise when patients who are included in the initial patient or eligible population for a measure do not meet the denominator criteria specific to the intervention required by the numerator. Exclusions are absolute and apply to all patients and therefore are not part of clinical judgment within a measure. Patients who expired and patients who left against medical advice (AMA) are categorized by inpatient facilities as having been "discharged" (with specific discharge status codes) and must therefore be excluded from the denominators for these measures. The Care Transitions Work Group acknowledges that it may be feasible to provide patients who leave AMA with a medication list and transition record (and to transmit this information to the facility/physician providing follow-up care), but not necessarily with the level of detail specified in

	these measures.
Harmonization with Existing Measures	Harmonization with existing measures was not applicable to this measure.

Measure Designation

Measure purpose	• Quality Improvement • Accountability
Type of measure	• Process
Level of Measurement	• Facility
Care setting	• Discharge from an inpatient facility (eg, hospital inpatient or observation, skilled nursing facility, or rehabilitation facility)
Data source	• Administrative data • Medical record • Electronic health record system • Retrospective data collection flowsheet

Technical Specifications: Administrative Data

Administrative claims data collection requires users to identify the eligible population (denominator) and numerator using medical record abstraction (electronic or paper). Users report a rate based on all patients in a given practice for whom data are available and who meet the eligible population/denominator criteria.
The specifications listed below are those needed for performance calculation.
Note: Facilities are responsible for determining the appropriate use of codes.

	Facility-Level Specifications
Denominator (Eligible Population)	Identify patients discharged from inpatient facility using the following: UB-04 (Form Locator 04 - Type of Bill): • 0111 (Hospital Inpatient (Including Medicare Part A), Admit through Discharge Claim) • 0114 (Hospital Inpatient (Including Medicare Part A), Interim - Last Claim) • 0121 (Hospital Inpatient (Medicare Part B only), Admit through Discharge Claim) • 0124 (Hospital Inpatient (Medicare Part B only), Interim - Last Claim) • 0181 (Hospital - Swing Beds, Admit through Discharge Claim) • 0184 (Hospital - Swing Beds, Interim - Last Claim) • 0211 (Skilled Nursing-Inpatient (Including Medicare Part A), Admit through Discharge Claim) • 0214 (Skilled Nursing-Inpatient (Including Medicare Part A), Interim - Last Claim) • 0221 (Skilled Nursing-Inpatient (Medicare Part B only), Admit through Discharge Claim) • 0224 (Skilled Nursing- Inpatient (Medicare Part B only), Interim - Last Claim) • 0281 (Skilled Nursing-Swing Beds, Admit through Discharge Claim) • 0284 (Skilled Nursing-Swing Beds, Interim - Last Claim) AND Discharge Status (Form Locator 17) • 01 (Discharged to home or self care (routine discharge) • 02 (Discharged/transferred to a short term general hospital for inpatient care) • 03 (Discharged/transferred to skilled nursing facility (SNF) with Medicare certification in anticipation of skilled care) • 04 (Discharged/transferred to a facility that provides custodial or supportive care) • 05 (Discharged/transferred to a designated cancer center or children's hospital) • 06 (Discharged/transferred to home under care of an organized home health

service organization in anticipation of covered skilled care)
- 21 (Discharged/transferred to court/law enforcement)
- 43 (Discharged/transferred to a federal health care facility)
- 50 (Hospice – home)
- 51 (Hospice - medical facility (certified) providing hospice level of care)
- 61 (Discharged/transferred to hospital-based Medicare approved swing bed)
- 62 (Discharged/transferred to an inpatient rehabilitation facility (IRF) including rehabilitation distinct part units of a hospital)
- 63 (Discharged/transferred to a Medicare certified long term care hospital (LTCH))
- 64 (Discharged/transferred to a nursing facility certified under Medicaid but not certified under Medicare)
- 65 (Discharged/transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital)
- 66 (Discharged/transferred to a Critical Access Hospital (CAH))
- 69 (Discharged/transferred to a designated disaster alternative care site)
- 70 (Discharged/transferred to another type of health care institution not defined elsewhere in this code list)
- 81 (Discharged to home or self care with a planned acute care hospital inpatient readmission)
- 82 (Discharged/transferred to a short term general hospital for inpatient care with a planned acute care hospital inpatient readmission)
- 83 (Discharged/transferred to a skilled nursing facility (SNF) with Medicare certification with a planned acute care hospital inpatient readmission)
- 84 (Discharged/transferred to a facility that provides custodial or supportive care with a planned acute care hospital inpatient readmission)
- 85 (Discharged/transferred to a designated cancer center or children's hospital with a planned acute care hospital inpatient readmission)
- 86 (Discharged/transferred to home under care of organized home health service organization with a planned acute care hospital inpatient readmission)
- 87 (Discharged/transferred to court/law enforcement with a planned acute care hospital inpatient readmission)
- 88 (Discharged/transferred to a federal health care facility with a planned acute care hospital inpatient readmission
- 89 (Discharged/transferred to a hospital-based Medicare approved swing bed with a planned acute care hospital inpatient readmission)
- 90 (Discharged/transferred to an inpatient rehabilitation facility (IRF) including rehabilitation distinct part units of a hospital with a planned acute care hospital inpatient readmission)
- 91 (Discharged/transferred to a Medicare certified long term care hospital (LTCH) with a planned acute care hospital inpatient readmission)
- 92 (Discharged/transferred to nursing facility certified under Medicaid but not certified under Medicare with a planned acute care hospital inpatient readmission)
- 93 (Discharged/transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital with a planned acute care hospital inpatient readmission)
- 94 (Discharged/transferred to a critical access hospital (CAH) with a planned acute care hospital inpatient readmission)
- 95 (Discharged/transferred to another type of health care institution not defined elsewhere in this code list with a planned acute care hospital inpatient readmission)

OR

UB-04 (Form Locator 04 - Type of Bill):

- 0131 (Hospital Outpatient, Admit through Discharge Claim)
- 0134 (Hospital Outpatient, Interim - Last Claim)

AND
UB-04 (Form Locator 42 - Revenue Code):

- 0762 (Hospital Observation)
- 0490 (Ambulatory Surgery)
- 0499 (Other Ambulatory Surgery)

AND
Discharge Status (Form Locator 17)

- 01 (Discharged to home or self care (routine discharge)
- 02 (Discharged/transferred to a short term general hospital for inpatient care)
- 03 (Discharged/transferred to skilled nursing facility (SNF) with Medicare certification in anticipation of skilled care)
- 04 (Discharged/transferred to a facility that provides custodial or supportive care)
- 05 (Discharged/transferred to a designated cancer center or children's hospital
- 06 (Discharged/transferred to home under care of an organized home health service organization in anticipation of covered skilled care)
- 21 (Discharged/transferred to court/law enforcement)
- 43 (Discharged/transferred to a federal health care facility)
- 50 (Hospice – home)
- 51 (Hospice - medical facility (certified) providing hospice level of care)
- 61 (Discharged/transferred to hospital-based Medicare approved swing bed)
- 62 (Discharged/transferred to an inpatient rehabilitation facility (IRF) including rehabilitation distinct part units of a hospital)
- 63 (Discharged/transferred to a Medicare certified long term care hospital (LTCH))
- 64 (Discharged/transferred to a nursing facility certified under Medicaid but not certified under Medicare)
- 65 (Discharged/transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital)
- 66 (Discharged/transferred to a Critical Access Hospital (CAH))
- 69 (Discharged/transferred to a designated disaster alternative care site)
- 70 (Discharged/transferred to another type of health care institution not defined elsewhere in this code list)
- 81 (Discharged to home or self-care with a planned acute care hospital inpatient readmission)
- 82 (Discharged/transferred to a short term general hospital for inpatient care with a planned acute care hospital inpatient readmission)
- 83 (Discharged/transferred to a skilled nursing facility (SNF) with Medicare certification with a planned acute care hospital inpatient readmission)
- 84 (Discharged/transferred to a facility that provides custodial or supportive care with a planned acute care hospital inpatient readmission)
- 85 (Discharged/transferred to a designated cancer center or children's hospital with a planned acute care hospital inpatient readmission)
- 86 (Discharged/transferred to home under care of organized home health service organization with a planned acute care hospital inpatient readmission)
- 87 (Discharged/transferred to court/law enforcement with a planned acute care hospital inpatient readmission)
- 88 (Discharged/transferred to a federal health care facility with a planned acute care hospital inpatient readmission
- 89 (Discharged/transferred to a hospital-based Medicare approved swing bed

	with a planned acute care hospital inpatient readmission) • 90 (Discharged/transferred to an inpatient rehabilitation facility (IRF) including rehabilitation distinct part units of a hospital with a planned acute care hospital inpatient readmission) • 91 (Discharged/transferred to a Medicare certified long term care hospital (LTCH) with a planned acute care hospital inpatient readmission) • 92 (Discharged/transferred to nursing facility certified under Medicaid but not certified under Medicare with a planned acute care hospital inpatient readmission) • 93 (Discharged/transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital with a planned acute care hospital inpatient readmission) • 94 (Discharged/transferred to a critical access hospital (CAH) with a planned acute care hospital inpatient readmission) • 95 (Discharged/transferred to another type of health care institution not defined elsewhere in this code list with a planned acute care hospital inpatient readmission)
Numerator	**Numerator Elements to be identified through medical record abstraction:** See Sample Data Collection Tool below.
Denominator Exclusions	UB-04 (Form Locator 17 - Discharge Status): • 07 (Left against medical advice or discontinued care) • 20 (Expired) • 40 (Expired at home) • 41 (Expired in a medical facility (e.g. hospital, SNF, ICF, or free standing hospice)) • 42 (Expired-place unknown)

Technical Specifications: Electronic Health Record System

The PCPI seeks to facilitate the integration of its measures into electronic health record (EHR) systems, registries, and applications used by physicians and other health care professionals that improve health care quality and prevent medical errors. In particular, it is valuable to have data for measurement and improvement available at the point of care and for practice-wide or facility-wide analysis as well as for external reporting.

The Care Transitions measures do not lend themselves to a "traditional specification" for EHR reporting, where data elements, logic and clinical coding are identified to calculate the measure, due to the fact the fact that every facility may have a different template for a transition record and the information required for this measure is based on individualized patient information unique to one episode of care (ie, inpatient stay). We have provided guidance on how a facility should query the electronic health record for the information required for this measure.

As the quality measures arena moves forward with EHR reporting, the Care Transitions measures will be aligned with the ONC Health IT Standards Committee (HITSC) recommendations that certain vocabulary standards be used for quality measure reporting, in accordance with the Quality Data Model (https://ecqi.healthit.gov/qdm).

Producing the Transition Record with Specified Elements

Facilities that have implemented an EHR should utilize their system to produce a standardized template that providers will complete to generate the Transition Record. A standardized template will ensure that all data elements specified in the performance measure are included each time a Transition Record is prepared. Each facility has the autonomy to customize the format of the Transition Record, based on clinical workflow, policies and procedures, and the patient population treated at the individual institution

Transmitting the Transition Record with Specified Elements

This performance measure does not require that the Transition Record be transmitted to the next provider(s) of care. However, if the Transition Record is transmitted to the next provider(s) of care, it should be done so in accordance with established approved standards for interoperability. The ONC Health IT Standards Committee (HITSC) has recommended that certain vocabulary standards are used for quality measure reporting, in accordance with the Quality Data Model. In addition, the use of recognized interoperability standards for the transmission of the Transition Record information will ensure that the information can be received into the destination EHR.

