

**Massachusetts Quality Alignment Taskforce Annual Review
Specifications for Core, Menu, Monitoring, and On Deck Measures in the
2022 Aligned Measure Set**

Measure Name	Page Number
Asthma Medication Ratio	2
Breast Cancer Screening	9
Cervical Cancer Screening	15
CG-CAHPS (MHQP version)	20
Child and Adolescent Well-care Visits	28
Childhood Immunization Status	31
Chlamydia Screening in Women	38
Colorectal Cancer Screening	42
Comprehensive Diabetes Care	51
Continuity of Pharmacotherapy for Opioid Use Disorder	69
Controlling High Blood Pressure	76
Follow-up After Emergency Department Visit for Mental Illness	85
Follow-up After Hospitalization for Mental Illness	90
Health-Related Social Needs Screening	95
Immunizations for Adolescents	97
Influenza Immunization	102
Informed, Patient-Centered Hip and Knee Replacement	107
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment	116
Metabolic Monitoring for Children and Adolescents on Antipsychotics	126
Prenatal and Postpartum Care	130
Race, Ethnicity, Language Stratification	138
Screening for Depression and Follow-Up Plan (CMS)	146
Screening for Depression and Follow-Up Plan (MassHealth)	151
Shared Decision-making Process	155
Substance Use Assessment in Primary Care	162
Use of Imaging Studies for Low Back Pain	164
Well-Child Visits in the First 30 Months of Life	169

Asthma Medication Ratio (AMR)

SUMMARY OF CHANGES TO HEDIS MY 2020 & MY 2021

- Removed the restriction that only three of the four visits with an asthma diagnosis be an outpatient telehealth, telephone visit, e-visit or virtual check-in when identifying the event/diagnosis.
- Clarified in step 1 when the diagnosis must be on the discharge claim.
- Added Dupilumab to the “Anti-interleukin-4” description in the [Dupilumab Medications List](#).
- Clarified NDC code mapping requirements in the *Notes*.

Description

The percentage of members 5–64 years of age who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater during the measurement year.

Definitions

Oral medication dispensing event

One prescription of an amount lasting 30 days or less. To calculate dispensing events for prescriptions longer than 30 days, divide the days supply by 30 and round down to convert. For example, a 100-day prescription is equal to three dispensing events ($100/30 = 3.33$, rounded down to 3). Allocate the dispensing events to the appropriate year based on the date on which the prescription is filled.

Multiple prescriptions for different medications dispensed on the same day are counted as separate dispensing events. If multiple prescriptions for the same medication are dispensed on the same day, sum the days supply and divide by 30.

Use the medication lists to determine if drugs are the same or different. Drugs in different medication lists are considered different drugs.

Inhaler dispensing event

When *identifying the eligible population*, use the definition below to count inhaler dispensing events.

All inhalers (i.e., canisters) of the same medication dispensed on the same day count as one dispensing event. Different inhaler medications dispensed on the same day are counted as different dispensing events. For example, if a member received three canisters of Medication A and two canisters of Medication B on the same date, it would count as two dispensing events.

Allocate the dispensing events to the appropriate year based on the date when the prescription was filled.

Use the medication lists to determine if drugs are the same or different. Drugs in different medication lists are considered different drugs.

Injection dispensing event	<p>Each injection counts as one dispensing event. Multiple dispensed injections of the same or different medications count as separate dispensing events. For example, if a member received two injections of Medication A and one injection of Medication B on the same date, it would count as three dispensing events.</p> <p>Use the medication lists to determine if drugs are the same or different. Drugs in different medication lists are considered different drugs.</p> <p>Allocate the dispensing events to the appropriate year based on the date when the prescription was filled.</p>
Units of medication	<p>When identifying medication units for the numerator, count each individual medication, defined as an amount lasting 30 days or less, as one medication unit. One medication unit equals one inhaler canister, one injection, one infusion or a 30-day or less supply of an oral medication. For example, two inhaler canisters of the same medication dispensed on the same day count as two medication units and only one dispensing event.</p> <p>Use the package size and units columns in the medication lists to determine the number of canisters or injections. Divide the dispensed amount by the package size to determine the number of canisters or injections dispensed. For example, if the package size for an inhaled medication is 10 g and pharmacy data indicates the dispensed amount is 30 g, three inhaler canisters were dispensed.</p>

Eligible Population

Note: Members in hospice are excluded from the eligible population. Refer to General Guideline 17: Members in Hospice.

Product lines	Commercial, Medicaid (report each product line separately).
Ages	<p>Ages 5–64 as of December 31 of the measurement year. Report the following age stratifications and total rate:</p> <ul style="list-style-type: none"> • 5–11 years. • 12–18 years. • 19–50 years. • 51–64 years. • Total.
Continuous enrollment	<p>The total is the sum of the age stratifications for each product line.</p> <p>The measurement year and the year prior to the measurement year.</p>
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 during each year of continuous enrollment.
Anchor date	December 31 of the measurement year.
Benefits	Medical. Pharmacy during the measurement year.

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

Step 1 Identify members as having persistent asthma 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 ED visit (ED Value Set), with a principal diagnosis of asthma (Asthma Value Set).
- At least one acute inpatient encounter (Acute Inpatient Value Set), with a principal diagnosis of asthma (Asthma Value Set) **without** telehealth (Telehealth Modifier Value Set; Telehealth POS Value Set).
- At least one acute inpatient discharge with a principal diagnosis of asthma (Asthma 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 four outpatient visits (Outpatient Value Set), observation visits (Observation Value Set), telephone visits (Telephone Visits Value Set) or e-visits or virtual check-ins (Online Assessments Value Set), on different dates of service, with any diagnosis of asthma (Asthma Value Set) **and** at least two asthma medication dispensing events for any controller or reliever medication. Visit type need not be the same for the four visits. Use all the medication lists in the tables below to identify asthma controller and reliever medications.
- At least four asthma medication dispensing events for any controller or reliever medication. Use all the medication lists in the tables below to identify asthma controller and reliever medications.

Step 2 A member identified as having persistent asthma because of at least four asthma medication dispensing events, where leukotriene modifiers or antibody inhibitors were the sole asthma medication dispensed in that year, must also have at least one diagnosis of asthma (Asthma Value Set), in any setting, in the same year as the leukotriene modifier or antibody inhibitor (the measurement year or the year prior to the measurement year).

**Step 3:
Required
exclusions**

Exclude members who met any of the following criteria:

- Members who had any diagnosis from any of the following value sets, any time during the member's history through December 31 of the measurement year:
 - Emphysema Value Set.
 - Other Emphysema Value Set.
 - COPD Value Set.
 - Obstructive Chronic Bronchitis Value Set.
 - Chronic Respiratory Conditions Due to Fumes or Vapors Value Set.
 - Cystic Fibrosis Value Set.
 - Acute Respiratory Failure Value Set.

- Members who had no asthma controller or reliever medications dispensed during the measurement year. Use all the medication lists in the tables below to identify asthma controller and reliever medications.

Administrative Specification

Denominator The eligible population.

Numerator The number of members who have a medication ratio of 0.50 or greater during the measurement year. Follow the steps below to calculate the ratio.

Use all the medication lists in the Asthma Controller Medications table below to identify asthma controller medications. Use all the medication lists in the Asthma Reliever Medications table below to identify asthma reliever medications.

- Step 1** For each member, count the units of asthma controller medications dispensed during the measurement year. Refer to the definition of *Units of medications*.
- Step 2** For each member, count the units of asthma reliever medications dispensed during the measurement year. Refer to the definition of *Units of medications*.
- Step 3** For each member, sum the units calculated in step 1 and step 2 to determine units of total asthma medications.
- Step 4** For each member, calculate the ratio of controller medications to total asthma medications using the following formula. Round (using the .5 rule) to the nearest whole number.

$$\frac{\text{Units of Controller Medications (step 1)}}{\text{Units of Total Asthma Medications (step 3)}}$$

- Step 5** Sum the total number of members who have a ratio of 0.50 or greater in step 4.

Asthma Controller Medications

Description	Prescriptions	Medication Lists	Route
Antiasthmatic combinations	• Dyphylline-guaifenesin	Dyphylline Guaifenesin Medications List	Oral
Antibody inhibitors	• Omalizumab	Omalizumab Medications List	Injection
Anti-interleukin-4	• Dupilumab	Dupilumab Medications List	Injection
Anti-interleukin-5	• Benralizumab	Benralizumab Medications List	Injection
Anti-interleukin-5	• Mepolizumab	Mepolizumab Medications List	Injection
Anti-interleukin-5	• Reslizumab	Reslizumab Medications List	Injection
Inhaled steroid combinations	• Budesonide-formoterol	Budesonide Formoterol Medications List	Inhalation
Inhaled steroid combinations	• Fluticasone-salmeterol	Fluticasone Salmeterol Medications List	Inhalation

Description	Prescriptions	Medication Lists	Route
Inhaled steroid combinations	• Fluticasone-vilanterol	Fluticasone Vilanterol Medications List	Inhalation
Inhaled steroid combinations	• Formoterol-mometasone	Formoterol Mometasone Medications List	Inhalation
Inhaled corticosteroids	• Beclomethasone	Beclomethasone Medications List	Inhalation
Inhaled corticosteroids	• Budesonide	Budesonide Medications List	Inhalation
Inhaled corticosteroids	• Ciclesonide	Ciclesonide Medications List	Inhalation
Inhaled corticosteroids	• Flunisolide	Flunisolide Medications List	Inhalation
Inhaled corticosteroids	• Fluticasone	Fluticasone Medications List	Inhalation
Inhaled corticosteroids	• Mometasone	Mometasone Medications List	Inhalation
Leukotriene modifiers	• Montelukast	Montelukast Medications List	Oral
Leukotriene modifiers	• Zafirlukast	Zafirlukast Medications List	Oral
Leukotriene modifiers	• Zileuton	Zileuton Medications List	Oral
Methylxanthines	• Theophylline	Theophylline Medications List	Oral

Asthma Reliever Medications

Description	Prescriptions	Medication Lists	Route
Short-acting, inhaled beta-2 agonists	Albuterol	Albuterol Medications List	Inhalation
Short-acting, inhaled beta-2 agonists	Levalbuterol	Levalbuterol Medications List	Inhalation

Note

- Do not use RxNorm codes when assessing the numerator.
- When mapping NDC codes, medications described as “injection,” “prefilled syringe,” “subcutaneous,” “intramuscular” or “auto-injector” are considered “injections” (route).
- When mapping NDC codes, medications described as “metered dose inhaler,” “dry powder inhaler” or “inhalation powder” are considered “inhalation” (route) medications.
- Do not map medications described as “nasal spray” to “inhalation” medications.

Data Elements for Reporting

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

Table AMR-1/2: Data Elements for Asthma Medication Ratio

Data Elements	Administrative
Measurement year	✓
Eligible population	<i>For each age stratification and total</i>
Number of required exclusions	<i>For each age stratification and total</i>
Numerator events by administrative data	<i>For each age stratification and total</i>
Numerator events by supplemental data	<i>For each age stratification and total</i>
Reported rate	<i>For each age stratification and total</i>

Rules for Allowable Adjustments of HEDIS

This section *may not* be used for reporting health plan 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.

Rules for Allowable Adjustments for Asthma Medication Ratio

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 within the specified age range (ages 5–64 years). The denominator age may also be expanded to 65 years of age and older.
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	Yes, with limits	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. <i>Note: This measure uses dispensed medications; modifying the measurement period can affect other dates; however, the order and relationship of the events may not be changed.</i>
Denominator Exclusions	Adjustments Allowed (Yes/No)	Notes
Required Exclusions	No	Apply required exclusions according to specified value sets.
Numerator Criteria	Adjustments Allowed (Yes/No)	Notes
Medication ratio of 0.50 or greater	No	Medication Lists and logic may not be changed.

Breast Cancer Screening (BCS)

SUMMARY OF CHANGES TO HEDIS MY 2020 & MY 2021

- Added palliative care as a required exclusion.
- Added telephone visits, e-visits and virtual check-ins to the advanced illness exclusion.
- Added Donepezil-memantine to the “Dementia combinations” description in the Dementia Medications List.
- Added the “Number of required exclusions” data element to the Data Elements for Reporting table.
- Added guidance adjusting required exclusions criteria in the *Rules for Allowable Adjustments* section.

Description

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

Eligible Population

Note: Members in hospice are excluded from the eligible population. Refer to General Guideline 17: Members in Hospice.

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 exclusion 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	<ul style="list-style-type: none"> • Donepezil • Galantamine • Rivastigmine
Miscellaneous central nervous system agents	<ul style="list-style-type: none"> • Memantine
Dementia combinations	<ul style="list-style-type: none"> • Donepezil-memantine

Administrative Specification

Denominator	The eligible population.
Numerator	One or more mammograms (<u>Mammography Value Set</u>) 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).
- Unilateral mastectomy found in clinical data (Clinical Unilateral Mastectomy Value Set) with a bilateral modifier (Clinical Bilateral Modifier Value Set).
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)
<ul style="list-style-type: none"> Unilateral mastectomy (<u>Unilateral Mastectomy Value Set</u>) with a left-side modifier (<u>Left Modifier Value Set</u>) (same procedure) 	<ul style="list-style-type: none"> Unilateral mastectomy (<u>Unilateral Mastectomy Value Set</u>) with a right-side modifier (<u>Right Modifier Value Set</u>) (same procedure)
<ul style="list-style-type: none"> Unilateral mastectomy found in clinical data (<u>Clinical Unilateral Mastectomy Value Set</u>) with a left-side modifier (<u>Clinical Left Modifier Value Set</u>) (same procedure) 	<ul style="list-style-type: none"> Unilateral mastectomy found in clinical data (<u>Clinical Unilateral Mastectomy Value Set</u>) with a right-side modifier (<u>Clinical Right Modifier Value Set</u>) (same procedure)
<ul style="list-style-type: none"> Absence of the left breast (<u>Absence of Left Breast Value Set</u>) 	<ul style="list-style-type: none"> Absence of the right breast (<u>Absence of Right Breast Value Set</u>)
<ul style="list-style-type: none"> Left unilateral mastectomy (<u>Unilateral Mastectomy Left Value Set</u>) 	<ul style="list-style-type: none"> Right unilateral mastectomy (<u>Unilateral Mastectomy Right Value Set</u>)

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

	Administrative
Measurement year	✓
Eligible population	✓
Number of optional exclusions	✓
Number of required exclusions	✓
Numerator events by administrative data	✓
Numerator events by supplemental data	✓
Reported rate	✓

Table BCS-3: Data Elements for Breast Cancer Screening

	Administrative
Measurement year	✓
Eligible population	<i>Each of the 6 stratifications and total</i>
Number of optional exclusions	<i>Each of the 6 stratifications and total</i>
Number of required exclusions	<i>Each of the 6 stratifications and total</i>
Numerator events by administrative data	<i>Each of the 6 stratifications and total</i>
Numerator events by supplemental data	<i>Each of the 6 stratifications and total</i>
Reported rate	<i>Each of the 6 stratifications and total</i>

Rules for Allowable Adjustments of HEDIS

This section *may not* be used for reporting health plan 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.

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 palliative care exclusion is not required. Refer to <i>Exclusions</i> in the <i>Guidelines for the Rules for Allowable Adjustments</i> .
Exclusions: I-SNP, LTI, Frailty or Advanced Illness	Yes	These exclusions are not required. Refer to <i>Exclusions</i> in the <i>Guidelines for the Rules for Allowable Adjustments</i> .
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 2020 & MY 2021

- Added palliative care as a required exclusion.
- Updated the Hybrid Specification to indicate that sample size reduction is allowed.
- Clarified that documentation of “vaginal hysterectomy” meets criteria for documentation of hysterectomy with no residual cervix (optional exclusion).
- Added the “Number of required exclusions” data element to the Data Elements for Reporting table.
- Added guidance adjusting required exclusions criteria in the *Rules for Allowable Adjustments* section.

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

Note: Members in hospice are excluded from the eligible population. If an organization reports this measure using the Hybrid method, and a member is found to be in hospice or using hospice services during medical record review, the member is removed from the sample and replaced by a member from the oversample. Refer to General Guideline 17: Members in Hospice.