Systematic External Reporting of the Transition Record

In order to report, at the facility level, which of the discharged patients have received a Transition Record, a discrete data field and code indicating the patient received a Transition Record at discharge may be needed in the EHR.

Technical Specifications: Retrospective Data Collection Flowsheet

This form is intended to be used for patients who were discharged from the inpatient setting, does not include patients that left against medical advice (AMA) or patients that expired during their inpatient visit.

Transition Record with Specified Elements Received by Discharged Patients
and
Timely Transmission of Transition Record
(Inpatient Discharges to Home/Self Care or Any Other Site of Care)

Patient Name:

Medical Record Number or other patient identifier:

Date of Discharge:

Numerator:

		Yes	No	Instructions
Transition Record with all of the specified elements	**Did patient receive a Transition Record at discharge?** *(Underlined terms are defined below)*			If yes, answer questions below to determine that all appropriate elements were included in the Transition Record.
	Are the following elements included in Transition Record?	**Yes**	**No**	If a given element does not apply to patient, transition record should state the same (eg, no pending studies at discharge)
Inpatient Care	Reason for inpatient admission			
	Major procedures and tests, including summary of results			
	Principal diagnosis at discharge			
Post-Discharge/ Patient Self-Management	Current Medication List			
	Studies Pending at Discharge (or documentation that no studies are pending)			
	Patient Instructions			
Advance Care Plan	Advance directives or surrogate decision maker documented OR Documented reason for not providing advance care plan			
Contact Information/ Plan for Follow-Up Care	24-hour/7-day contact information including physician for emergencies related to inpatient stay			
	Contact information for obtaining results of studies pending at discharge			
	Plan for follow-up care			
	Primary physician, other health care professional, or site designated for follow-up care			

Transition Record with all of the specified elements	**Are ALL specified elements included in the transition record?**			*Review responses above to determine if all elements were included in transition record*

Discharge Information	Date and time patient was discharged from facility		
	Date and time Transition Record was transmitted to receiving facility, or physician, or other health care professional		
	Was Transition Record transmitted within 24 hours of discharge?	**Yes**	**No**

Definition of Terms:

Transition record	A core, standardized set of data elements related to patient's diagnosis, treatment, and care plan that is discussed with and provided to patient in a printed or electronic format at each transition of care, and transmitted to the facility/physician/other health care professional providing follow-up care. The Transition record may be provided only in electronic format if acceptable to patient.
Current medication list	All medications to be taken by patient after discharge, including all continued and new medications
Advance directives	eg, written statement of patient wishes regarding future use of life-sustaining medical treatment
Documented reason for not providing advance care plan	Documentation that advance care plan was discussed but patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan, OR documentation as appropriate that the patient's cultural and/or spiritual beliefs preclude a discussion of advance care planning as it would be viewed as harmful to the patient's beliefs and thus harmful to the physician-patient relationship
Contact information/ plan for follow-up care	For patients discharged to an inpatient facility, the transition record may indicate that these four elements are to be discussed between the discharging and the "receiving" facilities.
Plan for follow-up care	May include any post-discharge therapy needed (eg, oxygen therapy, physical therapy, occupational therapy), any durable medical equipment needed, family/psychosocial resources available for patient support, etc.
Primary physician or other health care professional designated for follow-up care	May be designated primary care physician (PCP), medical specialist, or other physician or health care professional
Transmitted	Transition record may be transmitted to the facility or physician or other health care professional designated for follow-up care via fax, secure e-mail, or mutual access to an electronic health record (EHR).

Additional Information

By requiring the completion and prompt transmission of a detailed "transition record" for discharged patients, these measures are promoting a significant enhancement to the customary use of the "discharge summary," the traditional means of information transfer for which existing standards require completion within 30 days. Numerous studies have documented the prevalence of communication gaps and discontinuities in care for patients after discharge,[9-11] and the significant effect of these lapses on hospital readmissions and other indicators of the quality of transitional care.[17-20] Current information and communication technology can facilitate the routine completion and transmission of a transition record within 24 hours of discharge, which could greatly reduce communication gaps and may have a positive downstream effect on patient outcomes.

Consistent with the cited Joint Commission standards, the information in the transition record should be provided in a manner that can be understood by patients or their caregivers. Patient/caregiver understanding of this information may be assessed by various methods, including "teach-back."

Measures 1, 2, & 3 address closely related, interdependent aspects of the transition in care for patients discharged from an inpatient facility and are therefore proposed as a bundled set of measures. The intent of this proposal is that the measures always be used together when assessing performance; no one of these measures should be selected for use independently. The bundling of the measures is *not* intended to suggest the use of any particular scoring methodology (ie, a composite score), nor does it imply either equality or difference in the relative "weights" of the three measures. A performance score for each of the three measures should be reported individually.

This rationale and methodology for a measure bundle are consistent with the definitions for "bundle" and "composite" provided by the Institute for Healthcare Improvement (IHI):

> Bundle – a series of interventions related to a specific condition that, when implemented together, will achieve significantly better outcomes than when implemented individually.
>
> Composite measure – a combination of two or more individual measures into a single measure that results in a single score. (www.ihi.org)

*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.

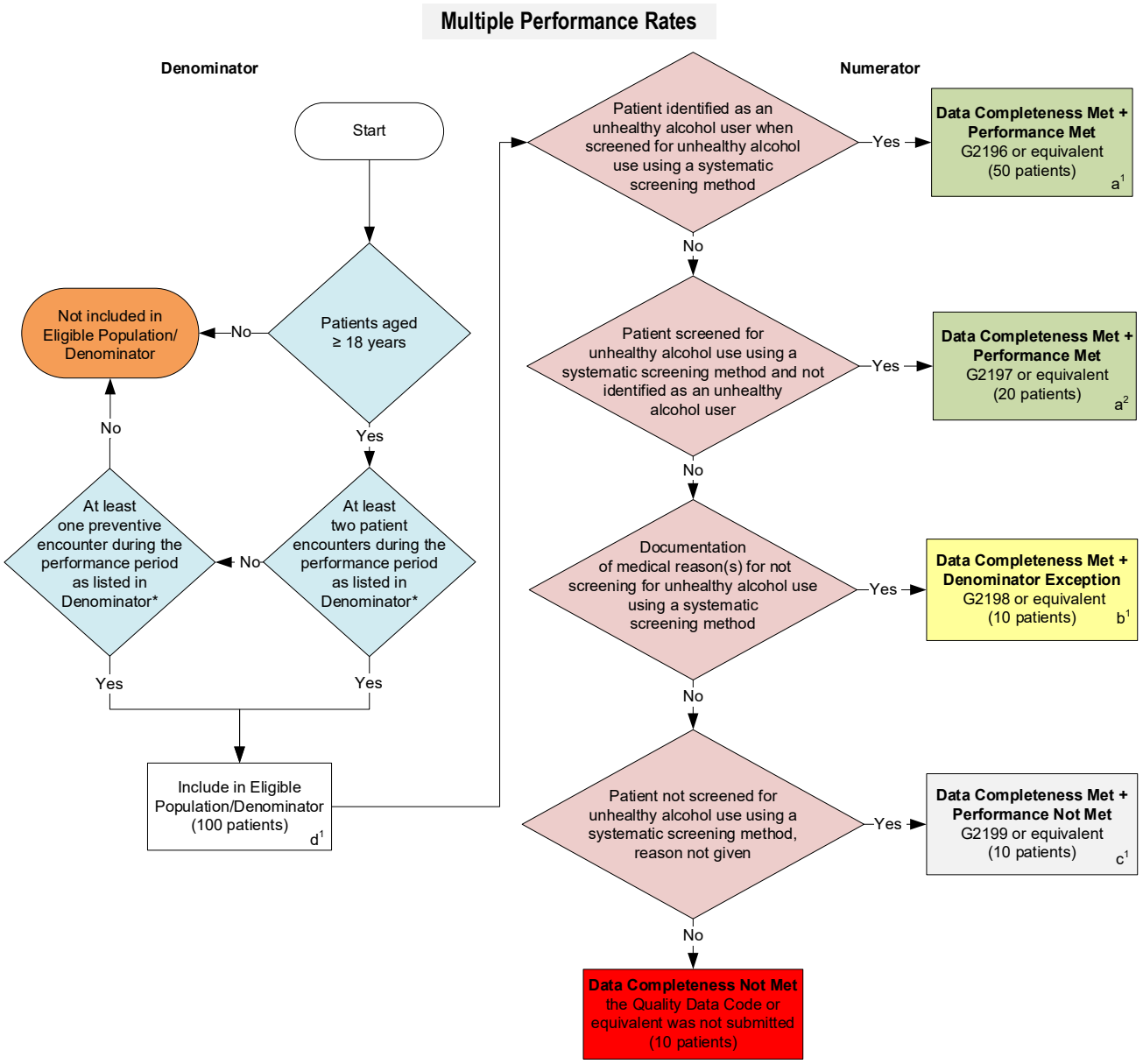
A number of studies, including patient and provider surveys, have documented low rates of alcohol misuse screening and counseling in primary care settings. According to a study analyzing the quality of health care in the United States, on average, 45% of patients (n=6,676) were screened for problem drinking. (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=

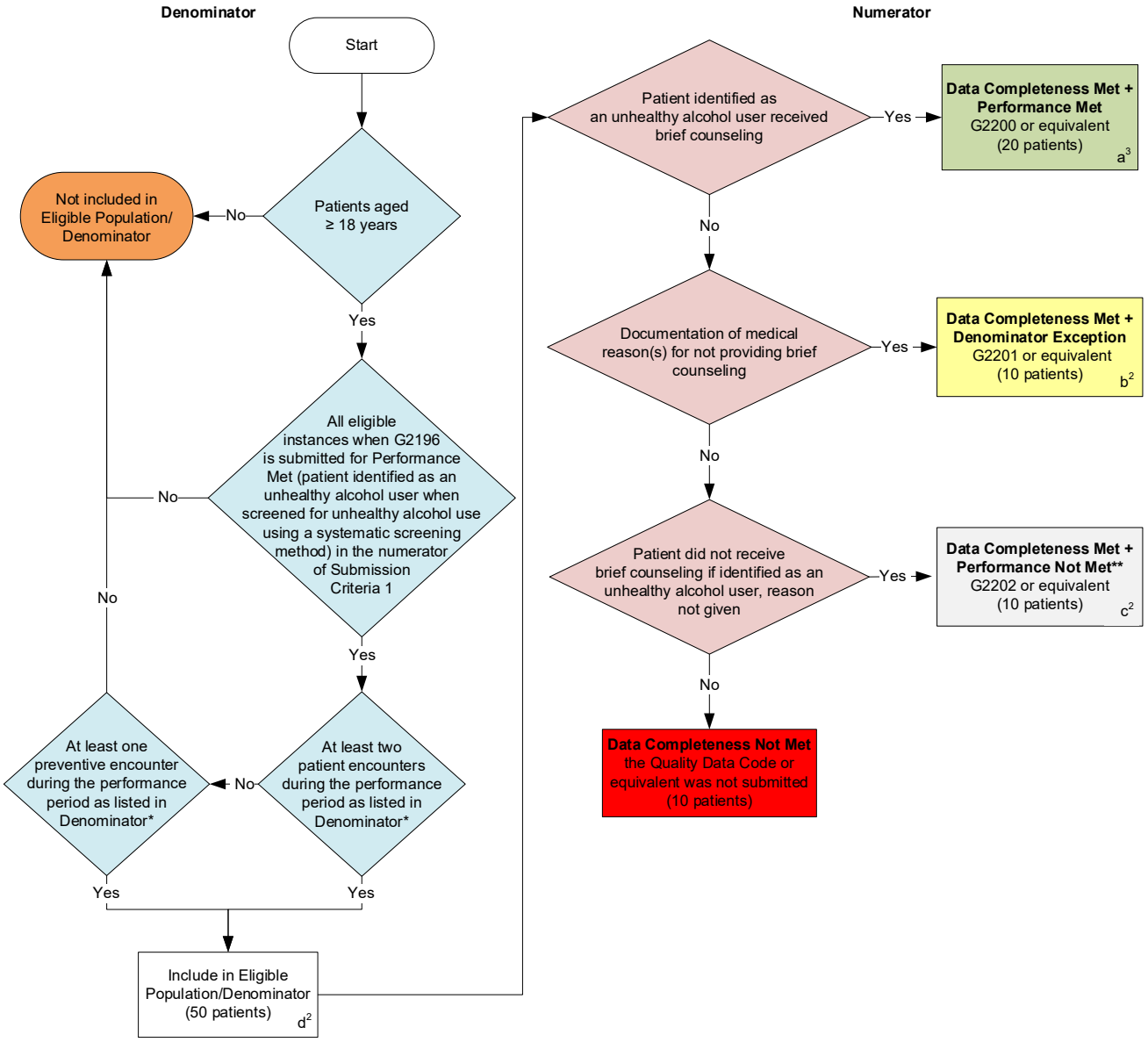
Performance Met (a^1+a^2=70 patients) = 70 patients = **87.50%**