Product lines	Commercial, Medicaid (report each product line separately).
Ages	Women 24–64 years as of December 31 of the measurement year.
Continuous enrollment	<p><i>Commercial:</i> The measurement year and the two years prior to the measurement year.</p> <p><i>Medicaid:</i> The measurement year.</p>
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 exclusion	Members receiving palliative care (<u>Palliative Care Assessment Value Set</u> ; <u>Palliative Care Encounter Value Set</u> ; <u>Palliative Care Intervention Value Set</u>) during the measurement year.

Administrative Specification

Denominator	The eligible population.
Numerator	<p>The number of women who were screened for cervical cancer. Either of the following meets criteria:</p> <ul style="list-style-type: none"> • Women 24–64 years of age as of December 31 of the measurement year who had cervical cytology (<u>Cervical Cytology Lab Test Value Set</u>; <u>Cervical Cytology Result or Finding Value Set</u>) 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 (<u>High Risk HPV Lab Test Value Set</u>, <u>High Risk HPV Test Result or Finding Value Set</u>) 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. <p>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.</p>

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 <i>Guidelines for Calculations and Sampling</i> 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 <i>Administrative Specification</i> to identify positive numerator hits from the administrative data.
Medical record	<p>Appropriate screenings are defined by any of the following:</p> <ul style="list-style-type: none"> • 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. <ul style="list-style-type: none"> – Documentation in the medical record must include both of the following: <ul style="list-style-type: none"> ▪ 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

	Administrative	Hybrid
Measurement year	✓	✓
Data collection methodology (Administrative or Hybrid)	✓	✓
Eligible population	✓	✓
Number of required exclusions	✓	✓
Number of numerator events by administrative data in eligible population (before exclusions)		✓
Current year's administrative rate (before exclusions)		✓
Minimum required sample size (MRSS)		✓
Oversampling rate		✓
Number of oversample records		✓
Number of medical records excluded because of valid data errors		✓
Number of administrative data records excluded		✓
Number of medical records excluded		✓
Number of employee/dependent medical records excluded		✓
Records added from the oversample list		✓
Denominator		✓
Numerator events by administrative data	✓	✓
Numerator events by medical records		✓
Numerator events by supplemental data	✓	✓
Reported rate	✓	✓

Rules for Allowable Adjustments of HEDIS

This section *may not* be used for reporting health plan 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.

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 palliative care exclusion is not required. Refer to <i>Exclusions</i> in the <i>Guidelines for the Rules for Allowable Adjustments</i>
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.

SURVEY ABOUT YOUR EXPERIENCES WITH YOUR PROVIDER

YOUR PROVIDER

1. Our records show that you got care from the provider named below in the last 12 months.

Is that right?

- ☐ Yes
☐ No → **If No, go to #31 on page 3**

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

2. Is this the provider you usually see if you need a check-up, want advice about a health problem, or get sick or hurt?
- ☐ Yes
☐ No
3. How long have you been going to this provider?
- ☐ Less than 6 months
☐ At least 6 months but less than 1 year
☐ At least 1 year but less than 3 years
☐ At least 3 years but less than 5 years
☐ 5 years or more
4. In the last 12 months, did you call this provider’s office to get an appointment for an illness, injury, or condition that **needed care right away**?
- ☐ Yes
☐ No → **If No, go to #6**
5. In the last 12 months, when you called this provider’s office to get an appointment for **care you needed right away**, how often did you get an appointment as soon as you needed?
- ☐ Never
☐ Sometimes
☐ Usually
☐ Always

6. In the last 12 months, did you make any appointments for a **check-up or routine care** with this provider?
- ☐ Yes
☐ No → **If No, go to #8**
7. In the last 12 months, when you made an appointment for a **check-up or routine care** with this provider, how often did you get an appointment as soon as you needed?
- ☐ Never
☐ Sometimes
☐ Usually
☐ Always
8. Did this provider’s office give you information about what to do if you needed care during evenings, weekends, or holidays?
- ☐ Yes
☐ No
9. In the last 12 months, did you call this provider’s office with a medical question during regular office hours?
- ☐ Yes
☐ No → **If No, go to #11**
10. In the last 12 months, when you called this provider’s office during regular office hours, how often did you get an answer to your medical question that same day?
- ☐ Never
☐ Sometimes
☐ Usually
☐ Always

MANAGING YOUR CARE

11. In the last 12 months, how often did this provider explain things in a way that was easy to understand?
- ☐ Never
☐ Sometimes
☐ Usually
☐ Always
12. In the last 12 months, how often did this provider listen carefully to you?
- ☐ Never
☐ Sometimes
☐ Usually
☐ Always

13. In the last 12 months, how often did this provider seem to know the important information about your medical history?

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

14. In the last 12 months, how often did this provider show respect for what you had to say?

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

15. In the last 12 months, how often did this provider spend enough time with you?

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

16. How would you rate this provider's knowledge of you as a person, including values and beliefs that are important to you?

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

COORDINATING YOUR CARE

17. Specialists are doctors like surgeons, heart doctors, allergy doctors, skin doctors, and other doctors who specialize in one area of health care. In the last 12 months, did you see a specialist for a particular health problem?

- ☐ Yes
- ☐ No → **If No, go to #19**

18. In the last 12 months, how often did the provider named in Question 1 seem informed and up-to-date about the care you got from specialists?

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

19. In the last 12 months, did the provider named in Question 1 order a blood test, x-ray, or other test for you?

- ☐ Yes
- ☐ No → **If No, go to #21**

20. In the last 12 months, when this provider ordered a blood test, x-ray, or other test for you, how often did someone from this provider's office follow up to give you these results?

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

OVERALL RATING

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

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

22. Would you **recommend** this provider to your family and friends?

- ☐ Definitely yes
- ☐ Probably yes
- ☐ Not sure
- ☐ Probably not
- ☐ Definitely not

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

23. In the last 12 months, did you and anyone in this provider's office talk about specific goals for your health?
- ☐ Yes
 - ☐ No
24. In the last 12 months, did anyone in this provider's office ask you if there are things that make it hard for you to take care of your health?
- ☐ Yes
 - ☐ No
25. In the last 12 months, did you take any prescription medicine?
- ☐ Yes
 - ☐ No → **If No, go to #27**
26. In the last 12 months, how often did you and someone from this provider's office talk about all the prescription medicines you were taking?
- ☐ Never
 - ☐ Sometimes
 - ☐ Usually
 - ☐ Always
27. In the last 12 months, did anyone in this provider's office ask you if there was a period of time when you felt sad, empty, or depressed?
- ☐ Yes
 - ☐ No
28. In the last 12 months, did you and anyone in this provider's office talk about things in your life that worry you or cause you stress?
- ☐ Yes
 - ☐ No

OFFICE STAFF

29. In the last 12 months, how often were the front office staff at this provider's office as helpful as you thought they should be?
- ☐ Never
 - ☐ Sometimes
 - ☐ Usually
 - ☐ Always
30. In the last 12 months, how often did the front office staff at this provider's office treat you with courtesy and respect?
- ☐ Never
 - ☐ Sometimes
 - ☐ Usually
 - ☐ Always

ABOUT YOU

31. In general, how would you rate your overall health?
- ☐ Excellent
 - ☐ Very good
 - ☐ Good
 - ☐ Fair
 - ☐ Poor
32. In general, how would you rate your overall **mental or emotional** health?
- ☐ Excellent
 - ☐ Very good
 - ☐ Good
 - ☐ Fair
 - ☐ Poor
33. What is your age?
- ☐ 18 to 24
 - ☐ 25 to 34
 - ☐ 35 to 44
 - ☐ 45 to 54
 - ☐ 55 to 64
 - ☐ 65 to 74
 - ☐ 75 or older

34. Are you male or female?

- ☐ Male
- ☐ Female

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

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

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

- ☐ Yes, Hispanic or Latino
- ☐ No, not Hispanic or Latino

37. What is your race? Mark one or more.

- ☐ White
- ☐ Black or African American
- ☐ Asian
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ American Indian or Alaska Native
- ☐ Other

38. Did someone help you complete this survey?

- ☐ Yes
- ☐ No



Thank you.

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

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

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

Please print: _____

THANK YOU

Please return the completed survey in the postage-paid envelope to:

**The Center for the Study of Services
PO Box 10820
Herndon, VA 20172-9940**

If you have any questions please call the toll-free number 1-888-344-0430. Please do not include any other correspondence.

SURVEY ABOUT YOUR EXPERIENCES WITH YOUR CHILD'S PROVIDER

YOUR CHILD'S PROVIDER

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

1. Our records show that your child got care from the provider named below in the last 12 months.

Is that right?

☐ Yes

☐ No → If No, go to #45 on page 4

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

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

☐ Yes

☐ No

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

☐ Less than 6 months

☐ At least 6 months but less than 1 year

☐ At least 1 year but less than 3 years

☐ At least 3 years but less than 5 years

☐ 5 years or more

4. In the last 12 months, did you ever stay in the exam room with your child during a visit to this provider?

☐ Yes

→ If Yes, go to #6

☐ No

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

☐ Yes

→ If Yes, go to #9

☐ No

→ If No, go to #9

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

☐ Yes

☐ No → If No, go to #9

7. In the last 12 months, how often did this provider explain things in a way that was easy for **your child** to understand?

☐ Never

☐ Sometimes

☐ Usually

☐ Always

8. In the last 12 months, how often did this provider listen carefully to **your child**?

☐ Never

☐ Sometimes

☐ Usually

☐ Always

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

☐ Yes

☐ No → If No, go to #11

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

☐ Yes

☐ No

SCHEDULING APPOINTMENTS AND CONTACTING THIS PROVIDER

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

☐ Yes

☐ No → If No, go to #13

12. In the last 12 months, when you called this provider's office for an appointment for care your child **needed right away**, how often did you get an appointment as soon as your child needed?

☐ Never

☐ Sometimes

☐ Usually

☐ Always

13. In the last 12 months, did you make any appointments for a **check-up or routine care** for your child with this provider?

☐ Yes

☐ No → If No, go to #15 on page 2

14. In the last 12 months, when you made an appointment for a **check-up or routine care** for your child with this provider, how often did you get an appointment as soon as your child needed?

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

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

- ☐ Yes
- ☐ No

16. In the last 12 months, did you call this provider's office with a medical question about your child during regular office hours?

- ☐ Yes
- ☐ No

→ **If No, go to #18**

17. In the last 12 months, when you called this provider's office during regular office hours, how often did you get an answer to your medical question that same day?

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

MANAGING YOUR CHILD'S CARE

18. In the last 12 months, how often did this provider explain things about your child's health in a way that was easy to understand?

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

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

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

20. In the last 12 months, how often did this provider seem to know the important information about your child's medical history?

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

21. In the last 12 months, how often did this provider show respect for what you had to say?

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

22. In the last 12 months, how often did this provider spend enough time with your child?

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

23. How would you rate this provider's knowledge about your child as a person – special abilities, concerns, fears?

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

COORDINATING YOUR CHILD'S CARE

24. Specialists are doctors like surgeons, heart doctors, allergy doctors, skin doctors, and other doctors who specialize in one area of health care. In the last 12 months, did your child see a specialist for a particular health problem?

- ☐ Yes
- ☐ No

→ **If No, go to #26**

25. In the last 12 months, how often did the provider named in Question 1 seem informed and up-to-date about the care your child got from specialists?

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

26. In the last 12 months, did the provider named in Question 1 order a blood test, x-ray, or other test for your child?

- ☐ Yes
- ☐ No

→ **If No, go to #28 on page 3**

27. In the last 12 months, when this provider ordered a blood test, x-ray, or other test for your child, how often did someone from this provider's office follow up to give you these results?

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

OVERALL RATING

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

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

29. Would you **recommend** this provider to your family and friends?

☐ Definitely yes
☐ Probably yes
☐ Not sure
☐ Probably not
☐ Definitely not

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

30. In the last 12 months, did you and anyone in this provider's office talk about your child's learning ability?

☐ Yes
☐ No

31. In the last 12 months, did you and anyone in this provider's office talk about the kinds of behaviors that are normal for your child at this age?

☐ Yes
☐ No

32. In the last 12 months, did you and anyone in this provider's office talk about how your child's body is growing?

☐ Yes
☐ No

33. In the last 12 months, did you and anyone in this provider's office talk about your child's moods and emotions?

☐ Yes
☐ No

34. In the last 12 months, did you and anyone in this provider's office talk about things you can do to keep your child from getting injured?

☐ Yes
☐ No

35. In the last 12 months, did anyone in this provider's office give you information about how to keep your child from getting injured?

☐ Yes
☐ No

36. In the last 12 months, did you and anyone in this provider's office talk about how much time your child spends on a computer and in front of a TV?

☐ Yes
☐ No

37. In the last 12 months, did you and anyone in this provider's office talk about how much or what kind of food your child eats?

☐ Yes
☐ No

38. In the last 12 months, did you and anyone in this provider's office talk about how much or what kind of exercise your child gets?

☐ Yes
☐ No

39. In the last 12 months, did you and anyone in this provider's office talk about how your child gets along with others?

☐ Yes
☐ No

40. In the last 12 months, did you and anyone in this provider's office talk about whether there are any problems in your household that might affect your child?

☐ Yes
☐ No

41. In the last 12 months, did you and anyone in this provider's office talk about specific goals for your child's health?

☐ Yes
☐ No

42. In the last 12 months, did anyone in this provider's office ask you if there are things that make it hard for you to take care of your child's health?

☐ Yes
☐ No

OFFICE STAFF

43. In the last 12 months, how often were the front office staff at this provider's office as helpful as you thought they should be?
- ☐ Never
 - ☐ Sometimes
 - ☐ Usually
 - ☐ Always
44. In the last 12 months, how often did the front office staff at this provider's office treat you with courtesy and respect?
- ☐ Never
 - ☐ Sometimes
 - ☐ Usually
 - ☐ Always

ABOUT YOUR CHILD AND YOU

45. In general, how would you rate your child's overall health?
- ☐ Excellent
 - ☐ Very good
 - ☐ Good
 - ☐ Fair
 - ☐ Poor
46. In general, how would you rate your child's overall **mental or emotional** health?
- ☐ Excellent
 - ☐ Very good
 - ☐ Good
 - ☐ Fair
 - ☐ Poor
47. What is your child's age?
- ☐ Less than 2 years old
 - ☐ 2 to 4 years old
 - ☐ 5 to 9 years old
 - ☐ 10 to 14 years old
 - ☐ 15 to 18 years old
48. Is your child male or female?
- ☐ Male
 - ☐ Female
49. Is your child of Hispanic or Latino origin or descent?
- ☐ Yes, Hispanic or Latino
 - ☐ No, not Hispanic or Latino

50. What is your child's race? Mark one or more.
- ☐ White
 - ☐ Black or African American
 - ☐ Asian
 - ☐ Native Hawaiian or Other Pacific Islander
 - ☐ American Indian or Alaska Native
 - ☐ Other

51. What is **your** age?

- ☐ Under 18
- ☐ 18 to 24
- ☐ 25 to 34
- ☐ 35 to 44
- ☐ 45 to 54
- ☐ 55 to 64
- ☐ 65 to 74
- ☐ 75 or older

52. Are you male or female?

- ☐ Male
- ☐ Female

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

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

54. How are you related to the child?

- ☐ Mother or father
- ☐ Grandparent
- ☐ Aunt or uncle
- ☐ Older brother or sister
- ☐ Other relative
- ☐ Legal guardian
- ☐ Someone else

Please print: _____

THANK YOU

Please return the completed survey in the postage-paid envelope to:

**The Center for the Study of Services
PO Box 10820
Herndon, VA 20172-9940**

If you have any questions please call the toll-free number 1-888-344-0430. Please do not include any other correspondence.

Child and Adolescent Well-Care Visits (WCV)

SUMMARY OF CHANGES TO HEDIS MY 2020 & MY 2021

- This measure is a combination measure that replaces the former “Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life” and “Adolescent Well-Care Visits” HEDIS measures.
- Added members age 7–11 years.
- Added age stratifications.
- Removed the Hybrid Data Collection Method.
- Removed the telehealth exclusion.
- Revised the Data Elements for Reporting table.
- Revised the Ages criteria in the *Rules for Allowable Adjustments* section to only allow ranges within the specified age range.

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.

Eligible Population

Note: Members in hospice are excluded from the eligible population. Refer to General Guideline 17: Members in Hospice.