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%**

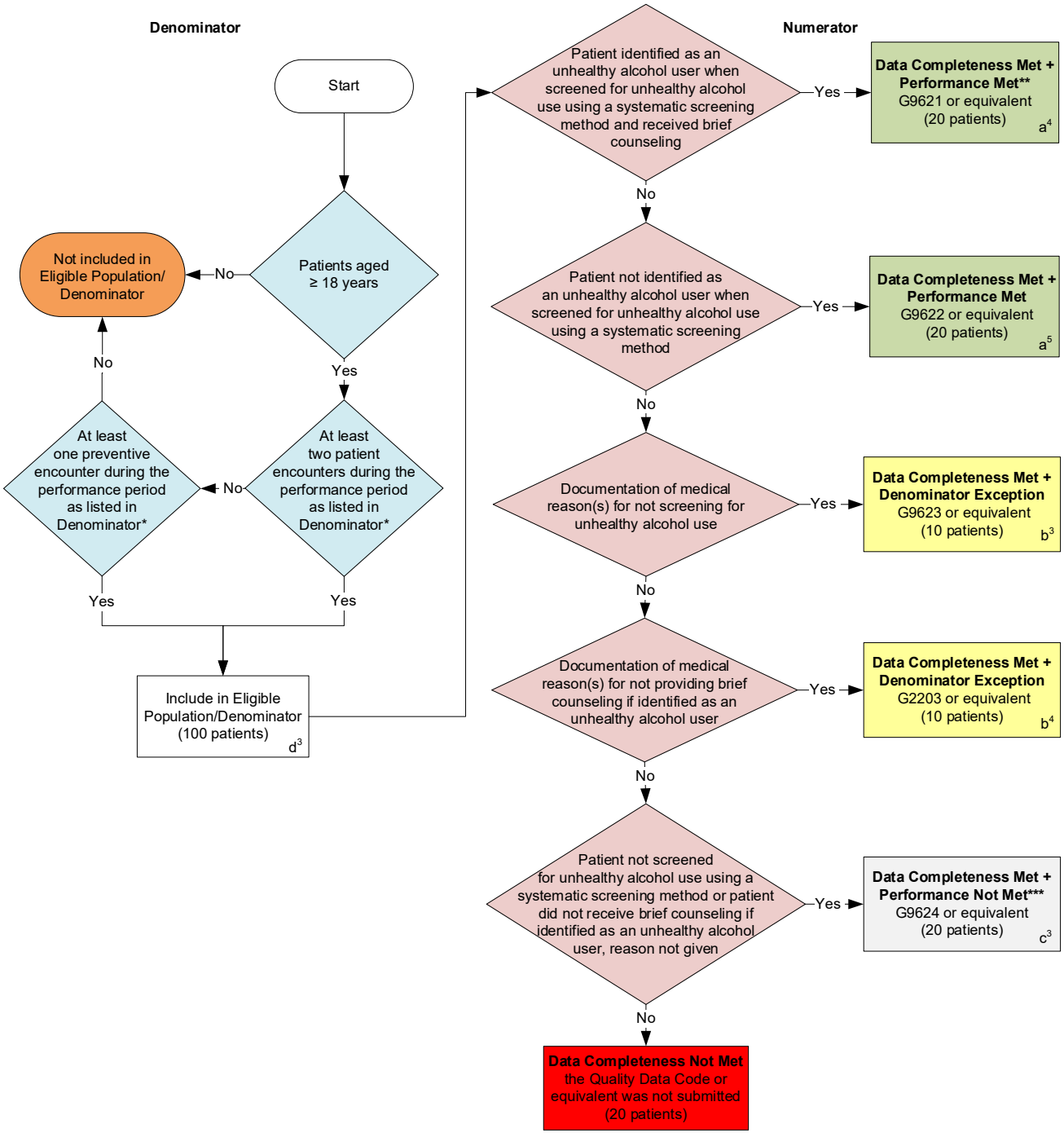
Data Completeness Numerator (40 patients) – Denominator Exception (b^2=10 patients) = 30 patients

*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.

Use of Imaging Studies for Low Back Pain (LBP)

SUMMARY OF CHANGES TO HEDIS MY 2022

- Added the Medicare product line.
- Expanded the age range to increase the upper age limit to 75 years.
- Added age stratifications.
- Added required exclusions for osteoporosis, lumbar surgery, spondylopathy, fragility fractures and palliative care.
- Clarified that members in hospice or using hospice services anytime during the measurement year are a required exclusion.
- Added exclusions for members with advanced illness and frailty.
- Updated the exclusions criteria in the Rules for Allowable Adjustments.

Description

The percentage of members 18–75 years of age with a principal diagnosis of low back pain who did not have an imaging study (plain X-ray, MRI, CT scan) within 28 days of the diagnosis.

Calculation

The measure is reported as an inverted rate [1–(numerator/eligible population)]. A higher score indicates appropriate treatment of low back pain (i.e., the proportion for whom imaging studies did not occur).

Definitions

Intake Period	January 1–December 3 of the measurement year. The Intake Period is used to identify the first eligible encounter with a principal diagnosis of low back pain.
IESD	Index Episode Start Date. The earliest date of service for an eligible encounter during the Intake Period with a principal diagnosis of low back pain.
Negative Diagnosis History	A period of 180 days (6 months) prior to the IESD when the member had no claims/encounters with any diagnosis of low back pain.

Eligible Population

Product line	Commercial, Medicaid, Medicare (report each product line separately).
Ages	18 years as of January 1 of the measurement year to 75 years as of December 31 of the measurement year. Report two age stratifications and a total rate: • 18–64. • 65–75. • Total. The total is the sum of the age stratifications.

Continuous enrollment 180 days (6 months) prior to the IESD through 28 days after the IESD.

Allowable gap None.

Anchor date IESD.

Benefit Medical.

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

Step 1 Identify all members in the specified age range who had any of the following during the Intake Period:

- An outpatient visit (Outpatient Value Set), observation visit (Observation Value Set) or an ED visit (ED Value Set) with a principal diagnosis of uncomplicated low back pain (Uncomplicated Low Back Pain Value Set).
  - Do not include visits that result in an inpatient stay (Inpatient Stay Value Set).
- Osteopathic or chiropractic manipulative treatment (Osteopathic and Chiropractic Manipulative Treatment Value Set) with a principal diagnosis of uncomplicated low back pain (Uncomplicated Low Back Pain Value Set).
- Physical therapy visit (Physical Therapy Value Set) with a principal diagnosis of uncomplicated low back pain (Uncomplicated Low Back Pain Value Set).
- Telephone visit (Telephone Visits Value Set) with a principal diagnosis of uncomplicated low back pain (Uncomplicated Low Back Pain Value Set).
- E-visit or virtual check-in (Online Assessments Value Set) with a principal diagnosis of uncomplicated low back pain (Uncomplicated Low Back Pain Value Set).

Step 2 Determine the IESD. For each member identified in step 1, determine the earliest episode of low back pain. If the member had more than one encounter, include only the first encounter.

Step 3 Test for Negative Diagnosis History. Exclude members with a diagnosis of uncomplicated low back pain (Uncomplicated Low Back Pain Value Set) during the 180 days (6 months) prior to the IESD.

Step 4: Required exclusions Exclude members who meet any of the following criteria:

- *Cancer.* Cancer any time during the member's history through 28 days after the IESD. Any of the following meet criteria:
  - Malignant Neoplasms Value Set.
  - Other Neoplasms Value Set.
  - History of Malignant Neoplasm Value Set.
  - Other Malignant Neoplasm of Skin Value Set.
- *Recent trauma.* Trauma (Trauma Value Set) any time during the 3 months (90 days) prior to the IESD through 28 days after the IESD.
- *Intravenous drug abuse.* IV drug abuse (IV Drug Abuse Value Set) any time during the 12 months (1 year) prior to the IESD through 28 days after the IESD.

- *Neurologic impairment*. Neurologic impairment (Neurologic Impairment Value Set) any time during the 12 months (1 year) prior to the IESD through 28 days after the IESD.
- *HIV.* HIV (HIV Value Set) any time during the member's history through 28 days after the IESD.
- *Spinal infection.* Spinal infection (Spinal Infection Value Set) any time during the 12 months (1 year) prior to the IESD through 28 days after the IESD.
- *Major organ transplant.* Major organ transplant (Organ Transplant Other Than Kidney Value Set; Kidney Transplant Value Set; History of Kidney Transplant Value Set) any time in the member's history through 28 days after the IESD.
- *Prolonged use of corticosteroids.* 90 consecutive days of corticosteroid treatment any time during the 366-day period that begins 365 days prior to the IESD and ends on the IESD.

  To identify consecutive treatment days, identify calendar days covered by at least one dispensed corticosteroid (Corticosteroid Medications List). For overlapping prescriptions and multiple prescriptions on the same day assume the member started taking the second prescription after exhausting the first prescription. For example, if a member had a 30-days prescription dispensed on June 1 and a 30-days prescription dispensed on June 26, there are 60 covered calendar days (June 1–July 30).

  Count only medications dispensed during the 12 months (1 year) prior to and including the IESD. When identifying consecutive treatment days, do not count days supply that extend beyond the IESD. For example, if a member had a 90-days prescription dispensed on the IESD, there is one covered calendar day (the IESD).

  No gaps are allowed.

Corticosteroid Medications

Description	Prescription	
Corticosteroid	• Hydrocortisone	• Methylprednisolone
	• Cortisone	• Triamcinolone
	• Prednisone	• Dexamethasone
	• Prednisolone	• Betamethasone/Betamethasone acetate

- *Osteoporosis*. Osteoporosis therapy (Osteoporosis Medication Therapy Value Set, Long-Acting Osteoporosis Medications Value Set) or a dispensed prescription to treat osteoporosis (Osteoporosis Medication List) any time during the member's history through 28 days after the IESD.