Product lines	Commercial, Medicaid (report each product line separately).
Ages	3–21 years as of December 31 of the measurement year. Report three age stratifications and total rate: <ul style="list-style-type: none">• 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.

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 practitioners.
- 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-1/2: Data Elements for Child and Adolescent Well-Care Visits

	Administrative
Measurement year	✓
Eligible population	<i>For each age stratification and total</i>
Numerator events by administrative data	<i>For each age stratification and total</i>
Numerator events by supplemental data	<i>For each age stratification and total</i>
Reported rate	<i>For each age stratification and total</i>

Rules for Allowable Adjustments of HEDIS

This section *may not* be used for reporting health plan 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.

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
Exclusions	NA	There are no exclusions for this measure.
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 2020 & MY 2021

- Added a requirement that LAIV (influenza) vaccination must occur on the child's second birthday.

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 nine separate combination rates.

Eligible Population

Note: Members in hospice are excluded from the eligible population. If an organization reports this measure using the Hybrid method, and a member is found to be in hospice or using hospice services during medical record review, the member is removed from the sample and replaced by a member from the oversample. Refer to General Guideline 17: Members in Hospice.

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.

Administrative Specification

Denominator	The eligible population.
Numerators	For MMR, hepatitis B, VZV and hepatitis A, count any of the following: <ul style="list-style-type: none"> Evidence of the antigen or combination vaccine, or Documented history of the illness, or A seropositive test result for each antigen.

For DTaP, IPV, HiB, pneumococcal conjugate, rotavirus 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.

DTaP At least four DTaP vaccinations (DTaP Immunization Value Set; DTaP 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.

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 Any of the following meet 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.
- At least one measles and rubella vaccination (Measles Rubella Immunization Value Set; Measles Rubella Vaccine Procedure Value Set) on or between the child's first and second birthdays **and** one of the following:
 - At least one mumps vaccination (Mumps Immunization Value Set; Mumps Vaccine Procedure Value Set) on or between the child's first and second birthdays.
 - History of mumps illness (Mumps Value Set) any time on or before the child's second birthday.
- Any combination of codes from the table below that indicates evidence of all three antigens (on the same or different date of service).

Measles (any of the following)	Mumps (any of the following)	Rubella (any of the following)
<ul style="list-style-type: none"> • At least one measles vaccination (<u>Measles Immunization Value Set</u>; <u>Measles Vaccine Procedure Value Set</u>) administered on or between the child's first and second birthdays. 	<ul style="list-style-type: none"> • At least one mumps vaccination (<u>Mumps Immunization Value Set</u>; <u>Mumps Vaccine Procedure Value Set</u>) administered on or between the child's first and second birthdays. 	<ul style="list-style-type: none"> • At least one rubella vaccination (<u>Rubella Immunization Value Set</u>; <u>Rubella Vaccine Procedure Value Set</u>) administered on or between the child's first and second birthdays.
<ul style="list-style-type: none"> • History of measles (<u>Measles Value Set</u>) illness anytime on or before the child's second birthday. 	<ul style="list-style-type: none"> • History of mumps (<u>Mumps Value Set</u>) illness anytime on or before the child's second birthday. 	<ul style="list-style-type: none"> • History of rubella (<u>Rubella Value Set</u>) illness anytime on or before the child's second birthday.

Note: General Guideline 35: Collecting Data for Measures With Multiple Numerator Events (the 14-day rule) does not apply to MMR.

HiB 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 on or before the child's second birthday. Do not count a vaccination administered prior to 42 days after birth.

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 illness (Hepatitis B Value Set).

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

Influenza

Vaccine (3 Dose Schedule) Procedure Value Set), all on different dates of service.

- 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 Combination 2–Combination 10.

Combination Vaccinations for Childhood Immunization Status

Combination	DTaP	IPV	MMR	HiB	HepB	VZV	PCV	HepA	RV	Influenza
Combination 2	✓	✓	✓	✓	✓	✓				
Combination 3	✓	✓	✓	✓	✓	✓	✓			
Combination 4	✓	✓	✓	✓	✓	✓	✓	✓		
Combination 5	✓	✓	✓	✓	✓	✓	✓		✓	
Combination 6	✓	✓	✓	✓	✓	✓	✓			✓
Combination 7	✓	✓	✓	✓	✓	✓	✓	✓	✓	
Combination 8	✓	✓	✓	✓	✓	✓	✓	✓		✓
Combination 9	✓	✓	✓	✓	✓	✓	✓		✓	✓
Combination 10	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓

Exclusion (optional)

- Exclude children who had a contraindication for a specific vaccine from the denominator for all antigen rates and the combination rates. The denominator for all rates must be the same.
- Exclude contraindicated children only if administrative data do not indicate that the contraindicated immunization was rendered in its entirety.

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

Any particular vaccine

- Anaphylactic reaction to the vaccine or its components (Anaphylactic Reaction Due To Vaccination Value Set).

DTaP

- Encephalopathy (Encephalopathy Due To Vaccination Value Set) **with** a vaccine adverse-effect code (Vaccine Causing Adverse Effect Value Set).

MMR, VZV and influenza

- 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).

- Anaphylactic reaction to neomycin.

- Rotavirus**
 - Severe combined immunodeficiency (Severe Combined Immunodeficiency Value Set).
 - History of intussusception (Intussusception Value Set).
- IPV**
 - Anaphylactic reaction to streptomycin, polymyxin B or neomycin.
- Hepatitis B**
 - Anaphylactic reaction to common baker's yeast.

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 <i>Guidelines for Calculations and Sampling</i> for information on reducing sample size.
Numerators	<p>For MMR, hepatitis B, VZV and hepatitis A, count any of the following:</p> <ul style="list-style-type: none"> • Evidence of the antigen or combination vaccine. • Documented history of the illness. • A seropositive test result. <p>For DTaP, HiB, IPV, pneumococcal conjugate, rotavirus and influenza, count <i>only</i>:</p> <ul style="list-style-type: none"> • Evidence of the antigen or combination vaccine. <p>For combination vaccinations that require more than one antigen (DTaP and MMR), the organization must find evidence of all the antigens.</p>
Administrative	Refer to <i>Administrative Specification</i> to identify positive numerator hits from the administrative data.
Medical record	<p>For immunization evidence obtained from the medical record, count members where there is evidence that the antigen was rendered from one of the following:</p> <ul style="list-style-type: none"> • 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. <p>For documented history of illness or a seropositive test result, there must be a note indicating the date of the event, which must have occurred by the member's second birthday.</p> <p>Notes in the medical record indicating that the member received the immunization "at delivery" or "in the hospital" may be counted toward the numerator <i>only</i> 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.</p>

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.

Exclusion (*optional*)

Refer to *Administrative Specification* for exclusion criteria. The exclusion must have occurred by the member’s second birthday.

Note

- *This measure follows the CDC and ACIP guidelines for immunizations.*

Chlamydia Screening in Women (CHL)

SUMMARY OF CHANGES TO HEDIS MY 2020 & MY 2021

- No changes to this measure.

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

Note: Members in hospice are excluded from the eligible population. Refer to General Guideline 17: Members in Hospice.

Product lines	Commercial, Medicaid (report each product line separately).
Ages	<p>Women 16–24 years as of December 31 of the measurement year. Report two age stratifications and a total rate:</p> <ul style="list-style-type: none"> • 16–20 years. • 21–24 years. • Total. <p>The total is the sum of the age stratifications.</p>
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	<p><i>Sexually active.</i> 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.</p> <p><i>Claim/encounter data.</i> Members who had a claim or encounter indicating sexual activity during the measurement year. A code from any of the following meets criteria:</p> <ul style="list-style-type: none"> • <u>Pregnancy Value Set.</u> • <u>Sexual Activity Value Set.</u> • <u>Pregnancy Tests Value Set.</u>

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

Contraceptive Medications

Description	Prescription
Contraceptives	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • Diaphragm
Spermicide	<ul style="list-style-type: none"> • Nonoxynol 9

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	<ul style="list-style-type: none"> • 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

	Administrative
Measurement year	✓
Eligible population	<i>For each age stratification and total</i>
Number of optional exclusions	<i>For each age stratification and total</i>
Numerator events by administrative data	<i>For each age stratification and total</i>
Numerator events by supplemental data	<i>For each age stratification and total</i>
Reported rate	<i>For each age stratification and total</i>

Rules for Allowable Adjustments of HEDIS

This section *may not* be used for reporting health plan 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.

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
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 2020 & MY 2021

- Added palliative care as a required exclusion.
- Added telephone visits, e-visits and virtual check-ins to the advanced illness exclusion.
- Added Donepezil-memantine to the “Dementia combinations” description in the Dementia Medications List.
- Added the “Number of required exclusions” data element to the Data Elements for Reporting table.
- Added guidance adjusting required exclusions criteria in the *Rules for Allowable Adjustments* section.

Description

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

Eligible Population

Note: Members in hospice are excluded from the eligible population. If an organization reports this measure using the Hybrid method, and a member is found to be in hospice or using hospice services during medical record review, the member is removed from the sample and replaced by a member from the oversample. Refer to General Guideline 17: Members in Hospice.

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: The stratifications are mutually exclusive, and the sum of all six stratifications 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
exclusion**

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	<ul style="list-style-type: none"> • Donepezil • Galantamine • Rivastigmine
Miscellaneous central nervous system agents	<ul style="list-style-type: none"> • Memantine
Dementia combinations	<ul style="list-style-type: none"> • Donepezil-memantine

Administrative Specification

Denominator	The eligible population.
Numerator	<p>One or more screenings for colorectal cancer. Any of the following meet criteria:</p> <ul style="list-style-type: none"> • Fecal occult blood test (<u>FOBT Lab Test Value Set</u>; <u>FOBT Test Result or Finding Value Set</u>) during the measurement year. For administrative data, assume the required number of samples were returned, regardless of FOBT type. • Flexible sigmoidoscopy (<u>Flexible Sigmoidoscopy Value Set</u>; <u>History of Flexible Sigmoidoscopy Value Set</u>) during the measurement year or the four years prior to the measurement year. • Colonoscopy (<u>Colonoscopy Value Set</u>; <u>History of Colonoscopy Value Set</u>) during the measurement year or the nine years prior to the measurement year. • CT colonography (<u>CT Colonography Value Set</u>) during the measurement year or the four years prior to the measurement year. • FIT-DNA test (<u>FIT DNA Lab Test Value Set</u>; <u>FIT DNA Test Result or Finding Value Set</u>) 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	<p>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 <i>Guidelines for Calculations and Sampling</i> for information on reducing the sample size.</p>
--------------------	---

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-2: Data Elements for Colorectal Cancer Screening

	Administrative	Hybrid
Measurement year	✓	✓
Data collection methodology (Administrative or Hybrid)	✓	✓
Eligible population	✓	✓
Number of required exclusions	✓	✓
Number of numerator events by administrative data in eligible population (before exclusions)		✓
Current year's administrative rate (before exclusions)		✓
Minimum required sample size (MRSS)		✓
Oversampling rate		✓
Number of oversample records		✓
Number of medical records excluded because of valid data errors		✓
Number of administrative data records excluded		✓
Number of medical records excluded		✓
Number of employee/dependent medical records excluded		✓
Records added from the oversample list		✓
Denominator		✓
Numerator events by administrative data	✓	✓
Numerator events by medical records		✓
Numerator events by supplemental data	✓	✓
Reported rate	✓	✓

Table COL-3: Data Elements for Colorectal Cancer Screening

	Administrative	Hybrid
Measurement year	✓	✓
Data collection methodology (Administrative or Hybrid)	✓	✓
Eligible population	<i>Each of the 6 stratifications and total</i>	<i>Each of the 6 stratifications and total</i>
Number of required exclusions	<i>Each of the 6 stratifications and total</i>	<i>Each of the 6 stratifications and total</i>
Number of numerator events by administrative data in eligible population (before exclusions)		✓
Current year's administrative rate (before exclusions)		✓
Minimum required sample size (MRSS)		✓
Oversampling rate		✓
Number of oversampling records		✓
Number of medical records excluded because of valid data errors		✓
Number of administrative data records excluded		✓
Number of medical records excluded		✓
Number of employee/dependent medical records excluded		✓
Records added from the oversample list		✓
Denominator		<i>Each of the 6 stratifications and total</i>
Numerator events by administrative data	<i>Each of the 6 stratifications and total</i>	<i>Each of the 6 stratifications and total</i>
Numerator events by medical records		<i>Each of the 6 stratifications and total</i>
Numerator events by supplemental data	<i>Each of the 6 stratifications and total</i>	<i>Each of the 6 stratifications and total</i>
Reported rate	<i>Each of the 6 stratifications and total</i>	<i>Each of the 6 stratifications and total</i>

Rules for Allowable Adjustments of HEDIS

This section *may not* be used for reporting health plan 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.

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 palliative care exclusion is not required. Refer to <i>Exclusions</i> in the <i>Guidelines for the Rules for Allowable Adjustments</i>
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 <i>Exclusions</i> in the <i>Guidelines for the Rules for Allowable Adjustments</i> .
Numerator Criteria	Adjustments Allowed (Yes/No)	Notes
Colorectal Cancer Screening	No	The value sets and the logic may not be changed.

Comprehensive Diabetes Care (CDC)

SUMMARY OF CHANGES TO HEDIS MY 2020 & MY 2021

- Retired the “HbA1c control (<7.0%) for a selected population” indicator.
- Retired the “Medical Attention for Nephropathy” indicator for the commercial and Medicaid product lines.
- Clarified in the measure description that organizations must use the same data collection method for the HbA1c testing and control indicators (this information was previously included in the General Guidelines).
- Removed the restriction that only one of the two visits with a diabetes diagnosis be an outpatient telehealth, telephone visit, e-visit or virtual check-in when identifying the event/diagnosis.
- Added telephone visits, e-visits and virtual check-ins to the advanced illness exclusion.
- Added palliative care as a required exclusion.
- Deleted the HbA1c Level 7.0–9.0 Value Set.
- Updated the Administrative Specification logic and value sets for the Eye Exam indicator.
- Added telephone visits, e-visits and virtual check-ins to the Administrative Specification as appropriate settings for BP readings.
- Added Nebivolol-valsartan to the “Antihypertensive combinations” description in the ACE inhibitor and ARB Medications List.
- Added Donepezil-memantine to the “Dementia combinations” description in the Dementia Medications List.
- Added polycystic ovarian syndrome to the optional exclusions.
- Added a *Note* to the *Denominator-Sample Size Reduction* section in the Hybrid Specification.
- Clarified that documentation of “HB1c” meets criteria for the Hybrid Specification of the HbA1c testing indicator.
- Clarified that eye exam results read by a system that provides an artificial intelligence (AI) interpretation meet criteria.
- Removed the requirements for remote monitoring devices to allow BPs taken by any digital device.
- Removed the exclusion of BP readings reported or taken by the member.
- Revised the Data Elements for Reporting tables.
- In the *Rules for Allowable Adjustments* section, clarified that the required exclusions criteria may be adjusted with limits.

Description

The percentage of members 18–75 years of age with diabetes (type 1 and type 2) who had each of the following:

- | | |
|------------------------------------|--|
| • Hemoglobin A1c (HbA1c) testing.* | • Eye exam (retinal) performed. |
| • HbA1c poor control (>9.0%).* | • Medical attention for nephropathy.** |
| • HbA1c control (<8.0%).* | • BP control (<140/90 mm Hg). |

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

**This indicator is only reported for the Medicare product line.

Eligible Population

Note: Members in hospice are excluded from the eligible population. If an organization reports this measure using the Hybrid method, and a member is found to be in hospice or using hospice services during medical record review, the member is removed from the sample and replaced by a member from the oversample. Refer to General Guideline 17: Members in Hospice.

Product lines	Commercial, Medicaid, Medicare (report each product line separately).
Stratification	<p>For only Medicare, for only the Eye Exam (retinal) indicator, report the following SES stratifications and total:</p> <ul style="list-style-type: none"> • Non-LIS/DE, Nondisability. • LIS/DE. • Disability. • LIS/DE and Disability. • Other. • Unknown. • Total Medicare. <p>Note: The stratifications are mutually exclusive and the sum of all six stratifications is the total population. The stratifications are reported in a separate table.</p>
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	<p>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.</p> <p><i>Claim/encounter data.</i> 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):</p> <ul style="list-style-type: none"> • At least one acute inpatient encounter (<u>Acute Inpatient Value Set</u>) with a diagnosis of diabetes (<u>Diabetes Value Set</u>) without telehealth (<u>Telehealth Modifier Value Set</u>; <u>Telehealth POS Value Set</u>). • At least one acute inpatient discharge with a diagnosis of diabetes (<u>Diabetes Value Set</u>) 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 on an ambulatory basis during the measurement year or the year prior to the measurement year (Diabetes Medications List).