Osteoporosis Medications

Description	Prescription	
Bisphosphonates	• Alendronate • Alendronate-cholecalciferol • Ibandronate	• Risedronate • Zoledronic acid
Other agents	• Abaloparatide • Denosumab • Raloxifene	• Romosozumab • Teriparatide

- *Fragility fracture.* Fragility fracture (Fragility Fractures Value Set) any time during the 3 months (90 days) prior to the IESD through 28 days after the IESD.
- *Lumbar surgery.* Lumbar surgery (Lumbar Surgery Value Set) any time during the member's history through 28 days after the IESD.
- *Spondylopathy.* Spondylopathy (Spondylopathy Value Set) any time during the member's history through 28 days after the IESD.
- *Palliative care*. Members receiving palliative care (Palliative Care Assessment Value Set; Palliative Care Encounter Value Set; Palliative Care Intervention Value Set) during the measurement year.
- Members in hospice or using hospice services anytime during the measurement year. Refer to *General Guideline 17: Members in Hospice.*

Step 5: Exclusions

Exclude members who meet any of the following criteria:

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

- Members 66 years of age and older as of December 31 of the measurement year (all product lines) with frailty ***and*** advanced illness. Members must meet ***BOTH*** of the following frailty and advanced illness criteria to be excluded:
  1. At least 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 Medication List).

Dementia Medications

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

Step 6 Calculate continuous enrollment. Members must be continuously enrolled for 180 days (6 months) prior to the IESD through 28 days after the IESD.

Administrative Specification

Denominator The eligible population.

Numerator An imaging study (Imaging Study Value Set) with a diagnosis of uncomplicated low back pain (Uncomplicated Low Back Pain Value Set) on the IESD or in the 28 days following the IESD.

Note

- *Although denied claims are not included when assessing the numerator, all claims (paid, suspended, pending and denied) must be included when identifying the eligible population.*
- *Do not include supplemental data when identifying the eligible population or assessing the numerator. Supplemental data can be used for only required exclusions for this measure.*

Data Elements for Reporting

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

Table LBP-1/2/3: Data Elements for Use of Imaging Studies for Low Back Pain

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

Rules for Allowable Adjustments of HEDIS

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 Use of Imaging Studies for Low Back Pain

NONCLINICAL COMPONENTS		
Eligible Population	**Adjustments Allowed (Yes/No)**	**Notes**
Product Lines	Yes	Organizations are not required to use product line criteria; product lines may be combined, and all (or no) product line criteria may be used.
Ages	Yes, with limits	The age determination dates may be changed (e.g., select, "age as of June 30"). Changing the denominator age range is allowed if the limits are within the specified age range (18–50 years). The denominator age may not be expanded.
Continuous enrollment, Allowable gap, Anchor Date	Yes	Organizations are not required to use enrollment criteria; adjustments are allowed. ***Note:*** *Changes to* these *criteria can affect how* the *event/diagnosis will be calculated using* the *Intake Period, IESD, Negative Diagnosis History*.
Benefits	Yes	Organizations are not required to use a benefit; adjustments are allowed.
Other	Yes	Organizations may use additional eligible population criteria to focus on 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, treatment, therapy or e-visits or virtual check-ins. The value sets and logic may not be changed.
Denominator Exclusions	**Adjustments Allowed (Yes/No)**	**Notes**
Required Exclusions	Yes, with limits	Apply required exclusions according to specified medication lists and value sets. The hospice and palliative care exclusions are not required. Refer to *Exclusions* in the *Guidelines for the Rules for Allowable Adjustments*.
Numerator Criteria	**Adjustments Allowed (Yes/No)**	**Notes**
Imaging Study	Yes, with limits	Value sets and logic may not be changed. Organizations may include denied claims to calculate the numerator.

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

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

SUMMARY OF CHANGES TO HEDIS MY 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.

Quality ID #134: Preventive Care and Screening: Screening for Depression and Follow-Up Plan
– National Quality Strategy Domain: Community/Population Health
– Meaningful Measure Area: Prevention, Treatment, and Management of Mental Health

2021 COLLECTION TYPE:
MIPS CLINICAL QUALITY MEASURES (CQMS)

MEASURE TYPE:
Process

DESCRIPTION:
Percentage of patients aged 12 years and older screened for depression on the date of the encounter or up to 14 days prior to the date of the encounter using an age-appropriate standardized depression screening tool AND if positive, a follow-up plan is documented on the date of the eligible encounter

INSTRUCTIONS:
This measure is to be submitted a minimum of **once per measurement period** for patients seen during the measurement period. The most recent screening submitted will be used for performance calculation. 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. The follow-up plan must be related to a positive depression screening, example: "Patient referred for psychiatric evaluation due to positive depression screening".

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 years and older at the beginning of the measurement period with at least one eligible encounter during the measurement period

Definition:
Not Eligible for Depression Screening or Follow-Up Plan (Denominator Exclusion) –

- Patients who have been diagnosed with depression- F01.51, F32.0, F32.1, F32.2, F32.3, F32.4, F32.5, F32.89, F32.9, F33.0, F33.1, F33.2, F33.3, F33.40, F33.41, F33.42, F33.8, F33.9, F34.1, F34.81, F34.89, F43.21, F43.23, F53.0, F53.1, O90.6, O99.340, O99.341, O99.342, O99.343, O99.345
- Patients who have been diagnosed with bipolar disorder- F31.10, F31.11, F31.12, F31.13, F31.2, F31.30, F31.31, F31.32, F31.4, F31.5, F31.60, F31.61, F31.62, F31.63, F31.64, F31.70, F31.71, F31.72, F31.73, F31.74, F31.75, F31.76, F31.77, F31.78, F31.81, F31.89, F31.9

DENOMINATOR NOTE: The intent of the measure is to screen for depression in patients who have never had a diagnosis of depression or bipolar disorder prior to the eligible encounter used to evaluate the numerator. Patients who have ever been diagnosed with depression or bipolar disorder will be excluded from

the measure.

**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 ≥ 12 years
AND
Patient encounter during the performance period (CPT or HCPCS): 59400, 59510, 59610, 59618, 90791, 90792, 90832, 90834, 90837, 92625, 96105, 96110, 96112, 96116, 96125, 96136, 96138, 96156, 96158, 97161, 97162, 97163, 97165, 97166, 97167, 99078, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99315, 99316, 99318, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99339, 99340, 99401*, 99402*, 99403*, 99483, 99484, 99492, 99493, 99384*, 99385*, 99386*, 99387*, 99394*, 99395*, 99396*, 99397*, G0101, G0402, G0438, G0439, G0444
AND NOT
DENOMINATOR EXCLUSION:
Documentation stating the patient has had a diagnosis of depression or has had a diagnosis of bipolar disorder: G9717

NUMERATOR:
Patients screened for depression on the date of the encounter or up to 14 days prior to the date of the encounter using an age-appropriate standardized tool AND if positive, a follow-up plan is documented on the date of the eligible encounter

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 patient population in which it is being utilized..

Examples of standardized 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), Patient Health Questionnaire (PHQ-9), Pediatric Symptom Checklist (PSC-17), and PRIME MD-PHQ-2
- **Adult Screening Tools (18 years and older)**
  Patient Health Questionnaire (PHQ-9), 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 for Depression in Dementia (CSDD), PRIME MD-PHQ-2, Hamilton Rating Scale for Depression (HAM-D), Quick Inventory of Depressive Symptomatology Self-Report (QID-SR), Computerized Adaptive Testing Depression Inventory (CAT-DI), and Computerized Adaptive Diagnostic Screener (CAD-MDD)
- **Perinatal Screening Tools**
  Edinburgh Postnatal Depression Scale, Postpartum Depression Screening Scale, Patient Health Questionnaire 9 (PHQ-9), Beck Depression Inventory, Beck Depression Inventory–II, Center for Epidemiologic Studies Depression Scale, and Zung Self-rating Depression Scale

Follow-Up Plan – Documented follow-up for a positive depression screening ***must*** include one or more of the following:

- Referral to a practitioner who is qualified to diagnose and treat depression
- Pharmacological interventions

- Other interventions or follow-up for the diagnosis or treatment of depression

Examples of a follow-up plan include but are not limited to:

- Referral to a practitioner or program for further evaluation for depression, for example, referral to a psychiatrist, psychologist, social worker, mental health counselor, or other mental health service such as family or group therapy, support group, depression management program, or other service for treatment of depression
- Other interventions designed to treat depression such as behavioral health evaluation, psychotherapy, pharmacological interventions, or additional treatment options

Patients with a Documented Reason for not Screening for Depression (Denominator Exception) –

Patient Reason(s)

Patient refuses to participate

OR

Medical Reason(s)

Documentation of medical reason for not screening patient for depression (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)

Numerator Instructions:

A depression screen is completed on the date of the encounter or up to 14 days prior to the date of the encounter using an age-appropriate standardized depression screening tool AND if positive, a follow-up plan must be documented on the date of the encounter, such as referral to a practitioner who is qualified to treat depression, pharmacological interventions or other interventions for the treatment of depression.

Depression screening is required once per measurement period, not at all encounters. An age-appropriate, standardized, and validated depression screening tool must be used for numerator compliance. The name of the age-appropriate standardized depression screening tool utilized must be documented in the medical record. The depression screening must be reviewed and addressed in the office of the provider on the date of the encounter. Positive pre-screening results indicating a patient is at high risk for self-harm should receive more urgent intervention as determined by the provider practice. The screening should occur during a qualifying encounter or up to 14 days prior to the date of the qualifying encounter.

The measure assesses the most recent depression screening completed either during the eligible encounter or within the 14 days prior to that encounter. Therefore, a clinician would not be able to complete another screening at the time of the encounter to count towards a follow-up, because that would serve as the most recent screening. In order to satisfy the follow-up requirement for a patient screening positively, the eligible clinician would need to provide one of the aforementioned follow-up actions, which does not include use of a standardized depression screening tool.

Should a patient screen positive for depression, a clinician should opt to complete a suicide risk assessment when appropriate and based on individual patient characteristics. However, for the purposes of this measure, a suicide risk assessment or additional screening using a standardized tool, will not qualify as a follow-up plan.

Numerator Options:

Performance Met: Screening for depression is documented as being positive AND a follow-up plan is documented **(G8431)**

OR

Performance Met: Screening for depression is documented as negative, a follow-up plan is not required **(G8510)**

OR

Denominator Exception: Screening for depression not completed, documented reason **(G8433)**

OR

Performance Not Met: Depression screening not documented, reason not given **(G8432)**

OR

Performance Not Met: Screening for depression documented as positive, follow-up plan not documented, reason not given **(G8511)**

RATIONALE:

Depression is a serious medical illness associated with higher rates of chronic disease, increased health care utilization, and impaired functioning (Katon, 2003; Wells et al., 1989). 2016 U.S. survey data indicate that 12.8 percent of adolescents (3.1 million adolescents) had a major depressive episode (MDE) in the past year, with nine percent of adolescents (2.2 million adolescents) having one MDE with severe impairment. The same data indicate that 6.7 percent of adults aged 18 or older (16.2 million adults) had at least one MDE with 4.3 percent of adults (10.3 million adults) having one MDE with severe impairment in the past year (Substance Abuse and Mental Health Services Administration, 2017). Data indicate that severity of depressive symptoms factor into having difficulty with work, home, or social activities. For example, as the severity of depressive symptoms increased, rates of having difficulty with work, home, or social activities related to depressive symptoms increased. For those twelve and older with mild depressive symptoms, 45.7% reported difficulty with activities and those with severe depressive symptoms, 88.0% reported difficulty (Pratt & Brody, 2014). Children and teens with major depressive disorder (MDD) have been found to have difficulty carrying out their daily activities, relating to others, growing up healthy, and also are at an increased risk of suicide (Siu on behalf of the U.S. Preventive Services Task Force [USPSTF], 2016). Additionally, perinatal depression (considered here as depression arising in the period from conception to the end of the first postnatal year) affects up to 12% of women (Woody, Ferrari, Siskind, Whiteford, & Harris, 2017). Depression and other mood disorders, such as bipolar disorder and anxiety disorders, especially during the perinatal period, can have devastating effects on women, infants, and families (American College of Obstetricians and Gynecologists, 2018). Maternal suicide rates rise over hemorrhage and hypertensive disorders as a cause of maternal mortality (Palladino, Singh, Campbell, Flynn, & Gold, 2011).