Diabetes Medications

Description	Prescription	
Alpha-glucosidase inhibitors	<ul style="list-style-type: none"> • Acarbose • Miglitol 	
Amylin analogs	<ul style="list-style-type: none"> • Pramlintide 	
Antidiabetic combinations	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • Nateglinide • Repaglinide 	
Glucagon-like peptide-1 (GLP1) agonists	<ul style="list-style-type: none"> • Dulaglutide • Exenatide • Albiglutide • Liraglutide (excluding Saxenda®) 	

Description	Prescription		
Sodium glucose cotransporter 2 (SGLT2) inhibitor	• Canagliflozin	• Dapagliflozin	• 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 exclusion

Exclude 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 Testing An HbA1c test (HbA1c Lab Test Value Set; HbA1c Test Result or Finding Value Set) performed during the measurement year.

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
<u>HbA1c Level Less Than 7.0 Value Set</u>	Not compliant
<u>HbA1c Level Greater Than or Equal To 7.0 and Less Than 8.0 Value Set</u>	Not compliant
<u>HbA1c Level Greater Than or Equal To 8.0 and Less Than or Equal To 9.0 Value Set</u>	Not compliant
<u>HbA1c Level Greater Than 9.0 Value Set</u>	Compliant

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

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
<u>HbA1c Level Less Than 7.0 Value Set</u>	Compliant
<u>HbA1c Level Greater Than or Equal To 7.0 and Less Than 8.0 Value Set</u>	Compliant
<u>HbA1c Level Greater Than or Equal To 8.0 and Less Than or Equal To 9.0 Value Set</u>	Not compliant
<u>HbA1c Level Greater Than 9.0 Value Set</u>	Not compliant

Eye Exam 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 negative result (negative for retinopathy).
- 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 or Eye Exam Without Evidence of Retinopathy 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.

**Medical
Attention for
Nephropathy**

A nephropathy screening or monitoring test **or** evidence of nephropathy, as documented through administrative data. This includes diabetics who had one of the following during the measurement year:

- A nephropathy screening or monitoring test (Urine Protein Tests Value Set).
- Evidence of treatment for nephropathy or ACE/ARB therapy (Nephropathy Treatment Value Set).
- Evidence of stage 4 chronic kidney disease (CKD Stage 4 Value Set).
- Evidence of ESRD (ESRD Diagnosis Value Set) or dialysis (Dialysis Procedure Value Set).
- Evidence of nephrectomy (Nephrectomy Value Set) or kidney transplant (Kidney Transplant Value Set).
- A visit with a nephrologist, as identified by the organization's specialty provider codes (no restriction on the diagnosis or procedure code submitted).

- At least one ACE inhibitor or ARB dispensing event (ACE Inhibitor and ARB Medications List).

ACE Inhibitor and ARB Medications

Description	Prescription					
Angiotensin converting enzyme inhibitors	• Benazepril	• Enalapril	• Lisinopril	• Perindopril	• Ramipril	
	• Captopril	• Fosinopril	• Moexipril	• Quinapril	• Trandolapril	
Angiotensin II inhibitors	• Azilsartan	• Eprosartan	• Losartan	• Telmisartan		
	• Candesartan	• Irbesartan	• Olmesartan	• Valsartan		
Antihypertensive combinations	• Amlodipine-benazepril	• Azilsartan-chlorthalidone	• Hydrochlorothiazide-moexipril			
	• Amlodipine-hydrochlorothiazide-valsartan	• Benazepril-hydrochlorothiazide	• Hydrochlorothiazide-olmesartan			
	• Amlodipine-hydrochlorothiazide-olmesartan	• Candesartan-hydrochlorothiazide	• Hydrochlorothiazide-quinapril			
	• Amlodipine-olmesartan	• Captopril-hydrochlorothiazide	• Hydrochlorothiazide-telmisartan			
	• Amlodipine-perindopril	• Enalapril-hydrochlorothiazide	• Hydrochlorothiazide-valsartan			
	• Amlodipine-telmisartan	• Fosinopril-hydrochlorothiazide	• Nebivolol-valsartan			
	• Amlodipine-valsartan	• Hydrochlorothiazide-irbesartan	• Sacubitril-valsartan			
		• Hydrochlorothiazide-lisinopril	• Trandolapril-verapamil			
		• Hydrochlorothiazide-losartan				

BP Control <140/90 mm Hg Identify the most recent BP reading (Systolic Blood Pressure Value Set; Diastolic Blood Pressure Value Set) taken during an outpatient visit (Outpatient Value Set) telephone visit (Telephone Visits Value Set), e-visit or virtual check-in (Online Assessments Value Set), or a nonacute inpatient encounter (Nonacute Inpatient Value Set), or remote monitoring event (Remote Blood Pressure Monitoring Value Set) during the measurement year.

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
<u>Systolic Less Than 140 Value Set</u>	Systolic compliant
<u>Systolic Greater Than or Equal To 140 Value Set</u>	Systolic not compliant
<u>Diastolic Less Than 80 Value Set</u>	Diastolic compliant
<u>Diastolic 80–89 Value Set</u>	Diastolic compliant
<u>Diastolic Greater Than or Equal To 90 Value Set</u>	Diastolic not compliant

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.

Organizations that apply optional exclusions must exclude members from the denominator for all indicators. The denominator for all rates must be the same. 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.

Hybrid Specification

Denominator

Organizations should use a sample size of 411.

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.

Denominator— sample size reduction

The organization 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 rate among all the reported CDC indicators. The lowest rate for all reported indicators must be used when reducing the sample size.

Note: The rate for the HbA1c control (<7.0%) for a selected population indicator may not be used to reduce the MY 2020 or MY 2021 sample size because it was retired. The rate for the Medical attention for nephropathy indicator may not be used to reduce the MY 2020 or MY 2021 sample size for the commercial and Medicaid product lines because it was retired.

Numerators

HbA1c Testing

An HbA1c test performed 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

At a minimum, documentation in the medical record must include a note indicating the date when the HbA1c test was performed and the result or finding. Count notation of the following in the medical record:

- A1c
- HB1c
- Glycohemoglobin
- HbA1c
- Hemoglobin A1c
- Glycated hemoglobin
- HgbA1c
- Glycohemoglobin A1c
- Glycosylated hemoglobin

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).

<u>Administrative</u>	Refer to <i>Administrative Specification</i> to identify positive numerator hits from administrative data.
<u>Medical record</u>	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 $\leq 9.0\%$.

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

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

<u>Administrative</u>	Refer to <i>Administrative Specification</i> to identify positive numerator hits from administrative data.
------------------------------	--

<u>Medical record</u>	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 $\geq 8.0\%$ 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.

<i>Eye Exam</i>	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: <ul style="list-style-type: none"> • A retinal or dilated eye exam by an eye care professional (optometrist or ophthalmologist) in the measurement year. • A <i>negative</i> 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.
------------------------	--

<u>Administrative</u>	Refer to <i>Administrative Specification</i> to identify positive numerator hits from administrative data.
------------------------------	--

<u>Medical record</u>	At a minimum, documentation in the medical record must include one of the following: <ul style="list-style-type: none"> • 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.

**Medical
Attention for
Nephropathy**

A nephropathy screening or monitoring test during the measurement year **or** evidence of nephropathy during the measurement year, as documented through either administrative data or medical record review.

Note: A process flow diagram is included at the end of this specification to help implement this measure.

Administrative

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

Medical record

Any of the following during the measurement year meet criteria for a nephropathy screening or monitoring test or evidence of nephropathy.

- A urine test for albumin or protein. At a minimum, documentation must include a note indicating the date when a urine test was performed, and the result or finding. Any of the following meet the criteria:
 - 24-hour urine for albumin or protein.
 - Timed urine for albumin or protein.
 - Spot urine (e.g., urine dipstick or test strip) for albumin or protein.
 - Urine for albumin/creatinine ratio.
 - 24-hour urine for total protein.
 - Random urine for protein/creatinine ratio.
- Documentation of a visit to a nephrologist.
- Documentation of a renal transplant.
- Documentation of a nephrectomy.

- Documentation of medical attention for any of the following (no restriction on provider type):
 - Diabetic nephropathy.
 - ESRD.
 - Chronic renal failure (CRF).
 - Chronic kidney disease (CKD).
 - Renal insufficiency.
 - Proteinuria.
 - Albuminuria.
 - Renal dysfunction.
 - Acute renal failure (ARF).
 - Dialysis, hemodialysis or peritoneal dialysis.
- Evidence of ACE inhibitor/ARB therapy. Documentation in the medical record must include evidence that the member received ACE inhibitor/ARB therapy during the measurement year. Any of the following meet criteria:
 - Documentation that a prescription for an ACE inhibitor/ARB was written during the measurement year.
 - Documentation that a prescription for an ACE inhibitor/ARB was filled during the measurement year.
 - Documentation that the member took an ACE inhibitor/ARB during the measurement year.

BP Control
<140/90 mm Hg

The *most recent* BP level (taken during the measurement year) is <140/90 mm Hg, as documented through administrative data or medical record review.

Administrative

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

Medical record

The organization should use the medical record from which it abstracts data for the other CDC indicators. If the organization does not abstract for other indicators, it should use the medical record of the provider that manages the member's diabetes. If that medical record does not contain a BP, the organization may use the medical record of another PCP or specialist from whom the member receives care.

Identify the most recent BP reading noted during the measurement year. Do not include BP readings that meet the following criteria:

- 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.

The member is not numerator compliant if the BP does not meet the specified threshold or is missing, or if there is no BP reading during the measurement year or if the reading is incomplete (i.e., the systolic or diastolic level is missing).

Exclusions (optional)

Refer to *Administrative Specification* for exclusion criteria. Identify members who did not have a diagnosis of diabetes, in any setting, during the measurement year or the year prior to the measurement year, **and** who had a diagnosis of gestational diabetes or steroid-induced diabetes, in any setting, during the measurement year or the year prior to the measurement year.

Note

- Organizations may select a data collection method (Administrative vs. Hybrid) at the indicator level, but the method used for HbA1c testing and control rates must be consistent.
- 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.
- To facilitate HEDIS reporting the denominator for all rates must be the same. While an eye exam is not possible, services measured in the other indicators are important for members with bilateral eye enucleation. For these reasons bilateral eye enucleation is considered a numerator hit (rather than an optional exclusion).
- Hypertensive retinopathy is not handled differently from diabetic retinopathy when reporting the Eye Exam indicator; 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 the Eye Exam indicator 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.
- If a combination of administrative, supplemental or hybrid data are used, the most recent result must be used, regardless of data source, for the indicators that require use of the most recent result.
- If an organization chooses to apply the optional exclusions, members must be numerator negative for at least one indicator, with the exception of HbA1c Poor Control (>9%). Remove members from the eligible population who are numerator negative for any indicator (other than for HbA1c Poor Control [>9%]) and substitute members from the oversample. Do not exclude members who are numerator compliant for all indicators except HbA1c Poor Control (>9%), because a lower rate indicates better performance for this indicator.
- When excluding BP readings from the BP Control <140/90 mm Hg indicator, 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 patient receives a common low-intensity or preventive procedure are eligible for use. For example, the following procedures are considered common low-intensity or preventive procedures (this list is 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 CDC-1/2: Data Elements for Comprehensive Diabetes Care

	Administrative	Hybrid
Measurement year	✓	✓
Data collection methodology (Administrative or Hybrid)	<i>Each of the 5 rates</i>	<i>Each of the 5 rates</i>
Eligible population	<i>Each of the 5 rates</i>	<i>Each of the 5 rates</i>
Number of required exclusions	<i>Each of the 5 rates</i>	<i>Each of the 5 rates</i>
Number of numerator events by administrative data in eligible population (before exclusions)		<i>Each of the 5 rates</i>
Current year's administrative rate (before exclusions)		<i>Each of the 5 rates</i>
Minimum required sample size (MRSS)		<i>Each of the 5 rates</i>
Oversampling rate		<i>Each of the 5 rates</i>
Number of oversample records		<i>Each of the 5 rates</i>
Number of medical records excluded because of valid data errors		<i>Each of the 5 rates</i>
Number of administrative data records excluded		<i>Each of the 5 rates</i>
Number of medical records excluded		<i>Each of the 5 rates</i>
Number of employee/dependent medical records excluded		<i>Each of the 5 rates</i>
Records added from the oversample list		<i>Each of the 5 rates</i>
Denominator		<i>Each of the 5 rates</i>
Numerator events by administrative data	<i>Each of the 5 rates</i>	<i>Each of the 5 rates</i>
Numerator events by supplemental data	<i>Each of the 5 rates</i>	<i>Each of the 5 rates</i>
Numerator events by medical records		<i>Each of the 5 rates</i>
Reported rate	<i>Each of the 5 rates</i>	<i>Each of the 5 rates</i>

Table CDC-A-3: Data Elements for Comprehensive Diabetes Care

	Administrative	Hybrid
Measurement year	✓	✓
Data collection methodology (Administrative or Hybrid)	<i>Each of the 6 rates</i>	<i>Each of the 6 rates</i>
Eligible population	<i>Each of the 6 rates</i>	<i>Each of the 6 rates</i>
Number of required exclusions	<i>Each of the 6 rates</i>	<i>Each of the 6 rates</i>
Number of numerator events by administrative data in eligible population (before exclusions)		<i>Each of the 6 rates</i>
Current year's administrative rate (before exclusions)		<i>Each of the 6 rates</i>
Minimum required sample size (MRSS)		<i>Each of the 6 rates</i>
Oversampling rate		<i>Each of the 6 rates</i>
Number of oversample records		<i>Each of the 6 rates</i>
Number of medical records excluded because of valid data errors		<i>Each of the 6 rates</i>

	Administrative	Hybrid
Number of administrative data records excluded		Each of the 6 rates
Number of medical records excluded		Each of the 6 rates
Number of employee/dependent medical records excluded		Each of the 6 rates
Records added from the oversample list		Each of the 6 rates
Denominator		Each of the 6 rates
Numerator events by administrative data	Each of the 6 rates	Each of the 6 rates
Numerator events by supplemental data	Each of the 6 rates	Each of the 6 rates
Numerator events by medical records		Each of the 6 rates
Reported rate	Each of the 6 rates	Each of the 6 rates

Table CDC-B-3: Data Elements for Comprehensive Diabetes Care: Eye Exam (Medicare SES Stratifications only. Report the Total Medicare population in Table CDC-A-3)

	Administrative	Hybrid
Eligible population	Each of the 6 stratifications	Each of the 6 stratifications
Number of required exclusions	Each of the 6 stratifications	Each of the 6 stratifications
Denominator		Each of the 6 stratifications
Numerator events by administrative data	Each of the 6 stratifications	Each of the 6 stratifications
Numerator events by medical records		Each of the 6 stratifications
Numerator events by supplemental data	Each of the 6 stratifications	Each of the 6 stratifications
Reported rate	Each of the 6 stratifications	Each of the 6 stratifications

Rules for Allowable Adjustments of HEDIS

This section *may not* be used for reporting health plan 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.

Rules for Allowable Adjustments for Comprehensive Diabetes 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	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
Optional Exclusions	No, if applied	Optional exclusions are not required, but if they are used, only specified exclusions may be applied; value sets and logic may not be changed.
Required Exclusions	Yes	The palliative care exclusion is not required. Refer to <i>Exclusions</i> in the <i>Guidelines for the Rules for Allowable Adjustments</i>
Exclusions: I-SNP, LTI, Frailty or Advanced Illness	Yes	These exclusions are not required. Refer to <i>Exclusions</i> in the <i>Guidelines for the Rules for Allowable Adjustments</i> .

Numerator Criteria	Adjustments Allowed (Yes/No)	Notes
<ul style="list-style-type: none"> • Hemoglobin A1c (HbA1c) testing • HbA1c poor control (>9.0%) • HbA1c control (<8.0%) • Eye exam (retinal) performed • Medical attention for nephropathy • BP control (<140/90 mm HG) 	No	Medication lists, value sets and logic may not be changed.