Negative outcomes associated with depression make it crucial to screen in order to identify and treat depression in its early stages. While Primary Care Providers (PCPs) serve as the first line of defense in the detection of depression, studies show that PCPs fail to recognize up to 50% of depressed patients (Borner, Braunstein, St. Victor, & Pollack, 2010). "In nationally representative U.S. surveys, about eight percent of adolescents reported having major depression in the past year. Only 36% to 44% of children and adolescents with depression receive treatment, suggesting that the majority of depressed youth are undiagnosed and untreated" (Siu on behalf of USPSTF, 2016, p. 360 & p. 364). Evidence supports that screening for depression in pregnant and postpartum women is of moderate net benefit and treatment options for positive depression screening should be available for patients twelve and older including pregnant and postpartum women.

If preventing negative patient outcomes is not enough, the substantial economic burden of depression for individuals and society alike makes a case for screening for depression on a regular basis. Depression imposes economic burden through direct and indirect costs: "In the United States, an estimated $22.8 billion was spent on depression treatment in 2009, and lost productivity cost an additional estimated $23 billion in 2011" (Siu & USPSTF, 2016, p. 383-384).

This measure seeks to align with clinical guideline recommendations as well as the Healthy People 2020 recommendation for routine screening for mental health problems as a part of primary care for both children and adults (U.S. Department of Health and Human Services, 2014) and makes an important contribution to the quality domain of community and population health.

CLINICAL RECOMMENDATION STATEMENTS:

Adolescent Recommendation (12-18 years):

"The USPSTF recommends screening for MDD in adolescents aged 12 to 18 years. Screening should be

implemented with adequate systems in place to ensure accurate diagnosis, effective treatment, and appropriate follow-up (B recommendation)" (Siu on behalf of USPSTF, 2016, p. 360).

Adult Recommendation (18 years and older)

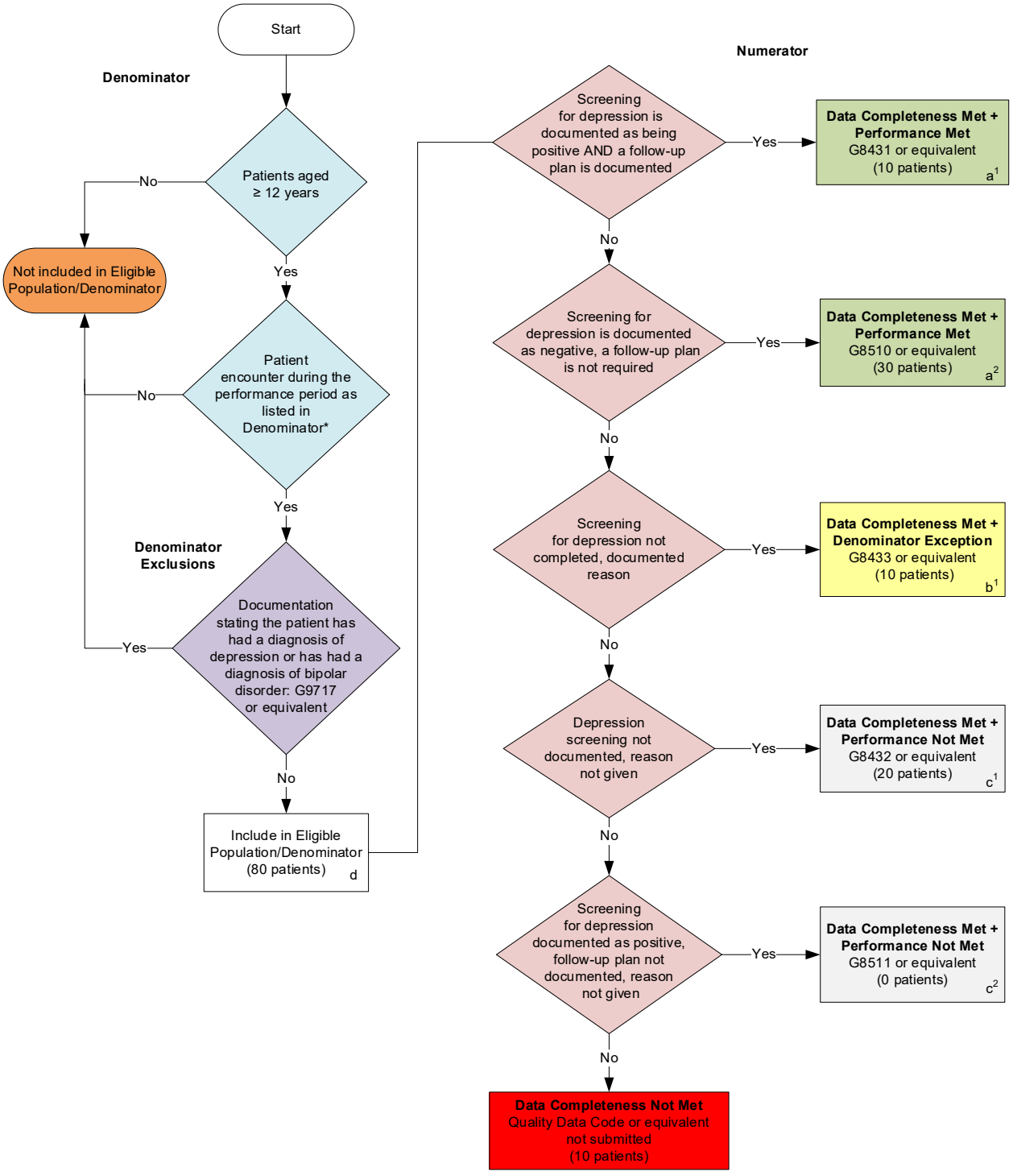
"The USPSTF recommends screening for depression in the general adult population, including pregnant and postpartum women. Screening should be implemented with adequate systems in place to ensure accurate diagnosis, effective treatment, and appropriate follow-up (B recommendation)" (Siu & USPSTF, 2016, p. 380).

The Institute for Clinical Systems Improvement (ICSI) health care guideline, Adult Depression in Primary Care, provides the following recommendations:

1. "Clinicians should routinely screen all adults for depression using a standardized instrument."
2. "Clinicians should establish and maintain follow-up with patients."
3. "Clinicians should screen and monitor depression in pregnant and post-partum women." (Trangle et al., 2016 p.. 8 – 10).

2021 Clinical Quality Measure Flow for Quality ID #134: Preventive Care and Screening: Screening for Depression and Follow-Up Plan

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



SAMPLE CALCULATIONS

Data Completeness Rate=

Performance Met (a^1+a^2=40 patients) + Denominator Exception (b^1=10 patients) + Performance Not Met (c^1+c^2=20 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 = **66.67%**

Data Completeness Numerator (70 patients) - Denominator Exception (b^1=10 patients) = 60 patients

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

NOTE: Submission Frequency: Patient-Intermediate

2021 Clinical Quality Measure Flow Narrative for Quality ID #134: Preventative Care and Screening: Screening for Depression and Follow-Up Plan

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 12 years*:

    a. If *Patients aged greater than or equal to 12 years* equals No, do not include in *Eligible Population/Denominator*. Stop processing.

    b. If *Patients aged greater than or equal to 12 years* 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, proceed to check *Documentation stating the patient has had a diagnosis of depression or has had a diagnosis of bipolar disorder*.

4. Check *Documentation stating the patient has had a diagnosis of depression or has had a diagnosis of bipolar disorder:*

    a. If *Documentation stating the patient has had a diagnosis of depression or has had a diagnosis of bipolar disorder* equals Yes, do not include in *Eligible Population/Denominator*. Stop processing.

    b. If *Documentation stating the patient has had a diagnosis of depression or has had a diagnosis of bipolar disorder* equals No, 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 equals 80 patients in the Sample Calculation.

6. Start Numerator

7. Check *Screening for depression is documented as being positive AND a follow-up plan is documented*:

    a. If *Screening for depression is documented as being positive AND a follow-up plan is documented* 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 10 patients in the Sample Calculation.

    b. If *Screening for depression is documented as being positive AND a follow-up plan is documented* equals No, proceed to check *Screening for depression is documented as negative, a follow-up plan is not*

required.

8. Check *Screening for depression is documented as negative, a follow-up plan is not required*:

    a. If *Screening for depression is documented as negative, a follow-up plan is not required* 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 30 patients in the Sample Calculation.

    b. If *Screening for depression is documented as negative, a follow-up plan is not required* equals No, proceed to check *Screening for depression not completed, documented reason*.

9. Check *Screening for depression not completed, documented reason* :

    a. If *Screening for depression not completed, documented reason* equals Yes, include in the *Data Completeness Met and Denominator Exception*.

        - *Data Completeness Met and Denominator Exception letter is represented as 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 *Screening for depression not completed, documented reason* equals No, proceed to check *Depression screening not documented, reason not given*.

10. Check *Depression screening not documented, reason not given*:

    a. If *Depression screening not documented, 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^1 equals 20 patients in the Sample Calculation.*

    b. If *Depression screening not documented, reason not given* equals No, proceed to check *Screening for depression documented as positive, follow-up plan not documented, reason not given.*

11. Check *Screening for depression documented as positive, follow-up plan not documented, reason not given*:

    a. If *Screening for depression documented as positive, follow-up plan not documented, 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^2 equals 0 patients in the Sample Calculation.*

    b. If *Screening for depression documented as positive, follow-up plan not documented, 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. 10 patients have been subtracted from the Data Completeness Numerator in the Sample Calculation.

Sample Calculations:

Data Completeness Rate equals Performance Met (a^1 plus a^2 equals 40 patients) plus Denominator Exception (b^1 equals 10 patients) plus Performance Not Met (c^1 plus c^2 equals 20 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^1 plus a^2 equals 40 patients) divided by Data Completeness Numerator (70 patients) minus Denominator Exception (b^1 equals 10 patients). All equals 40 patients divided by 60 patients. All equals 66.67 percent.

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

NOTE: Submission Frequency: Patient-Intermediate

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.

Quality ID #226 (NQF 0028): Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention
– 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 tobacco use one or more times within 12 months **AND** who received tobacco cessation intervention if identified as a tobacco user

INSTRUCTIONS:
This measure is to be submitted a minimum of **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 provided the measure-specific denominator coding. For this implementation of the measure, the 12 month look back period includes the program year and the year prior. For Quality Payment Program (QPP) 2021, the 12 month period would be from 1/1/2021-12/31/2021.

This measure will be calculated with 3 performance rates:

1) Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 12 months
2) Percentage of patients aged 18 years and older who were identified as a tobacco user who received tobacco cessation intervention
3) Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 12 months AND who received tobacco cessation intervention if identified as a tobacco user

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 tobacco users received an appropriate tobacco cessation intervention. 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 tobacco 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 tobacco 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 tobacco use

AND

2) All patients who were identified as a tobacco user and who received tobacco cessation intervention

AND

3) All patients who were screened for tobacco use and, if identified as a tobacco user received tobacco cessation intervention, or identified as a tobacco non-user

This measure contains three submission criteria which aim to identify patients who were screened for tobacco use (submission criteria 1), patients who were identified as tobacco users and who received tobacco cessation intervention (submission criteria 2), and a comprehensive look at the overall performance on tobacco screening and cessation intervention (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) can be utilized to compare performance to published versions of this measure prior to the 2018 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 TOBACCO 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):** 90791, 90792, 90832, 90834, 90837, 90845, 92002, 92004, 92012, 92014, 92521, 92522, 92523, 92524, 92540, 92557, 92625, 96156, 96158, 97161, 97162, 97163, 97165, 97166, 97167, 97168, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350
> **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 tobacco use at least once within 12 months

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

In the event that a patient is screened for tobacco use and tobacco status is unknown, submit G9905. Denominator Exception(s) are determined on the date of the most recent denominator eligible encounter for all submission criteria.

Numerator Options:

Performance Met: Patient screened for tobacco use AND identified as a tobacco user **(G9902)**

OR

Performance Met: Patient screened for tobacco use AND identified as a tobacco non-user **(G9903)**

OR

Denominator Exception: Documentation of medical reason(s) for not screening for tobacco use (e.g., limited life expectancy, other medical reason) **(G9904)**

OR

Performance Not Met: Patient not screened for tobacco use, reason not given **(G9905)**

SUBMISSION CRITERIA 2: ALL PATIENTS WHO WERE IDENTIFIED AS A TOBACCO USER AND WHO RECEIVED TOBACCO CESSATION INTERVENTION

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 tobacco use and identified as a tobacco 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 **G9902** is submitted for Performance Met (patient screened for tobacco use and identified as a tobacco user) in the numerator of Submission Criteria 1
AND
At least two patient encounters during the performance period (CPT): 90791, 90792, 90832, 90834, 90837, 90845, 92002, 92004, 92012, 92014, 92521, 92522, 92523, 92524, 92540, 92557, 92625, 96156, 96158, 97161, 97162, 97163, 97165, 97166, 97167, 97168, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350
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 tobacco cessation intervention

Definitions:

Tobacco Cessation Intervention Includes brief counseling (3 minutes or less), and/or pharmacotherapy. Note: For the purpose of this measure, brief counseling (e.g., minimal and intensive advice/counseling interventions conducted both in person and over the phone) qualifies for the numerator. Written self-help materials (e.g., brochures, pamphlets) and complementary/alternative therapies do not qualify for the numerator. Brief counseling also may be of longer duration or be performed more frequently, as evidence shows there is a dose-response relationship between the intensity of counseling provided (either length or frequency) and tobacco cessation rates (U.S. Preventive Services Task Force, 2015).

NUMERATOR NOTE: *If a patient uses any type of tobacco (i.e., smokes or uses smokeless tobacco), the expectation is that they should receive tobacco cessation intervention: either counseling and/or pharmacotherapy.*

This measure defines tobacco cessation counseling as lasting 3 minutes or less. Services typically provided under CPT codes 99406 and 99407 satisfy the requirement of tobacco cessation intervention, as these services provide tobacco cessation counseling for 3-10 minutes. If a patient received these types of services, submit G-code G9906.

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 a tobacco user received tobacco cessation intervention (counseling and/or pharmacotherapy) **(G9906)**
OR	
Denominator Exception:	Documentation of medical reason(s) for not providing tobacco cessation intervention (e.g., limited life expectancy, other medical reason) **(G9907)**
OR	
Performance Not Met:	Patient identified as tobacco user did not receive tobacco cessation intervention (counseling and/or pharmacotherapy), reason not given (**G9908)**

SUBMISSION CRITERIA 3: ALL PATIENTS WHO WERE SCREENED FOR TOBACCO USE AND, IF IDENTIFIED AS A TOBACCO USER RECEIVED TOBACCO CESSATION INTERVENTION, OR IDENTIFIED AS A TOBACCO NON-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): 90791, 90792, 90832, 90834, 90837, 90845, 92002, 92004, 92012, 92014, 92521, 92522, 92523, 92524, 92540, 92557, 92625, 96156, 96158, 97161, 97162, 97163, 97165, 97166, 97167, 97168, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350

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 tobacco use at least once within 12 months **AND** who received tobacco cessation intervention if identified as a tobacco user

Definitions:

Tobacco Use – Includes any type of tobacco.

Tobacco Cessation Intervention – Includes brief counseling (3 minutes or less), and/or pharmacotherapy. Note: For the purpose of this measure, brief counseling (e.g., minimal and intensive advice/counseling interventions conducted both in person and over the phone) qualifies for the numerator. Written self-help materials (e.g., brochures, pamphlets) and complementary/alternative therapies do not qualify for the numerator. Brief counseling also may be of longer duration or be performed more frequently, as evidence shows there is a dose-response relationship between the intensity of counseling provided (either length or frequency) and tobacco cessation rates (U.S. Preventive Services Task Force, 2015).

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

In the event that a patient is screened for tobacco use and identified as a user but did not receive tobacco cessation intervention or if tobacco status is unknown, submit 4004F with 8P.

If a patient uses any type of tobacco (i.e., smokes or uses smokeless tobacco), the expectation is that they should receive tobacco cessation intervention: either counseling and/or pharmacotherapy.

This measure defines tobacco cessation counseling as lasting 3 minutes or less. Services typically provided under CPT codes 99406 and 99407 satisfy the requirement of tobacco cessation intervention, as these services provide tobacco cessation counseling for 3-10 minutes. If a patient received these types of services, submit CPT II 4004F.

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

Numerator Options:

Performance Met:	Patient screened for tobacco use AND received tobacco cessation intervention (counseling, pharmacotherapy, or both), if identified as a tobacco user **(4004F)**
OR	
Performance Met:	Current tobacco non-user **(1036F)**

OR

Denominator Exception:	Documentation of medical reason(s) for not screening for tobacco use (e.g., limited life expectancy, other medical reason) **(4004F *with* 1P)**
OR	
Denominator Exception:	Documentation of medical reason(s) for not providing tobacco cessation intervention if identified as a tobacco user (e.g., limited life expectancy, other

	medical reason) **(G9909)**
OR	
Performance Not Met:	Tobacco screening not performed OR tobacco cessation intervention not provided, reason not otherwise specified **(4004F *with* 8P)**

RATIONALE:

This measure is intended to promote adult 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 using tobacco lower their risk for heart disease, lung disease, and stroke.

CLINICAL RECOMMENDATION STATEMENTS:

The USPSTF recommends that clinicians ask all adults about tobacco use, advise them to stop using tobacco, and provide behavioral interventions and U.S. Food and Drug Administration (FDA)-approved pharmacotherapy for cessation to adults who use tobacco (Grade A Recommendation) (U.S. Preventive Services Task Force, 2015).

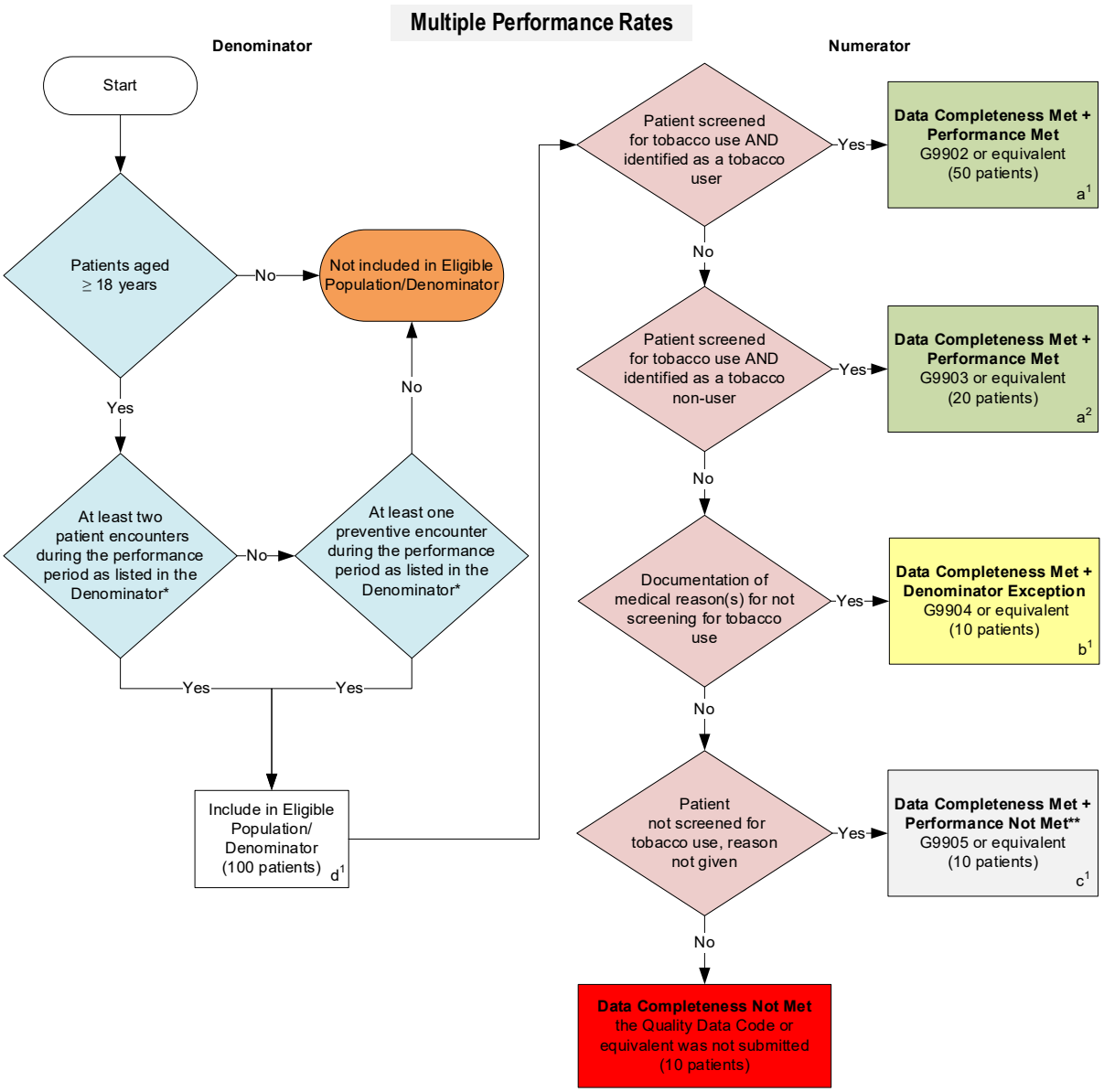
The USPSTF recommends that clinicians ask all pregnant women about tobacco use, advise them to stop using tobacco, and provide behavioral interventions for cessation to pregnant women who use tobacco (Grade A Recommendation) (U.S. Preventive Services Task Force, 2015).

The USPSTF concludes that the current evidence is insufficient to recommend electronic nicotine delivery systems for tobacco cessation in adults, including pregnant women. The USPSTF recommends that clinicians direct patients who smoke tobacco to other cessation interventions with established effectiveness and safety (previously stated) (Grade I Statement) (U.S. Preventive Services Task Force, 2015).