	3175 Continuity of Pharmacotherapy for Opioid Use Disorder
Status	Submitted
Steward	RAND Corporation
Description	Percentage of adults 18-64 years of age with pharmacotherapy for opioid use disorder (OUD) who have at least 180 days of continuous treatment
Type	Process
Data Source	<p>Claims (Other), Pharmacy For measure calculation, the following files from the Truven MarketScan® Commercial Database were used:</p> <ul style="list-style-type: none"> • Enrollment data • Drug claims • Medical claims <p>We used data from these files (including data from Standard Quarterly Updates) for calendar years 2010-2015. This database has long been a commonly used data source to study patterns of commercially insured patients. The database contains fully adjudicated, patient-level claims. All records in these files were used as input to identify individuals that met the measure's eligibility criteria. We present detailed results in the MIF for 2013-2014, as we have the most data for this time period, but we include measure scores for each of the two-year</p>

	3175 Continuity of Pharmacotherapy for Opioid Use Disorder
	<p>periods within 2010-2015. The final analytic file for 2013-2014 contained a total of 43,812 episodes.</p> <p>No data collection instrument provided Attachment NQF_3175_OUD_Code_Lists_1-12-17_To_NQF.xlsx</p>
Level	Health Plan, Population : Regional and State
Setting	Clinician Office/Clinic, Behavioral Health : Outpatient
Numerator Statement	Individuals in the denominator who have at least 180 days of continuous pharmacotherapy with a medication prescribed for OUD without a gap of more than seven days
Numerator Details	<p>The measure numerator is calculated based on commercial claims data for rolling two-year periods from 2010 to 2015: 2010-2011, 2011-2012, 2012-2013, 2013-2014, and 2014-2015. The measure numerator is defined as individuals in the denominator with at least 180 days of “continuous pharmacotherapy” with an OUD medication.</p> <p>Continuous pharmacotherapy for OUD is identified on the basis of the days covered by the days’ supply of all prescription claims for any OUD medication (see list below) or number of days for which the drug was dispensed in a physician office or treatment center with the exceptions noted in this paragraph. The period of continuous pharmacotherapy starts on the day the first claim for an OUD medication is filled/supplied (index date) and lasts through the days’ supply of the last claim for an OUD medication. To meet the 180-day requirement and be eligible for the measure, the date on the first claim for an OUD medication must fall at least 180 days before the end of the measurement period. For claims with a days’ supply that extends beyond the end of the measurement period, count only the days for which the drug was available to the individual during the measurement period. If two or more prescription claims occur on the same day or overlap, the surplus based on the days’ supplies accumulates over all prescriptions. However, if another claim is submitted after a claim for an injectable OUD medication or an oral OUD medication that is dispensed in an office or treatment center, the surplus from the day’s supply for the injectable or office-dispensed medication is not retained.</p> <p>An individual is considered to have continuous pharmacotherapy with OUD medication if there is no treatment gap of more than seven days. A gap is defined as a period during which the individual does not have oral OUD medication available based on the days’ supply, or is more than 7 days overdue for having an injection of an extended-release OUD medication.</p> <p>OUD medications were identified using National Drug Codes (NDCs) for the following:</p> <ul style="list-style-type: none"> • Buprenorphine • Naltrexone (oral) • Buprenorphine and Naloxone <p>And HCPCS codes for the following:</p> <ul style="list-style-type: none"> • Buprenorphine or Buprenorphine/naloxone, oral • Methadone administration • Naltrexone (extended-release injectable) <p>The National Drug Codes (NDCs) for the oral medications and the HCPCS codes for the injectable medications and office-dispensed oral medications (methadone and buprenorphine/naloxone) are contained in the sheets called “NDCs” and “HCPCS Codes”, respectively, in the Excel file called “NQF 3175 OUD Code Lists” which is attached to this form under Item S.2b. Note that the NDC code list DOES NOT include NDC codes for methadone, as it can legally only be dispensed as OUD pharmacotherapy in licensed treatment centers. Buprenorphine can be dispensed through a pharmacy or in an office and is therefore identified based on either NDC or HCPCS codes.</p> <p>Justification of Measure Definition: We define treatment continuity as (1) receiving at least</p>

	<p>3175 Continuity of Pharmacotherapy for Opioid Use Disorder</p> <p>180 days of treatment and (2) no gaps in medication use of more than 7 days.</p> <p>Our definition of minimum duration is based on the fact that the FDA registration trials for OUD drugs studied the effect of treatment over three to six months (US FDAa, undated; US FDAb, undated), and we have no evidence for effectiveness of shorter durations. In addition, several recommendations support a minimum six-month treatment period as the risk of relapse is the highest in the first 6-12 months after start of opioid abstinence (US FDAa, undated; US FDAb, undated; US DHHS, 2015). Longer treatment duration is associated with better outcomes compared to shorter treatments and the best outcomes have been observed among patients in long-term methadone maintenance programs (“Effective medical treatment of opiate addiction”, 1998; Gruber et al., 2008; Moos et al., 1999; NIDA, 1999; Ouimette et al., 1998; Peles et al., 2013). Studies with long-term follow-up suggest that ongoing pharmacotherapy is associated with improved odds of opioid abstinence (Hser et al., 2015; Weiss et al., 2015). We did not specify a maximum duration of treatment, as no upper limit for duration of treatment has been empirically established (US DHHS, 2015).</p> <p>We opted for using a treatment gap of more than seven days in our definition, given that the measure includes three active ingredients with different pharmacological profiles. There is substantial evidence for an elevated mortality risk immediately after treatment cessation (Cornish et al., 2010; Cousins et al., 2016; Davoli et al, 2007; Degenhardt et al., 2009; Gibson & Degenhardt, 2007; Pierce et al., 2016). Research suggests that methadone tolerance is lost after three days and this three-day threshold has been used in other observational methadone studies and in developing a United Kingdom treatment guideline which recommends reevaluating patients for intoxication and withdrawal after a three-day methadone treatment gap (Cousins et al., 2016; Cousins et al., 2011; “Drug Misuse and Dependence—Guidelines on Clinical Management”, 1999). Across all the medications, the mortality risk is highest in the first four weeks out of treatment, with many studies showing an increase in mortality in days 1-14 after treatment cessation.</p> <p>Citations</p> <p>Cornish R, Macleod J, Strang J, Vickerman P, Hickman M. Risk of death during and after opiate substitution treatment in primary care: prospective observational study in UK General Practice Research Database. <i>BMJ</i>. 2010;341:c5475.</p> <p>Cousins G, Teljeur C, Motterlini N, McCowan C, Dimitrov BD, Fahey T. Risk of drug-related mortality during periods of transition in methadone maintenance treatment: a cohort study. <i>J Subst Abuse Treat</i> 2011; 41: 252–60.</p> <p>Cousins G, Boland F, Courtney B, Barry J, Lyons S, Fahey T. Risk of mortality on and off methadone substitution treatment in primary care: a national cohort study. <i>Addiction</i>. 2016;111(1):73-82.</p> <p>Davoli M, Bargagli AM, Perucci CA, et al. Risk of fatal overdose during and after specialist drug treatment: the VEdette study, a national multisite prospective cohort study. <i>Addiction</i>. 2007;102:1954-9.</p> <p>Degenhardt L, Randall D, Hall W, Law M, Butler T, Burns L. Mortality among clients of a state-wide opioid pharmacotherapy program over 20 years: risk factors and lives saved. <i>Drug and alcohol dependence</i>. 2009;105:9-15.</p> <p>“Drug Misuse and Dependence—Guidelines on Clinical Management.” Scottish Office Department of Health, Welsh Office, Social Services Northern Ireland. London: Stationery Office, 1999.</p> <p>Effective medical treatment of opiate addiction. National Consensus Development Panel on Effective Medical Treatment of Opiate Addiction. <i>JAMA</i>.1998;280:1936-1943.</p> <p>Gibson AE, Degenhardt LJ. Mortality related to pharmacotherapies for opioid dependence: a</p>
--	--

	<p>3175 Continuity of Pharmacotherapy for Opioid Use Disorder</p> <p>comparative analysis of coronial records. Drug Alcohol Rev. 2007; 26(4), 405-410.</p> <p>Gruber VA, Delucchi KL, Kielstein A, Batki SL. A randomized trial of 6-month methadone maintenance with standard or minimal counseling versus 21-day methadone detoxification. Drug and Alcohol Dependence. 2008;94(1-3):199-206.</p> <p>Hser YI, Evans E, Grella C, Ling W, Anglin D. Long-term course of opioid addiction. Harvard Review of Psychiatry. 2015;23(2):76-89.</p> <p>Moos RH, Finney JW, Ouimette PC, Suchinsky RT. A comparative evaluation of substance abuse treatment: I. Treatment orientation, amount of care, and 1-year outcomes. Alcohol Clin Exp Res. 1999;23(3):529-36.</p> <p>National Institute on Drug Abuse (NIDA). Principles of Drug Addiction Treatment: A Research-Based Guide. NIH Publication No. 99-4180. Rockville, MD: NIDA, 1999, reprinted 2000</p> <p>Ouimette PC, Moos RH, Finney JW. Influence of outpatient treatment and 12-step group involvement on one-year substance abuse treatment outcomes. J Stud Alcohol. 1998;59:513-522</p> <p>Peles E, Schreiber S, Adelson M. Opiate-dependent patients on a waiting list for methadone maintenance treatment are at high risk for mortality until treatment entry. J Addict Med. 2013;7(3):177-82..</p> <p>Pierce M, Bird SM, Hickman M, Marsden J, Dunn G, Jones A, et al. Impact of treatment for opioid dependence on fatal drug-related poisoning: a national cohort study in England. Addiction. 2016;111:298-308.</p> <p>U.S. Department of Health and Human Services Assistant Secretary for Planning and Evaluation Office of Disability, Aging and Long-Term Care Policy. Review of Medication-Assisted Treatment Guidelines and Measures for Opioid and Alcohol Use. Washington, DC, 2015. Accessed November 9, 2016 at: https://aspe.hhs.gov/sites/default/files/pdf/205171/MATguidelines.pdf</p> <p>U.S. Food and Drug Administration (FDA) (a). REVIA Label. Accessed November 24, 2016 at: http://www.accessdata.fda.gov/drugsatfda_docs/label/2013/018932s017lbl.pdf</p> <p>U.S. Food and Drug Administration (FDA) (b). VIVITROL Label. Accessed November 24, 2016 at: http://www.accessdata.fda.gov/drugsatfda_docs/label/2006/021897lbl.pdf</p> <p>Weiss RD; Potter JS; Griffin ML, et al. Long-term outcomes from the National Drug Abuse Treatment Clinical Trials Network Prescription Opioid Addiction Treatment Study. Drug and Alcohol Dependence. 2015;150:112-119.</p>
Denominator Statement	Individuals 18-64 years of age who had a diagnosis of OUD and at least one claim for an OUD medication
Denominator Details	<p>The measure denominator is calculated for rolling two-year periods from 2010 to 2015: 2010-2011, 2011-2012, 2012-2013, 2013-2014, and 2014-2015. The denominator includes individuals 18-64 years of age during their treatment period who had a diagnosis code of OUD during an inpatient, intensive outpatient, partial hospitalization, outpatient, detoxification or emergency department encounter at any time during the measurement period. To meet the 180-day requirement and be eligible for the measure, the date on the first claim for an OUD medication must fall at least 180 days before the end of the measurement period.</p> <p>The diagnosis codes used to identify individuals with OUD included:</p> <ul style="list-style-type: none"> • ICD-9: 304.0x, 305.5x • ICD-10: F11.xxx <p>These codes and descriptions are contained in the sheets called "ICD-9 Diagnosis Codes" and "ICD-10 Diagnosis Codes" in the Excel file called "NQF 3175 OUD Code Lists" which is attached to this form under Item S.2b.</p> <p>OUD medications were identified using National Drug Codes (NDCs) for the following:</p>

	3175 Continuity of Pharmacotherapy for Opioid Use Disorder
	<ul style="list-style-type: none"> • Buprenorphine • Naltrexone (oral) • Buprenorphine and Naloxone <p>And HCPCS codes for the following:</p> <ul style="list-style-type: none"> • Buprenorphine or Buprenorphine/naloxone, oral • Methadone administration • Naltrexone (extended-release injectable) <p>The National Drug Codes (NDCs) for the oral medications and the HCPCS codes for the injectable medications and office- or treatment-center dispensed oral medications (methadone and buprenorphine) are contained in the sheets called “NDCs” and “HCPCS Codes”, respectively, in the Excel file called “NQF 3175 OUD Code Lists” which is attached to this form under Item S.2b. Note that the NDC code list DOES NOT include NDC codes for methadone, as it can legally only be dispensed as OUD pharmacotherapy in licensed treatment centers. Buprenorphine can be dispensed through a pharmacy or in an office/treatment center and is therefore identified based on either NDC or HCPCS codes.</p>
Exclusions	There are no denominator exclusions.
Exclusion details	There are no denominator exclusions.
Risk Adjustment	<p>No risk adjustment or risk stratification</p> <p>123001</p> <p>123001</p>
Stratification	<p>Measure results may be stratified by:</p> <ul style="list-style-type: none"> • Age – Divided into four categories: 18-34, 35-44, 45-54, 55-64 years • Gender: Male, Female • State • Health plan
Type Score	Rate/proportion better quality = higher score
Algorithm	<p>The measure score is calculated for rolling two-year periods from 2010 to 2015. The steps described below are repeated for five rolling two-year periods: 2010-2011, 2011-2012, 2012-2013, 2013-2014, and 2014-2015. We present detailed results in the MIF for 2013-2014, as we have the most data for this time period, but we include measure scores for each of the two-year periods within 2010-2015.</p> <p>DENOMINATOR: Individuals 18-64 years of age who had a diagnosis of OUD and at least one claim for an OUD medication</p> <p>CREATE DENOMINATOR:</p> <ol style="list-style-type: none"> 1. For each two-year period, identify individuals who are 18-64 years of age for the duration of the first year during which they appear in the period. 2. Of individuals identified in Step 1, keep those who had at least one encounter with any diagnosis (primary or secondary) of OUD in an outpatient setting, acute inpatient setting, or emergency department setting at any time during the two-year measurement period. The OUD diagnosis codes with descriptions are contained in the sheets called “ICD-9 Diagnosis Codes” and “ICD-10 Diagnosis Codes” in the Excel file called “NQF 3175 OUD Code Lists”, which is attached to this form under Item S.2b. 3. Of individuals identified in Step 2, keep those who have at least one claim with a National Drug Code (NDC) for any of the following oral OUD medications during the two-year period with a date at least 180 days before the end of the final calendar year of the measurement period:

	3175 Continuity of Pharmacotherapy for Opioid Use Disorder
	<ul style="list-style-type: none"> • Buprenorphine • Naltrexone (oral) • Buprenorphine and Naloxone <p>Or a HCPCS code for any of the following OUD medications:</p> <ul style="list-style-type: none"> • Buprenorphine or Buprenorphine/naloxone, oral • Methadone administration • Naltrexone (extended-release injectable) <p>Claims for oral medications with negative, missing, or zero days' supply were not included. The NDCs for the oral medications and the HCPCS codes for the injectable and office- or treatment center-dispensed medications are contained in the sheets called "NDCs" and "HCPCS Codes", respectively, in the Excel file called "NQF 3175 OUD Code Lists," which is attached to this form under Item S.2b.</p> <p>4. Of individuals identified in Step 3, keep individuals who were continuously enrolled in a commercial health plan captured by our data for at least 6 months after the month with the first OUD medication claim in the measurement period, with no gap in enrollment. Individuals who are not enrolled for 6 months, including those who die during the period, are not eligible and are not included in the analysis. This is the denominator.</p> <p>NUMERATOR: Individuals in the denominator who have at least 180 days of continuous pharmacotherapy with a medication prescribed for OUD without a gap of more than seven days</p> <p>CREATE NUMERATOR:</p> <p>For the individuals in the denominator, identify those who have at least 180 days of continuous pharmacotherapy with an OUD medication without a gap of more than seven days using the following method:</p> <ol style="list-style-type: none"> 1. Determine the number of days for the PDC denominator. The start date is the service date (fill date) of the first prescription or injection/dispensing claim for an OUD medication in the two-year measurement period. The end date is defined as the earliest of: <ul style="list-style-type: none"> • The date on which the individual exhausts their days' supply, including any pre-existing surplus, following their final claim (assuming daily use). • The individual's death date. • December 31st of the second year in the two-year period. 2. For each individual: Count the days during the observation period for which the individual was covered by at least one OUD medication based on the prescription drug or injection/dispensing claim service dates and days' supply. <ol style="list-style-type: none"> 2a. Sort OUD medication claims by individual's ID and service date. Scan the claims in order, calculating a rolling surplus which accumulates any remaining days' supply from other prior or same-day fills. 2b. Naltrexone injections contribute 30 days' supply unless another claim is found sooner, in which case the Naltrexone injection covers only the days up to the next claim. 2c. Methadone and buprenorphine/naloxone supply is determined by the start and end dates on the outpatient claims with the codes for in-office/treatment center dispensation of methadone (H0020) and buprenorphine/naloxone (J0571-J0575). 2d. Claims for Naltrexone injections and for licensed treatment center-dispensed methadone and office-dispensed buprenorphine/naloxone are not added to the surplus supply and only one such claim per day is counted. 2e. For claims with a days' supply that extends beyond the end of the measurement period, count only the days for which the drug was available to the individual during the measurement period.

	3175 Continuity of Pharmacotherapy for Opioid Use Disorder
	<p>3. Determine treatment gaps as periods, in which the individual has exhausted his/her available supply, defined as the days' supply from the most recent previous fill/dispensing and any pre-existing surplus available before that fill/dispensing.</p> <p>4. Of the individuals in Step 2, count the number of individuals who have a period of 180 days or greater from the start date of the first claim for OUD medication to the end date of the last claim for OUD medication within the two-year period and who do not have a gap of more than seven days without OUD medication available. This is the numerator.</p> <p>CALCULATE MEASURE SCORE:</p> <p>1. Calculate the measure score by dividing the numerator by the denominator.</p> <p>2. Calculate the measure score for each state. The state code on the claim record is used to identify individuals in each state. The measure score is then reported for each state that has at least 20 individuals in the denominator.</p> <p>3. Calculate the measure score for each health plan. Health plan membership is approximated based on a combination of two variables found on the claim record, industry type and Metropolitan Statistical Area (MSA). A health plan identifier is assigned based on each unique combination of industry and MSA. The health plan identifier is used to group individuals into health plans. The measure score is then reported for each health plan that has at least 20 individuals in the denominator. 123001</p>
Copyright / Disclaimer	<p>Copyright statement: Some proprietary codes are contained in the measure specifications for convenience of the user. Use of these codes may require permission from the code owner or agreement to a license.</p> <p>ICD-10 codes are copyrighted © World Health Organization (WHO), Fourth Edition, 2010. CPT © 2010 American Medical Association. CPT is a registered trademark of the American Medical Association. All rights reserved.</p> <p>Disclaimers: This performance measure does not establish a standard of medical care and has not been tested for all potential applications.</p>

	3185 Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention
Status	Submitted
Steward	PCPI Foundation
Description	Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received cessation intervention if identified as a tobacco user
Type	Process
Data Source	Electronic Health Record (Only) Not applicable. No data collection instrument provided Attachment EP_CMS138v5_NQF0028_ValueSets_20160401.xlsx
Level	Clinician : Group/Practice, Clinician : Individual
Setting	Clinician Office/Clinic, Home Health, Other, Behavioral Health : Outpatient Occupational therapy evaluation, speech and hearing evaluation, ophthalmological services visit
Numerator Statement	Patients who were screened for tobacco use at least once within 24 months AND who received tobacco cessation intervention if identified as a tobacco user

Controlling High Blood Pressure (CBP)

SUMMARY OF CHANGES TO HEDIS MY 2020 & MY 2021

- Revised the time frame in the event/diagnosis criteria to look for two outpatient visits with a diagnosis of hypertension in the first six months of the measurement year and the year prior to the measurement year.
- Removed the restriction that only one of the two visits with a hypertension diagnosis be an outpatient telehealth, telephone visit, e-visit or virtual check-in when identifying the event/diagnosis.
- Added palliative care as a required exclusion.
- Added telephone visits, e-visits and virtual check-ins to the advanced illness exclusion.
- Added Donepezil-memantine to the “Dementia combinations” description in the [Dementia Medications List](#).
- In the Administrative Specification, added telephone visits, e-visits and virtual check-ins as appropriate settings for BP readings.
- Updated the Hybrid Specification to indicate that sample size reduction is not allowed for MY 2020; sample size reduction is allowed for MY 2021.
- Removed the requirements for remote monitoring devices to allow BPs taken by any digital device.
- Removed the exclusion of BP readings reported or taken by the member.
- Added the “Number of required exclusions” data element to the Data Elements for Reporting table.
- Added guidance for adjusting required exclusions in the *Rules for Allowable Adjustments* section.

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

Note: Members in hospice are excluded from the eligible population. If a member is found to be in hospice or using hospice services during medical record review, the member is removed from the sample and replaced by a member from the oversample. Refer to General Guideline 17: Members in Hospice.

Product lines	Commercial, Medicaid, Medicare (report each product line separately).
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	<p>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:</p> <ul style="list-style-type: none"> • Outpatient visit (<u>Outpatient Without UBREV Value Set</u>) with any diagnosis of hypertension (<u>Essential Hypertension Value Set</u>). • A telephone visit (<u>Telephone Visits Value Set</u>) with any diagnosis of hypertension (<u>Essential Hypertension Value Set</u>). • An e-visit or virtual check-in (<u>Online Assessments Value Set</u>) with any diagnosis of hypertension (<u>Essential Hypertension Value Set</u>).
Required exclusion	Members receiving palliative care (<u>Palliative Care Assessment Value Set</u> ; <u>Palliative Care Encounter Value Set</u> ; <u>Palliative Care Intervention Value Set</u>) during the measurement year.
Exclusions	<p>Exclude members who meet any of the following criteria:</p> <p>Note: Supplemental and medical record data may not be used for these exclusions.</p> <ul style="list-style-type: none"> • Medicare members 66 years of age and older as of December 31 of the measurement year who meet either of the following: <ul style="list-style-type: none"> – 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 <i>both</i> 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	<ul style="list-style-type: none"> • Donepezil • Galantamine • Rivastigmine
Miscellaneous central nervous system agents	<ul style="list-style-type: none"> • Memantine
Dementia combinations	<ul style="list-style-type: none"> • 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 an outpatient visit (Outpatient Without UBREV Value Set), telephone visit (Telephone Visits Value Set), e-visit or virtual check-in (Online Assessments Value Set), a nonacute inpatient encounter (Nonacute Inpatient Value Set), or remote monitoring event (Remote Blood Pressure Monitoring Value Set) during the measurement year.

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
<u>Systolic Less Than 140 Value Set</u>	Systolic compliant
<u>Systolic Greater Than or Equal To 140 Value Set</u>	Systolic not compliant
<u>Diastolic Less Than 80 Value Set</u>	Diastolic compliant
<u>Diastolic 80–89 Value Set</u>	Diastolic compliant
<u>Diastolic Greater Than or Equal To 90 Value Set</u>	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:
 - Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
 - Confirm the stay was for nonacute care based on the presence of a nonacute code (Nonacute Inpatient Stay Value Set) on the claim.
 - Identify the admission date for the stay.

Hybrid Specification

Denominator	<p>A systematic sample drawn from the eligible population.</p> <p>For MY 2020 reporting, because Controlling High Blood Pressure has been significantly revised, sample size reduction is not allowed.</p> <p>For MY 2021 reporting, the organization may reduce the sample size using the current year's administrative rate or the prior year's audited, product line specific rate.</p> <p>Refer to the Guidelines for Calculations and Sampling for information on reducing the sample size.</p>
Identifying the medical record	<p>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.</p> <p>Use the following guidance to find the appropriate medical record to review.</p> <ul style="list-style-type: none"> • 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	<p>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.</p>
Administrative	<p>Refer to <i>Administrative Specification</i> to identify positive numerator hits from administrative data.</p>
Medical record	<p>Identify the most recent BP reading noted during the measurement year.</p> <p>The BP reading must occur on or after the date when the second diagnosis of hypertension (identified using the event/diagnosis criteria) occurred.</p> <p>Do not include BP readings:</p> <ul style="list-style-type: none"> • 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.

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

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

	Admin	Hybrid
Measurement year	✓	✓
Data collection methodology (Administrative or Hybrid)	✓	✓
Eligible population	✓	✓
Number of required exclusions	✓	✓
Number of numerator events by administrative data in eligible population (before exclusions)		✓
Current year's administrative rate (before exclusions)		✓
Minimum required sample size (MRSS)		✓
Oversampling rate		✓
Number of oversample records		✓
Number of medical records excluded because of valid data errors		✓
Number of administrative data records excluded		✓
Number of medical records excluded		✓
Number of employee/dependent medical records excluded		✓
Records added from the oversample list		✓
Denominator		✓
Numerator events by administrative data	✓	✓
Numerator events by medical records		✓
Numerator events by supplemental data	✓	✓
Reported rate	✓	✓

Rules for Allowable Adjustments of HEDIS

This section *may not* be used for reporting health plan 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.

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 palliative care exclusion is not required. Refer to <i>Exclusions</i> in the <i>Guidelines for the Rules for Allowable Adjustments</i> .
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 <i>Guidelines for the Rules for Allowable Adjustments</i> .
Numerator Criteria	Adjustments Allowed (Yes/No)	Notes
Adequate control of blood pressure	No	Value sets and logic may not be changed.

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

SUMMARY OF CHANGES TO HEDIS MY 2020 & MY 2021

- Added telephone visits, e-visits and virtual check-ins to the numerator.

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

Note: Members in hospice are excluded from the eligible population. Refer to General Guideline 17: Members in Hospice.

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 No gaps in enrollment.

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 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 (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.

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

	Administrative
Measurement year	✓
Eligible population	For each age stratification and total
Numerator events by administrative data	Each of the 2 rates for each age stratification and total
Numerator events by supplemental data	Each of the 2 rates for each age stratification and total
Reported rate	Each of the 2 rates for each age stratification and total

Rules for Allowable Adjustments of HEDIS

This section *may not* be used for reporting health plan 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.

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
Optional Exclusions	NA	There are no exclusions for this measure.
Numerator Criteria	Adjustments Allowed (Yes/No)	Notes
<ul style="list-style-type: none"> 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 2020 & MY 2021

- Replaced “mental health practitioner” with “mental health provider.”
- Removed the mental health provider requirement for follow-up visits for intensive outpatient encounters, partial hospitalizations, community mental health centers and electroconvulsive therapy settings.
- Added visits in a behavioral healthcare setting to the numerator.
- Added telephone visits to the numerator.
- Deleted the Mental Health Practitioner Value Set.
- Revised the instructions in the *Notes* for identifying mental health providers.

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

Note: Members in hospice are excluded from the eligible population. Refer to General Guideline 17: Members in Hospice.

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: <ul style="list-style-type: none">• 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	No gaps in enrollment.
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 (<u>Mental Illness Value Set</u> ; <u>Intentional Self-Harm Value Set</u>) 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.

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.

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.

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**

	Administrative
Measurement year	✓
Eligible population	<i>For each age stratification and total</i>
Numerator events by administrative data	<i>Each of the 2 rates for each age stratification and total</i>
Numerator events by supplemental data	<i>Each of the 2 rates for each age stratification and total</i>
Reported rate	<i>Each of the 2 rates for each age stratification and total</i>

Rules for Allowable Adjustments of HEDIS

This section *may not* be used for reporting health plan 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.

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
Optional Exclusions	NA	There are no exclusions for this measure.
Numerator Criteria	Adjustments Allowed (Yes/No)	Notes
<ul style="list-style-type: none"> 30-Day Follow-Up 7-Day Follow-Up 	No	Value sets and logic may not be changed.

Appendix B: Social Risk Factor Screening Measures

This appendix contains the current specifications for screening measures used in Massachusetts, North Carolina, and Rhode Island.

Massachusetts

Measure Name: Health-Related Social Needs Screening

Steward: Massachusetts EOHHS

NQF #: -

Description

The Health-Related Social Needs Screening (HRSN) is conducted to identify members who would benefit from receiving community services to address health-related social needs that include but are not limited to housing stabilization services, housing search and placement, utility assistance, transportation, and food insecurity.

Eligible Population

Product lines	Medicaid
Stratification	None
Ages	ACO-attributed members 0 to 64 years of age as of December 31st 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
Anchor date	December 31st of the measurement year
Lookback period	12 months
Event/diagnosis	None
Exclusions	Members in hospice (Hospice Value Set)

Specifications

The percentage of ACO-attributed members 0 to 64 years of age who were screened for health-related social needs in the measurement year.

Data Source	Clinical data
Data Collection Method	Sample
Denominator	A systematic sample drawn from the eligible population
Numerator	ACO-attributed members 0 to 64 years of age who were screened for health-related social needs in the measurement year.
Unit of Measurement	Individual
Setting of the Screen	Clinical and nonclinical settings

Documentation requirements	<p>To satisfy the measure requirements a member must have received one Health-Related Social Needs Screening during the measurement year.</p> <p>Results from an HRSN screening tool must be present in the member's health record in the measurement year and be readily accessible to the primary care provider. The screen may be completed by any member of the ACO care team. The screening may be completed over the phone, electronically, in-person, by mail, or by any other means approved by EOHHS.</p> <p>The numerator is met if the member's health record (as defined above) contains a completed Health-Related Social Needs screening tool which includes:</p> <ol style="list-style-type: none"> All four (4) core domains, and At least 1 supplemental domain <p>The following information must be reported to EOHHS for the purpose of measure performance calculation:</p> <p>Was an HRSN screening completed (including 4 core domains and 1 supplemental domain) (Y/N)</p> <p>Name of Screening Tool</p> <p>Source of Information (Mail, Phone, Email, In-person, Other)</p> <p>Was a need identified for each of the following domains? (Y/N/Unclear)</p>
Approved Screening Tools	EOHHS must approve the screening tool. The screening may be completed over the phone, electronically, in-person, by mail, or by any other means approved by EOHHS.
Required Domains	<p>Core Domains: The following domains must be completed and <i>results must be reported to EOHHS</i> in order to satisfy the measure:</p> <ol style="list-style-type: none"> Food Housing Transportation Utility <p>Supplemental Domains: At least one of the following domains must be completed:</p> <ol style="list-style-type: none"> Employment, training, or education Experience of Violence Social Supports

North Carolina

Measure Name: Screening for Social Determinants of Health

Steward: North Carolina DHHS

NQF #: -

Description

The percentage of Medicaid managed care enrollees who received a screening for social determinants of health.

Eligible Population

Product lines	Medicaid
Stratification	None
Ages	All
Continuous enrollment	None
Allowable gap	None
Anchor date	Date of enrollment
Lookback period	90 days of enrollment
Event/diagnosis	None
Exclusions	None

Immunizations for Adolescents (IMA)

SUMMARY OF CHANGES TO HEDIS MY 2020 & MY 2021

- No changes to this measure.

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

Note: Members in hospice are excluded from the eligible population. If an organization reports this measure using the Hybrid method, and a member is found to be in hospice or using hospice services during medical record review, the member is removed from the sample and replaced by a member from the oversample. Refer to General Guideline 17: Members in Hospice.

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.

Administrative Specification

Denominator	The eligible population.
Numerators	For meningococcal, Tdap and HPV count <i>only</i> evidence of the antigen or combination vaccine.
<i>Meningococcal serogroups A, C, W, Y</i>	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.

Tdap 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.

HPV • At least two HPV vaccines (HPV Immunization Value Set; HPV Vaccine Procedure Value Set), with dates of service at least 146 days apart on or between the member's 9th and 13th birthdays. For example, if the service date for the first vaccine was March 1, then the service date for the second vaccine must be after July 25.

OR

• 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.

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

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

Exclusion (optional)

Exclude adolescents who had a contraindication for a specific vaccine from the denominator for all antigen rates and the combination rates. The denominator for all rates must be the same. Contraindicated adolescents may be excluded only if administrative data do not indicate that the contraindicated immunization was rendered.