COPYRIGHT:

2021 Clinical Quality Measure for Quality ID #226 (NQF 0028): Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention Submission Criteria One

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



SAMPLE CALCULATIONS: SUBMISSION CRITERIA ONE

Data Completeness=

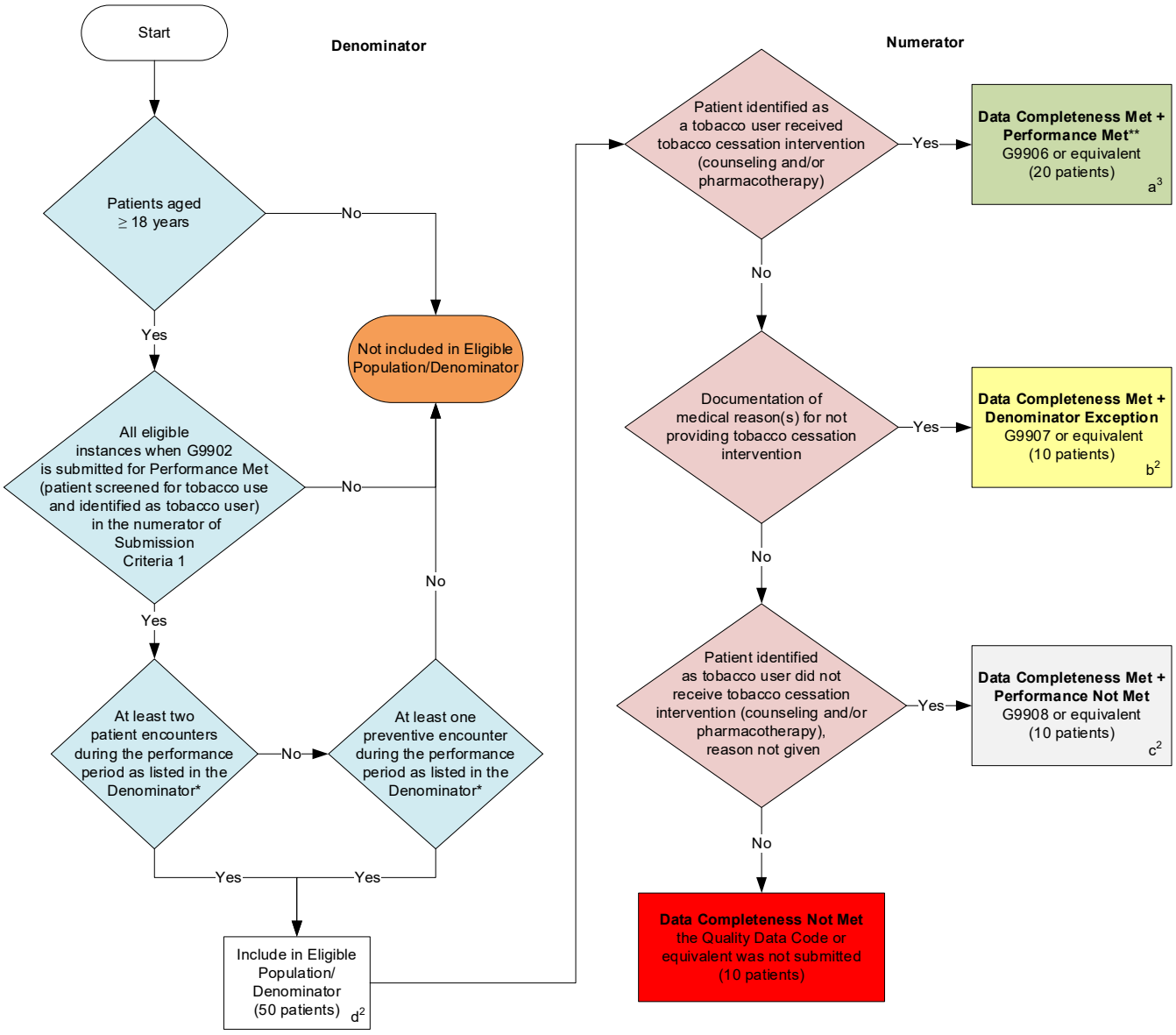
Performance Met (a^1+a^2=70 patients) + Denominator Exception (b^1=10 patients) + Performance Not Met (c^1=10 patients) / Eligible Population / Denominator (d^1=100 patients) = 90 patients / 100 patients = **90.00%**

Performance Rate=

Performance Met (a^1+a^2=70 patients) / Data Completeness Numerator (90 patients) – Denominator Exception (b^1=10 patients) = 70 patients / 80 patients = **87.50%**

*See the posted measure specification for specific coding and instructions to submit this measure.
**In the event that the tobacco status is unknown submit G9905.
NOTE: Submission Frequency: Patient-Process

Submission Criteria Two



SAMPLE CALCULATIONS: SUBMISSION CRITERIA TWO

Data Completeness=

$$\frac{\text{Performance Met } (a^3=20 \text{ patients}) + \text{Denominator Exception } (b^2=10 \text{ patients}) + \text{Performance Not Met } (c^2=10 \text{ patients})}{\text{Eligible Population / Denominator } (d^2=50 \text{ patients})} = \frac{40 \text{ patients}}{50 \text{ patients}} = \mathbf{80.00\%}$$

Performance Rate=

$$\frac{\text{Performance Met } (a^3=20 \text{ patients})}{\text{Data Completeness Numerator (40 patients)} - \text{Denominator Exception } (b^2=10 \text{ patients})} = \frac{20 \text{ patients}}{30 \text{ patients}} = \mathbf{66.67\%}$$

*See the posted measure specification for specific coding and instructions to submit this measure.
**This measure defines tobacco cessation counseling as lasting 3 minutes or less. Services typically provided under CPT codes 99406 and 99407 satisfy the requirement of tobacco cessation intervention, as these services provide tobacco cessation counseling for 3-10 minutes. If a patient received these types of services, submit G-code G9906.
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.
**This measure defines tobacco cessation counseling as lasting 3 minutes or less. Services typically provided under CPT codes 99406 and 99407 satisfy the requirement of tobacco cessation intervention, as these services provide tobacco cessation counseling for 3-10 minutes. If a patient received these types of services, submit 4004F.
***In the event that a patient is identified as a user but did not receive tobacco cessation intervention submit 4004F *with* 8P.
NOTE: Submission Frequency: Patient-Process

2021 Clinical Quality Measure Flow Narrative for Quality ID #226 (NQF 0028): Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention

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 *Patient aged greater than or equal to 18 years*:
    a. If *Patient aged greater than or equal to 18 years* equals No, do not include in *Eligible Population/Denominator*. Stop processing.
    b. If *Patient 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 the Denominator**.
3. Check *At least two patient encounters during the performance period as listed in the Denominator**:
    a. If *At least two patient encounters during the performance period as listed in the Denominator** equals No, proceed to check *At least one preventive encounter during the performance period as listed in the Denominator**.
    b. If *At least two patient encounters during the performance period as listed in the Denominator** equals Yes, include in *Eligible Population/Denominator*.
4. Check *At least one preventive encounter during the performance period as listed in the Denominator**:
    a. If At least one preventive encounter during the performance period as listed in the 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 the 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 screened for tobacco use AND identified as a tobacco user*:
    a. If Patient screened for tobacco use AND identified as a tobacco 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^1 equals 50 patients in the Sample Calculation.*
    b. If *Patient screened for tobacco use AND identified as a tobacco user* equals No, proceed to check *Patient screened for tobacco use AND identified as a tobacco non-user*.

8. Check *Patient screened for tobacco use AND identified as a tobacco non-user*:

    a. If *Patient screened for tobacco use AND identified as a tobacco non-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 tobacco use AND identified as a tobacco non-user* equals No, proceed to check *Documentation of medical reason(s) for not screening for tobacco use*.

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

    a. If *Documentation of medical reason(s) for not screening for tobacco 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^1 equals 10 patients in the Sample Calculation.*

    b. If *Documentation of medical reason(s) for not screening for tobacco use* equals No, proceed to check *Patient not screened for tobacco use, reason not given*.

10. Check *Patient not screened for tobacco use, reason not given*:

    a. If *Patient not screened for tobacco use, 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^1 equals 10 patients in the Sample Calculation.*

    b. If *Patient not screened for tobacco use, 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.

**In the event that the tobacco status is unknown submit G9905.

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 when G9902 is submitted for Performance Met (patient screened for tobacco use and identified as tobacco user) in the numerator of Submission Criteria 1*.
3. Check *All eligible instances when G9902 is submitted for Performance Met (patient screened for tobacco use and identified as tobacco user) in the numerator of Submission Criteria 1*:
    a. If *All eligible instances when G9902 is submitted for Performance Met (patient screened for tobacco use and identified as tobacco user) in the numerator of Submission Criteria 1* equals No, do not include in *Eligible Population/Denominator*. Stop processing.
    b. If *All eligible instances when G9902 is submitted for Performance Met (patient screened for tobacco use and identified as tobacco user) 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 a tobacco user received tobacco cessation intervention (counseling and/or pharmacotherapy)*:

    a. If *Patient identified as a tobacco user received tobacco cessation intervention (counseling and/or pharmacotherapy)* 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 a tobacco user received tobacco cessation intervention (counseling and/or pharmacotherapy)* equals No, proceed to check *Documentation of medical reason(s) for not providing tobacco cessation intervention*.

9. Check *Documentation of medical reason(s) for not providing tobacco cessation intervention*:

    a. If *Documentation of medical reason(s) for not providing tobacco cessation intervention* 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 tobacco cessation intervention* equals No, proceed to check *Patient identified as tobacco user did not receive tobacco cessation intervention (counseling and/or pharmacotherapy), reason not given*.

10. Check *Patient identified as tobacco user did not receive tobacco cessation intervention (counseling and/or pharmacotherapy), reason not given*:

    a. If *Patient identified as tobacco user did not receive tobacco cessation intervention (counseling and/or pharmacotherapy), 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^2 equals 10 patients in the Sample Calculation.

    b. If *Patient identified as tobacco user did not receive tobacco cessation intervention (counseling and/or pharmacotherapy), 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.

**This measure defines tobacco cessation counseling as lasting 3 minutes or less. Services typically provided under CPT codes 99406 and 99407 satisfy the requirement of tobacco cessation intervention, as these services provide tobacco cessation counseling for 3-10 minutes. If a patient received these types of services, submit G-code G9906.

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 *Patient aged greater than or equal to 18 years*:
    a. If *Patient aged greater than or equal to 18 years* equals No, do not include in *Eligible Population/Denominator*. Stop processing.
    b. If *Patient 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 screened for tobacco use and received tobacco cessation intervention (counseling, pharmacotherapy, or both), if identified as a tobacco user*:

a. If *Patient screened for tobacco use and received tobacco cessation intervention (counseling, pharmacotherapy, or both), 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 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 screened for tobacco use and received tobacco cessation intervention (counseling, pharmacotherapy, or both), if identified as a tobacco user* equals No, proceed to check *Current tobacco non-user*.

8. Check *Current tobacco non-user*:

    a. If *Current tobacco non-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^5 equals 20 patients in the Sample Calculation.

    b. If *Current tobacco non-user* equals No, proceed to check *Documentation of medical reason(s) for not screening for tobacco use*.

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

    a. If *Documentation of medical reason(s) for not screening for tobacco 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 tobacco use* equals No, proceed to check *Documentation of medical reason(s) for not providing tobacco cessation intervention if identified as a tobacco user*.

10. Check *Documentation of medical reason(s) for not providing tobacco cessation intervention if identified as a tobacco user*:

    a. If *Documentation of medical reason(s) for not providing tobacco cessation intervention if identified as a tobacco 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 tobacco cessation intervention if identified as a tobacco user* equals No, proceed to check *Tobacco screening not performed OR tobacco cessation intervention not provided, reason not otherwise specified*.

11. Check *Tobacco screening not performed OR tobacco cessation intervention not provided, reason not otherwise specified*:

    a. If *Tobacco screening not performed OR tobacco cessation intervention not provided, reason not otherwise*

specified 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^3 equals 20 patients in the Sample Calculation.

b. If *Tobacco screening not performed OR tobacco cessation intervention not provided, reason not otherwise specified* 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.