Any of the following meet optional exclusion criteria:

Any particular vaccine • Anaphylactic reaction to the vaccine or its components (Anaphylactic Reaction Due To Vaccination Value Set) any time on or before the member's 13th birthday.
• Anaphylactic reaction to the vaccine or its components (Anaphylactic Reaction Due To Serum Value Set), with a date of service prior to October 1, 2011.

Tdap • Encephalopathy (Encephalopathy Due To Vaccination Value Set) with a vaccine adverse-effect code (Vaccine Causing Adverse Effect Value Set) anytime on or before the member's 13th birthday.

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 <i>only</i> the evidence of the antigen or combination vaccine.
Administrative	Refer to <i>Administrative Specification</i> 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: <ul style="list-style-type: none"> • 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 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.

Exclusion (optional)

Refer to *Administrative Specification* for exclusion criteria. The exclusion must have occurred on or before the member’s 13th birthday.

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

	Administrative	Hybrid
Measurement year	✓	✓
Data collection methodology (administrative or hybrid)	✓	✓
Eligible population	✓	✓
Number of numerator events by administrative data in eligible population (before exclusions)		<i>Each of the 5 rates</i>
Current year's administrative rate (before exclusions)		<i>Each of the 5 rates</i>
Minimum required sample size (MRSS)		✓
Oversampling rate		✓
Number of oversample records		✓
Number of medical records excluded because of valid data errors		✓
Number of administrative data records excluded		✓
Number of medical record data records excluded		✓
Number of employee/dependent medical records excluded		✓
Records added from the oversample list		✓
Denominator		✓
Numerator events by administrative data	<i>Each of the 5 rates</i>	<i>Each of the 5 rates</i>
Numerator events by medical records		<i>Each of the 5 rates</i>
Numerator events by supplemental data	<i>Each of the 5 rates</i>	<i>Each of the 5 rates</i>
Reported rate	<i>Each of the 5 rates</i>	<i>Each of the 5 rates</i>

Rules for Allowable Adjustments of HEDIS

This section *may not* be used for reporting health plan 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.

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
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
<ul style="list-style-type: none"> • Meningococcal • Tdap • HPV 	No	Value sets and logic may not be changed. Vaccine dose requirements may not be changed.
<ul style="list-style-type: none"> • Combination Rates 	Yes, with limits	Organizations are not required to calculate combination rates; alternate combinations of specified immunizations are allowed.

eCQM Title	Preventive Care and Screening: Influenza Immunization		
eCQM Identifier (Measure Authoring Tool)	147	eCQM Version number	9.1.000
NQF Number	0041e	GUID	a244aa29-7d11-4616-888a-86e376bfcc6f
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 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		
Copyright	Copyright 2019 PCPI(R) Foundation and American Medical Association. All Rights Reserved.		
Disclaimer	<p>The Measure is not a clinical guideline, does not establish a standard of medical care, and has not been tested for all potential applications.</p> <p>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.</p> <p>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.</p> <p>AMA and PCPI encourage use of the Measure by other health care professionals, where appropriate.</p> <p>THE MEASURE AND SPECIFICATIONS ARE PROVIDED "AS IS" WITHOUT WARRANTY OF ANY KIND.</p> <p>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.</p> <p>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.</p> <p>Due to technical limitations, registered trademarks are indicated by (R) or [R].</p>		
Measure Scoring	Proportion		
Measure Type	Process		
Stratification	None		
Risk Adjustment	None		
Rate Aggregation	None		
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 Statement	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], 2018).		
Improvement Notation	Higher score indicates better quality		
Reference	Centers for Disease Control and Prevention. (2018, October 26). About Flu. Retrieved from http://www.cdc.gov/flu/about/disease/index.htm		
Reference	Centers for Disease Control and Prevention. (2015, September 17). Flu vaccination coverage: United States, 2014-15 influenza season. Retrieved from http://www.cdc.gov/flu/fluview/coverage-1415estimates.htm		
Reference	Grohskopf, L. A., Sokolow, L. Z., Broder, K. R., et al. (2018). Prevention and control of seasonal influenza with vaccines: Recommendations of the Advisory Committee on Immunization Practices—United States, 2018-19 influenza season. MMWR Recommendations and Reports, 67(3), 1-20. Retrieved from https://www.cdc.gov/mmwr/volumes/67/rr/pdfs/rr6703a1-H.pdf		
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)		
Guidance	<p>The timeframe for the visit during the "Encounter, Performed": "Encounter-Influenza" or "Procedure, Performed": "Peritoneal Dialysis" or "Procedure, Performed": "Hemodialysis" in the Population Criteria-Denominator, refers to the influenza season defined by the measure: October through March (October 1 for the year prior to the start of the reporting period through March 31 during the reporting period). The "Encounter-Influenza" Grouping OID detailed in the data criteria section below is comprised of several individual OIDs of different encounter types. The individual OIDs are included in the value set and should be reviewed to determine that an applicable visit occurred during the timeframe for "Encounter, Performed": "Encounter-Influenza" as specified in the denominator.</p> <p>To enable reporting of this measure at the close of the reporting period, this measure will only assess the influenza season that ends in March of the reporting period. The subsequent influenza season (ending March of the following year) will be measured and reported in the following year.</p> <p>As a result of updated CDC/ACIP guidelines which include the interim recommendation that live attenuated influenza vaccine (LAIV) should not be used due to low effectiveness against influenza A(H1N1)pdm09 in the United States during the 2013-14 and 2015-16 seasons, the measure specifications have been updated and no longer include LAIV or intranasal flu vaccine as an option for numerator eligibility.</p>		
Transmission Format	TBD		
Initial Population	All patients aged 6 months and older seen for a visit during the measurement period		

Denominator	Equals Initial Population and seen for a visit between October 1 and March 31
Denominator Exclusions	None
Numerator	Patients who received an influenza immunization OR who reported previous receipt of an influenza immunization
Numerator Exclusions	Not Applicable
Denominator Exceptions	Documentation of medical reason(s) for not receiving influenza immunization (e.g., patient allergy, other medical reasons). Documentation of patient reason(s) for not receiving influenza immunization (e.g., patient declined, other patient reasons). Documentation of system reason(s) for not receiving influenza immunization (e.g., vaccine not available, other system reasons).
Supplemental Data Elements	For every patient evaluated by this measure also identify payer, race, ethnicity and sex

Table of Contents

- [Population Criteria](#)
- [Definitions](#)
- [Functions](#)
- [Terminology](#)
- [Data Criteria \(QDM Data Elements\)](#)
- [Supplemental Data Elements](#)
- [Risk Adjustment Variables](#)

Population Criteria

Initial Population

```
exists ( ["Patient Characteristic Birthdate": "Birth date"] BirthDate
  where Global."CalendarAgeInMonthsAt"(BirthDate.birthDatetime, start of "Measurement Period")>= 6
)
and ( exists "Initial Qualifying Encounter During Measurement Period"
  or exists "Hemodialysis During Measurement Period"
  or exists "Peritoneal Dialysis During Measurement Period"
)
```

Denominator

```
"Initial Population"
and ( exists "Encounter During Influenza Season"
  or exists "Hemodialysis During Influenza Season"
  or exists "Peritoneal Dialysis During Influenza Season"
)
```

Denominator Exclusions

None

Numerator

```
exists "Influenza Vaccination Procedure"
or exists "Influenza Immunization Administered"
or exists "Influenza Vaccine Previously Received"
```

Numerator Exclusions

None

Denominator Exceptions

```
exists "Medical Patient or System Reason for Not Performing Influenza Vaccination"
or exists "Medical Patient or System Reason for Not Administering Influenza Vaccine"
or exists "Diagnosis of Allergy to Egg"
or exists "Egg Substance Allergy"
or exists "Diagnosis of Allergy to Influenza Vaccine"
or exists "Diagnosis of Intolerance to Influenza Vaccine"
or exists "Intolerance of Influenza Vaccination Procedure"
or exists "Allergy or Intolerance to Influenza Vaccine"
```

Stratification

None

Definitions

Allergy or Intolerance to Influenza Vaccine

```
["Allergy/Intolerance": "Influenza Vaccine"] FluVaccineAllergyIntolerance
where FluVaccineAllergyIntolerance.prevalencePeriod overlaps after "Influenza Season"
```

Denominator

```
"Initial Population"
and ( exists "Encounter During Influenza Season"
  or exists "Hemodialysis During Influenza Season"
  or exists "Peritoneal Dialysis During Influenza Season"
)
```

Denominator Exceptions

```
exists "Medical Patient or System Reason for Not Performing Influenza Vaccination"
or exists "Medical Patient or System Reason for Not Administering Influenza Vaccine"
or exists "Diagnosis of Allergy to Egg"
or exists "Egg Substance Allergy"
or exists "Diagnosis of Allergy to Influenza Vaccine"
or exists "Diagnosis of Intolerance to Influenza Vaccine"
```

or exists "Intolerance of Influenza Vaccination Procedure"
or exists "Allergy or Intolerance to Influenza Vaccine"

▲ Diagnosis of Allergy to Egg

["Diagnosis": "Allergy to Eggs"] EggAllergy
where EggAllergy.prevalencePeriod overlaps after "Influenza Season"

▲ Diagnosis of Allergy to Influenza Vaccine

["Diagnosis": "Allergy to Influenza Vaccine"] FluVaccineAllergyDiagnosis
where FluVaccineAllergyDiagnosis.prevalencePeriod overlaps after "Influenza Season"

▲ Diagnosis of Intolerance to Influenza Vaccine

["Diagnosis": "Intolerance to Influenza Vaccine"] FluVaccineIntoleranceDiagnosis
where FluVaccineIntoleranceDiagnosis.prevalencePeriod overlaps after "Influenza Season"

▲ Egg Substance Allergy

["Allergy/Intolerance": "Egg Substance"] AllergyEggSubstance
where AllergyEggSubstance.prevalencePeriod overlaps after "Influenza Season"

▲ Encounter During Influenza Season

["Encounter, Performed": "Encounter-Influenza"] FluEncounter
where FluEncounter.relevantPeriod starts during "Influenza Season"

▲ Hemodialysis During Influenza Season

["Procedure, Performed": "Hemodialysis"] FluSeasonHemodialysis
where FluSeasonHemodialysis.relevantPeriod starts during "Influenza Season"

▲ Hemodialysis During Measurement Period

["Procedure, Performed": "Hemodialysis"] Hemodialysis
where Hemodialysis.relevantPeriod during "Measurement Period"

▲ Influenza Immunization Administered

["Immunization, Administered": "Influenza Vaccine"] AdministeredFluVaccine
where AdministeredFluVaccine.authorDatetime during "Influenza Season Including August and September of the Prior Year"

▲ Influenza Season

Interval[start of "Measurement Period" - 3 months, start of "Measurement Period" + 3 months)

▲ Influenza Season Including August and September of the Prior Year

Interval[start of "Measurement Period" - 5 months, start of "Measurement Period" + 3 months)

▲ Influenza Vaccination Procedure

["Procedure, Performed": "Influenza Vaccination"] FluVaccination
where FluVaccination.relevantPeriod starts during "Influenza Season Including August and September of the Prior Year"

▲ Influenza Vaccine Previously Received

["Assessment, Performed": "Previous Receipt of Influenza Vaccine"] PreviousReceiptFluVaccine
where PreviousReceiptFluVaccine.authorDatetime during "Influenza Season Including August and September of the Prior Year"

▲ Initial Population

exists (["Patient Characteristic Birthdate": "Birth date"] BirthDate
where Global."CalendarAgeInMonthsAt"(BirthDate.birthDatetime, start of "Measurement Period")>= 6
)
and (exists "Initial Qualifying Encounter During Measurement Period"
or exists "Hemodialysis During Measurement Period"
or exists "Peritoneal Dialysis During Measurement Period"
)

▲ Initial Qualifying Encounter During Measurement Period

(["Encounter, Performed": "Office Visit"]
union ["Encounter, Performed": "Outpatient Consultation"]
union ["Encounter, Performed": "Care Services in Long-Term Residential Facility"]
union ["Encounter, Performed": "Home Healthcare Services"]
union ["Encounter, Performed": "Patient Provider Interaction"]
union ["Encounter, Performed": "Preventive Care Services, Initial Office Visit, 0 to 17"]
union ["Encounter, Performed": "Preventive Care Services-Initial Office Visit, 18 and Up"]
union ["Encounter, Performed": "Preventive Care Services-Individual Counseling"]
union ["Encounter, Performed": "Preventive Care Services - Group Counseling"]
union ["Encounter, Performed": "Preventive Care Services - Other"]
union ["Encounter, Performed": "Discharge Services - Nursing Facility"]
union ["Encounter, Performed": "Nursing Facility Visit"]
union ["Encounter, Performed": "Annual Wellness Visit"]
union ["Encounter, Performed": "Preventive Care, Established Office Visit, 0 to 17"]
union ["Encounter, Performed": "Preventive Care Services - Established Office Visit, 18 and Up"]) QualifyingEncounter
where QualifyingEncounter.relevantPeriod during "Measurement Period"

▲ Intolerance of Influenza Vaccination Procedure

["Allergy/Intolerance": "Influenza Vaccination"] FluVaccinationIntolerance
where FluVaccinationIntolerance.prevalencePeriod overlaps after "Influenza Season"

▲ Medical Patient or System Reason for Not Administering Influenza Vaccine

["Immunization, Not Administered": "Influenza Vaccine"] NoFluVaccine
where NoFluVaccine.authorDatetime during "Influenza Season Including August and September of the Prior Year"
and (NoFluVaccine.negativeRationale in "Medical Reason"
or NoFluVaccine.negativeRationale in "Patient Reason"

or NoFluVaccine.negationRationale in "System Reason"
or NoFluVaccine.negationRationale in "Influenza Vaccination Declined"

)

▲ Medical Patient or System Reason for Not Performing Influenza Vaccination

["Procedure, Not Performed": "Influenza Vaccination"] NoFluVaccination
where NoFluVaccination.authorDatetime during "Influenza Season Including August and September of the Prior Year"
and (NoFluVaccination.negationRationale in "Medical Reason"
or NoFluVaccination.negationRationale in "Patient Reason"
or NoFluVaccination.negationRationale in "System Reason"
or NoFluVaccination.negationRationale in "Influenza Vaccination Declined"

)

▲ Numerator

exists "Influenza Vaccination Procedure"
or exists "Influenza Immunization Administered"
or exists "Influenza Vaccine Previously Received"

▲ Peritoneal Dialysis During Influenza Season

["Procedure, Performed": "Peritoneal Dialysis"] FluSeasonPeritonealDialysis
where FluSeasonPeritonealDialysis.relevantPeriod starts during "Influenza Season"

▲ Peritoneal Dialysis During Measurement Period

["Procedure, Performed": "Peritoneal Dialysis"] PeritonealDialysis
where PeritonealDialysis.relevantPeriod during "Measurement Period"

▲ SDE Ethnicity

["Patient Characteristic Ethnicity": "Ethnicity"]

▲ SDE Payer

["Patient Characteristic Payer": "Payer"]

▲ SDE Race

["Patient Characteristic Race": "Race"]

▲ SDE Sex

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

Functions

▲ Global.CalendarAgeInMonthsAt(BirthDateTime DateTime, AsOf DateTime)

months between ToDate(BirthDateTime)and ToDate(AsOf)