**This measure defines tobacco cessation counseling as lasting 3 minutes or less. Services typically provided under CPT codes 99406 and 99407 satisfy the requirement of tobacco cessation intervention, as these services provide tobacco cessation counseling for 3-10 minutes. If a patient received these types of services, submit 4004F.

***In the event that a patient is identified as a user but did not receive tobacco cessation intervention submit 4004F *with* 8P.

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.

Disparity Measure: Emergency Department Utilization for Individuals Experiencing Mental Illness

Measure Basic Information

Name and date of specifications used: HEDIS® MY2020/2021 Technical Specifications for Health Plans (Volume 2) and Oregon-specific definition for identifying individuals with mental illness.

URL of Specifications: N/A

Measure Type:

☐HEDIS ☐PQI ☐Survey ■Other Specify: HEDIS with OHA modification

Measure Utility:

■CCO Incentive ☐State Quality ☐CMS Adult Core Set ☐CMS Child Core Set ☐Other Specify:

Data Source: MMIS/DSSURS

Measurement Period: January 1, 2020 – December 31, 2020; January 1, 2021 – December 31, 2021

Benchmark for OHA MY	2018	2019	2020[1]	2021
MHED	92.9/1000 MM	87.7/1000 MM	N/A (reporting-only)	86.5/1000 MM
Source:	CCO 90th percentile from two years prior			Original 2020 benchmark

2021 Improvement Targets: Minnesota method

Note on telehealth: This measure only counts visits to the emergency department for the numerator. However, the denominator logic for identifying members with mental illness is agnostic about the place of service for the mental illness history claims.

Incentive Measure changes in specifications from 2020 to MY2020/2021:

- HEDIS MY2020/2021 added 38 CPT codes and removed 19 CPT codes for the ED Procedure Code Value Set. Also added 21 ICD10 diagnosis codes for the Mental and Behavioral Disorders Value Set.

Member type: CCO A ■ CCO B ■ CCO G ☐

Specify claims used in the calculation:

MHED	Claim from matching CCO	Denied claims included

[1] Because of disruptions caused by the COVID-19 pandemic, the Metrics & Scoring Committee decided at its July 17, 2020, meeting to make all 2020 CCO incentive measures reporting only.

Mental illness claims for denominator member list	N	N
Numerator ED event	Y	N

Measure Details

Data elements required denominator: 1,000 member months of the adult members enrolled with the organization, who are identified as having experienced mental illness. The adult members are identified as age 18 or older at the end of the measurement year. OHA uses claims from the measurement year, and the two years preceding the measurement year (a rolling look back period for total of 36 months), and the members who had two or more visits[2] with any of the diagnoses in the Members Experiencing Mental Illness Value Set[3] below are identified for inclusion in the denominator:

Members Experiencing Mental Illness Value Set
ICD-10 CM Diagnosis
F200, F201, F202, F203, F205, F2081, F2089, F209, F21, F23, F24, F250, F251, F258, F259, F28, F29, F3010, F3011, F3012, F3013, F302, F303, F304, F308, F309, F310, F3110, F3111, F3112, F3113, F312, F3130, F3131, F3132, F314, F315, F3160, F3161, F3162, F3163, F3164, F3170, F3171, F3172, F3173, F3174, F3175, F3176, F3177, F3178, F3181, F3189, F319, F320, F321, F322, F323, F324, F325, F328, F3289, F329, F330, F331, F332, F333, F3340, F3341, F3342, F338, F339, F348, F3481, F3489, F349, F39, F42, F422, F423, F428, F429, F4310, F4311, F4312, F603

To note, the denominator members are identified on an individual-basis. A member could be included in the measure due to a history of qualifying mental illness claims in the 36-month look back period from any of the organizations in OHP with which they have coverage at the time. Once the members are identified, their length of enrollment (member months) within the measurement year is attributed according to the organizations they have enrolled with for the same year for the denominator. The mental illness claims in the 36-month look back period do not need to match the organization(s) to which the member has enrolled with during the measurement year.

Required exclusions for denominator: Members in hospice are excluded from this measure. These members are identified using HEDIS MY2020/2021 Hospice Encounter Value Set and Hospice Intervention Value Set, with claims within the measurement year. (See HEDIS MY2020/2021 General Guideline 17 for detail.)

Hospice Encounter Value Set	
CPT/HCPCS	**UBREV**
G9473-G9479, Q5003-Q5008, Q5010, S9126, T2042-T2046	0115, 0125, 0135, 0145, 0155, 0235, 0650-0652, 0655-0659

Hospice Intervention Value Set
CPT/HCPCS
99377, 99378, G0182

[2] A 'visit' is defined as a unique member and date of service.
[3] The 'Members Experiencing Mental Illness Value Set' is defined by OHA specifically for the Disparity measure, which should not be confused with the HEDIS Mental Illness Value Set.

Note HEDIS 2020 included SNOMED CT codes in Hospice Encounter Value Set and Hospice Intervention Value Set which are not in the administrative claims data that OHA uses for the measure, therefore these codes are omitted in the above code tables.

Deviations from cited specifications for denominator: None.

Continuous enrollment criteria: None.

Allowable gaps in enrollment: None.

Anchor Date (if applicable): None.

Data elements required numerator: Number of emergency department visits from the denominator members (members experiencing mental illness), during the enrollment span with the organization within the measurement year. Count each visit to an ED that does not result in an inpatient encounter once; count multiple ED visits on the same date of service as one visit. Emergency Department visits are specified by the following codes:

ED Value Set	
CPT	**UB Revenue**
99281-99285	0450, 0451, 0452, 0456, 0459, 0981

OR

ED Procedure Code Value Set		ED POS Value Set
CPT		**POS**
Total of 5,843 CPT codes are included. See HEDIS MY2020/2021 Value Set Dictionary for detail	With	23

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

HEDIS MY2020/2021 General Guideline 44: When an outpatient, ED or observation visit and an inpatient stay are billed on separate claims, the visit results in a stay when the visit date of service occurs on the day prior to the admission date or any time during the admission (admission date through discharge date). A visit billed on the same claim as a stay is considered a visit that resulted in a stay

Inpatient Stay Visits Value Set	
UBREV	0100, 0101, 0110 – 0114, 0116 – 0124, 0126 – 0134, 0136 – 0144, 0146 – 0154, 0156 – 0160, 0164, 0167, 0169 – 0174, 0179, 0190 – 0194, 0199 – 0204, 0206 – 0214, 0219, 1000 – 1002

Required exclusions for numerator: Mental health and chemical dependency services are excluded, using the following codes. Note OHA applies the exclusions at the claim line level and keeps all paid ED claim lines that do not have the exclusion codes, i.e., unless the entire claim was denied or all claim lines qualify for exclusion, the remaining paid lines without mental health and chemical dependency services would pass through the algorithm.

Mental and Behavioral Disorders Value Set
***Principal* ICD-10 CM Diagnosis**
Total of 745 diagnosis codes are included. See HEDIS MY2020/2021 Value Set Dictionary for detail

OR

Psychiatry Value Set
CPT
90785, 90791, 90792, 90832 – 90834, 90836 – 90840, 90845 – 90847, 90849, 90853, 90863, 90865, 90867 - 90870, 90875, 90876, 90880, 90882, 90885, 90887, 90889, 90899

OR

Electroconvulsive Therapy Value Set	
CPT	**ICD-10 PCS Procedure**
90870	GZB0ZZZ, GZB1ZZZ, GZB2ZZZ, GZB3ZZZ, GZB4ZZZ

Deviations from cited specifications for numerator: None.

*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.

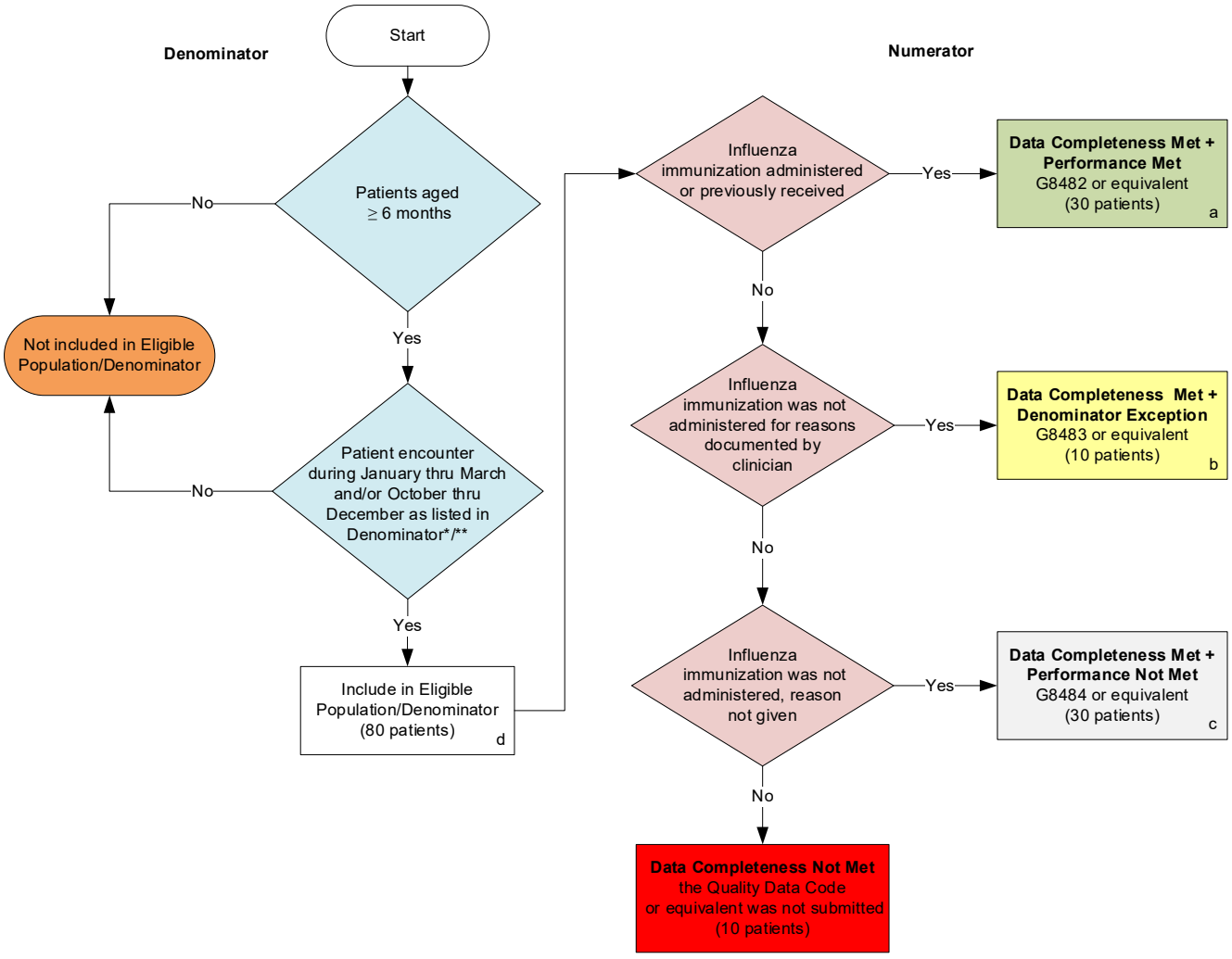
Routine annual influenza vaccination is recommended for all persons aged >= 6 months who do not have contraindications. Optimally, vaccination should occur before onset of influenza activity in the community. Although vaccination by the end of October is recommended, vaccine administered in December 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.