▲ Global.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)")
- valueset "Allergy to Eggs" (2.16.840.1.113883.3.526.3.1253)
- valueset "Allergy to Influenza Vaccine" (2.16.840.1.113883.3.526.3.1256)
- valueset "Annual Wellness Visit" (2.16.840.1.113883.3.526.3.1240)
- valueset "Care Services in Long-Term Residential Facility" (2.16.840.1.113883.3.464.1003.101.12.1014)
- valueset "Discharge Services - Nursing Facility" (2.16.840.1.113883.3.464.1003.101.12.1013)
- valueset "Egg Substance" (2.16.840.1.113883.3.526.3.1537)
- valueset "Encounter-Influenza" (2.16.840.1.113883.3.526.3.1252)
- valueset "Ethnicity" (2.16.840.1.114222.4.11.837)
- valueset "Hemodialysis" (2.16.840.1.113883.3.526.3.1083)
- valueset "Home Healthcare Services" (2.16.840.1.113883.3.464.1003.101.12.1016)
- valueset "Influenza Vaccination Declined" (2.16.840.1.113883.3.526.3.1255)
- valueset "Influenza Vaccination" (2.16.840.1.113883.3.526.3.402)
- valueset "Influenza Vaccine" (2.16.840.1.113883.3.526.3.1254)
- valueset "Intolerance to Influenza Vaccine" (2.16.840.1.113883.3.526.3.1257)
- valueset "Medical Reason" (2.16.840.1.113883.3.526.3.1007)
- valueset "Nursing Facility Visit" (2.16.840.1.113883.3.464.1003.101.12.1012)
- 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 "Patient Provider Interaction" (2.16.840.1.113883.3.526.3.1012)
- valueset "Patient Reason" (2.16.840.1.113883.3.526.3.1008)
- valueset "Payer" (2.16.840.1.114222.4.11.3591)
- valueset "Peritoneal Dialysis" (2.16.840.1.113883.3.526.3.1084)
- valueset "Preventive Care Services - Established Office Visit, 18 and Up" (2.16.840.1.113883.3.464.1003.101.12.1025)
- valueset "Preventive Care Services - Group Counseling" (2.16.840.1.113883.3.464.1003.101.12.1027)
- valueset "Preventive Care Services - Other" (2.16.840.1.113883.3.464.1003.101.12.1030)
- valueset "Preventive Care Services, Initial Office Visit, 0 to 17" (2.16.840.1.113883.3.464.1003.101.12.1022)
- valueset "Preventive Care Services-Individual Counseling" (2.16.840.1.113883.3.464.1003.101.12.1026)
- valueset "Preventive Care Services-Initial Office Visit, 18 and Up" (2.16.840.1.113883.3.464.1003.101.12.1023)
- valueset "Preventive Care, Established Office Visit, 0 to 17" (2.16.840.1.113883.3.464.1003.101.12.1024)
- valueset "Previous Receipt of Influenza Vaccine" (2.16.840.1.113883.3.526.3.1185)
- valueset "Race" (2.16.840.1.114222.4.11.836)
- valueset "System Reason" (2.16.840.1.113883.3.526.3.1009)

Data Criteria (QDM Data Elements)

- "Allergy/Intolerance: Egg Substance" using "Egg Substance (2.16.840.1.113883.3.526.3.1537)"
- "Allergy/Intolerance: Influenza Vaccination" using "Influenza Vaccination (2.16.840.1.113883.3.526.3.402)"
- "Allergy/Intolerance: Influenza Vaccine" using "Influenza Vaccine (2.16.840.1.113883.3.526.3.1254)"
- "Assessment, Performed: Previous Receipt of Influenza Vaccine" using "Previous Receipt of Influenza Vaccine (2.16.840.1.113883.3.526.3.1185)"

- "Diagnosis: Allergy to Eggs" using "Allergy to Eggs (2.16.840.1.113883.3.526.3.1253)"
- "Diagnosis: Allergy to Influenza Vaccine" using "Allergy to Influenza Vaccine (2.16.840.1.113883.3.526.3.1256)"
- "Diagnosis: Intolerance to Influenza Vaccine" using "Intolerance to Influenza Vaccine (2.16.840.1.113883.3.526.3.1257)"
- "Encounter, Performed: Annual Wellness Visit" using "Annual Wellness Visit (2.16.840.1.113883.3.526.3.1240)"
- "Encounter, Performed: Care Services in Long-Term Residential Facility" using "Care Services in Long-Term Residential Facility (2.16.840.1.113883.3.464.1003.101.12.1014)"
- "Encounter, Performed: Discharge Services - Nursing Facility" using "Discharge Services - Nursing Facility (2.16.840.1.113883.3.464.1003.101.12.1013)"
- "Encounter, Performed: Encounter-Influenza" using "Encounter-Influenza (2.16.840.1.113883.3.526.3.1252)"
- "Encounter, Performed: Home Healthcare Services" using "Home Healthcare Services (2.16.840.1.113883.3.464.1003.101.12.1016)"
- "Encounter, Performed: Nursing Facility Visit" using "Nursing Facility Visit (2.16.840.1.113883.3.464.1003.101.12.1012)"
- "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: Patient Provider Interaction" using "Patient Provider Interaction (2.16.840.1.113883.3.526.3.1012)"
- "Encounter, Performed: Preventive Care Services - Established Office Visit, 18 and Up" using "Preventive Care Services - Established Office Visit, 18 and Up (2.16.840.1.113883.3.464.1003.101.12.1025)"
- "Encounter, Performed: Preventive Care Services - Group Counseling" using "Preventive Care Services - Group Counseling (2.16.840.1.113883.3.464.1003.101.12.1027)"
- "Encounter, Performed: Preventive Care Services - Other" using "Preventive Care Services - Other (2.16.840.1.113883.3.464.1003.101.12.1030)"
- "Encounter, Performed: Preventive Care Services, Initial Office Visit, 0 to 17" using "Preventive Care Services, Initial Office Visit, 0 to 17 (2.16.840.1.113883.3.464.1003.101.12.1022)"
- "Encounter, Performed: Preventive Care Services-Individual Counseling" using "Preventive Care Services-Individual Counseling (2.16.840.1.113883.3.464.1003.101.12.1026)"
- "Encounter, Performed: Preventive Care Services-Initial Office Visit, 18 and Up" using "Preventive Care Services-Initial Office Visit, 18 and Up (2.16.840.1.113883.3.464.1003.101.12.1023)"
- "Encounter, Performed: Preventive Care, Established Office Visit, 0 to 17" using "Preventive Care, Established Office Visit, 0 to 17 (2.16.840.1.113883.3.464.1003.101.12.1024)"
- "Immunization, Administered: Influenza Vaccine" using "Influenza Vaccine (2.16.840.1.113883.3.526.3.1254)"
- "Immunization, Not Administered: Influenza Vaccine" using "Influenza Vaccine (2.16.840.1.113883.3.526.3.1254)"
- "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)"
- "Procedure, Not Performed: Influenza Vaccination" using "Influenza Vaccination (2.16.840.1.113883.3.526.3.402)"
- "Procedure, Performed: Hemodialysis" using "Hemodialysis (2.16.840.1.113883.3.526.3.1083)"
- "Procedure, Performed: Influenza Vaccination" using "Influenza Vaccination (2.16.840.1.113883.3.526.3.402)"
- "Procedure, Performed: Peritoneal Dialysis" using "Peritoneal Dialysis (2.16.840.1.113883.3.526.3.1084)"
- "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
-------------	------

Hip and Knee Osteoarthritis Informed, Patient-Centered Decision Measure User Guide

I. Purpose:

To measure the extent to which patients are informed and receive treatments that match their goals and preferences.

II. Survey Versions:

- Decision Quality IPC Version: Treatments for Hip Osteoarthritis v2.0, ©2010 [updated 2012, 2016].
- Decision Quality IPC Version: Treatments for Knee Osteoarthritis v2.0, ©2010 [updated 2012, 2016].
- Hoja de Trabajo Sobre La Calidad de Decision en Tratamientos de Osteoartritis de Cadera v.2.0 ©2012 [updated 2016] [Spanish version of Hip].
- Hoja de Trabajo Sobre La Calidad de Decision en Tratamientos de Osteoartritis de Rodilla v.2.0 ©2012 [updated 2016] [Spanish version of Knee].

III. Timing

The decision quality instrument (DQI) is designed to be administered after a decision has been made. For the IPC measure, the DQI survey is administered up to 6 months after surgery.

IV. Scoring:

The surveys contain 5 knowledge items and one preference item and are scored as follows.

1. Knowledge Score: For each fact, a correct response receives one point (see Table 1). Missing responses receive 0 points. A total score is calculated for all patients who complete at least half of the items. Total scores are scaled from 0-100%.

Table 1: Knowledge items and correct responses

Question	Correct response
#1. Which treatment is most likely to provide relief from hip/knee pain caused by osteoarthritis?	Surgery
# 2. After hip/knee replacement surgery, about how many months does it take <u>most</u> people to get back to doing their usual activities?	2 to 6 months
# 3. If 100 people have hip/knee replacement surgery, about how many will need to have <u>the same hip/knee replaced again</u> in less than 15[knee]/20 [hip] years?	Less than half
# 4. If 100 people have hip/knee replacement surgery, about how many will have <u>less hip/knee pain</u> after the surgery?	90 (hip); 80 (knee)
# 5. Serious complications can happen after hip/knee replacement surgery including life threatening blood clots, infections, heart attacks, and even	4

death. If 100 people have hip/knee replacement surgery, about how many will have a serious complication within <u>3 months</u> after surgery?	
---	--

Note: "I don't know" ("no estoy seguro" in Spanish version) can be added as a response to knowledge items. An "I don't know response" receives 0 points (see feasibility section for considerations with including this response option).

2. Concordance: We use patients' preferred treatment, assessed with a single item, "Which treatment did you want to do to treat your knee [hip] osteoarthritis?" with possible responses (Non surgical treatments, surgery, I am not sure). For the IPC measure, only patients who mark a preference for surgery are considered to be "matched."

V. Informed, Patient Centered Hip and Knee Replacement Surgery (NQF Measure #2958):

In 2016, NQF endorse a measure that is derived from patient responses to the Hip or Knee Decision Quality Instruments. The target population is adult patients who had a primary hip or knee replacement surgery for treatment of hip or knee osteoarthritis within the past 6 months.

- **Numerator Statement:** The numerator is the number of respondents who have an adequate knowledge score (60% or greater) and a clear preference for surgery.
- **Denominator Statement:** The denominator includes the number of respondents from the target population of adults who have undergone primary knee or hip replacement surgery for treatment of knee or hip osteoarthritis.
- **Denominator Exclusions:** Respondents who are missing 3 or more knowledge items do not get a total knowledge score and are excluded. Similarly, respondents who do not indicate a preferred treatment are excluded. No other exclusions as long as the respondent has the procedure for the designated condition.

Sampling: Patients of a particular surgeon or at a particular clinical site (which could be a group of providers or a hospital or other surgical site) who had a primary knee or hip replacement surgery are identified from medical records, claims or in some other way. Sampling should allow time for immediate recovery, while attempting to survey shortly after the procedure, for example, by sampling eligible patients 1- 6 months after the procedure. Patients can be sampled sequentially, or a pool of such patients who had the procedure in a particular time period (e.g. in the last 3 months) can be created and sampled at a rate that produces the desired number of potential respondents. A list of ICD and CPT codes to identify patients with hip and knee osteoarthritis who are undergoing a primary joint replacement are available from the measure developer (decisions@partners.org).

The measure can also be calculated from a population-based sample, such as a sample of a population in a geographic area. Eligible respondents could be identified from claims (such as Medicare claims files) or based on patient self- reports of having had the procedures within some time frame.

A sample size of about 150 would be needed to detect differences in proportions of 15% for the measure (e.g. from 25% to 40%) with 80% power. This size difference is what we have observed between sites that do and do not make an effort to do shared decision making.

Proxy respondents are not permitted. The patients who receive the procedure should answer the survey questions.

VI. Development Process:

This has been described in detail in Sepucha et al (2008), briefly to generate the survey we:

- Conducted a review of the clinical evidence & of focus groups and interviews with patients to generate a candidate set of facts and goals salient to the decision
- Surveyed a convenience sample of patients (n=88) and a multidisciplinary group of clinical experts (n=51) to rate the facts and goals for importance, completeness, and accuracy.
- Drafted the instrument and then conducted cognitive interviews with patients who had knee or hip osteoarthritis (n=10) to evaluate items for acceptability and comprehension
- Conducted field test to evaluate the instruments

Three field tests were used to evaluate psychometric properties:

- A cross-sectional study with 382 adults with knee or hip osteoarthritis in the U.S.
- A survey of 45 primary care providers and specialists in the U.S.
- A randomized controlled trial comparing use of knee and hip osteoarthritis decision aids to control with 127 patients in Canada

Additional studies have used the measure and examined relationship to other constructs.

VII. Psychometric Properties:

These data are taken from Sepucha et al (2011).

Feasibility: The survey was feasible and had very low missing data. Note: "I am not sure" was a response category for the knowledge items in the field test. We took it out of the worksheet versions as we felt that it was better to force respondents to guess; however, removing this response may increase missing items.

Acceptability: The survey was acceptable with high response rates when administered by mail and by phone, and took less than 5 minutes to complete.

Reliability:

- Knowledge score: Short term (~4 week) retest reliability ICC=0.80 (95% CI 0.69 to 0.87), n=91
- The short term (~4 week) retest reliability for the treatment preference is ICC > 0.72.

Note: We did not calculate the internal consistency of the knowledge score because the items do not draw from a single underlying construct.

Validity

- Discriminant validity (Sepucha et al 2011):
 - The total knowledge score discriminated between patients and providers, mean differences of 19%, 95% CI (13%, 25%), $p < 0.001$ for knee and 15%, 95% CI (9%, 21%), $p < 0.001$ for hip
 - The total knowledge scores also discriminated between patients who had seen a decision aid and those who had not, (67% (SD 21.2%) vs. 51% (SD 24.9%), $p < 0.0001$.)
 - The treatment preference item was able to discriminate among patients with different goals. For example, patients who stated a preference for surgery, those who were unsure and those who stated a preference for non-surgical options (model predicted probability of surgery 0.74 vs. 0.59 vs. 0.40, respectively, $p < 0.001$ for all comparisons).
- Content validity was confirmed through the extensive feedback from patients and providers in the development process as well as in the field test. (Sepucha et al 2008)
- Predictive validity: Patients who made IPC decisions had higher better health outcomes (EQ-5D, KOOS and Harris Hip Scores) and less decision regret compared to those who did not have concordant care. (See Sepucha et al 2018).
- Construct validity: Patients who reported more shared decision making were more likely to have IPC decisions. (See Brodney et al 2019).

Reproducibility: The short knowledge score had high reproducibility when compared with the longer version, $R = 0.92$ $p < 0.001$

VIII. Appropriate Use

The DQIs are protected by copyright. They are available to use at no cost, provided that you:

- Cite the reference in any questionnaires or publications
- Do not charge for or profit from them
- Do not alter them except for customization for a specific condition and reformatting

Suggested Citations for the DQIs:

Sepucha KR. Knee [or Hip] Osteoarthritis Decision Quality Instrument v.2.0. ©Massachusetts General Hospital, 2010 [updated 2012, 2016].

Sepucha KR. Decision Quality Worksheet: Treatments for Knee [or Hip] Osteoarthritis. v.2.0. ©Massachusetts General Hospital, 2010 [updated 2012, 2016]. Downloaded from: http://www.massgeneral.org/decisionsciences/research/DQ_Instrument_List.aspx.

Suggested Citation of the User Guide:

Sepucha KR. Hip and Knee Osteoarthritis Decision Quality Instrument User Guide. © 2019. Available from: <https://www.mghdecisionsciences.org>.

IX. Selected References

1. Brodney S, Fowler FJ Jr, Barry MJ, Chang Y, Sepucha K. Comparison of Three Measures of Shared Decision Making: SDM Process_4, CollaboRATE, and SURE Scales. *Med Decis Making*. 2019 Jun 21:272989X19855951. doi: 10.1177/0272989X19855951.
2. Sepucha KR, Atlas SJ, Chang Y, Freiberg A, Malchau H, Mangla M, Rubash H, Simmons LH, Cha T. Informed, Patient-Centered Decisions Associated with Better Health Outcomes in Orthopedics: Prospective Cohort Study. *Med Decis Making*. 2018 Nov;38(8):1018-1026. doi: 10.1177/0272989X18801308. PubMed PMID: 30403575.
3. Sepucha K, Fowler F, Mulley A. Policy Support For Patient-Centered Care: The Need For Measurable Improvements In Decision Quality. *Health Affairs*. 2004 Oct 7 [web publication].
4. Sepucha K, Levin C, Uzogara E, Barry M, O'Connor A, Mulley A. Developing instruments to measure the quality of decisions: Early results for a set of symptom-driven decisions. *Patient Education and Counseling* 2008 73:504-510.
5. Sepucha K, Stacey D, Clay C, Chang Y, Cosenza C, Dervin G, Dorrwachter J, Feibelman S, Katz JN, Kearing S, Malchau H, Taljaard M, Tomek I, Tugwell P, Levin C. Decision quality instrument for treatment of hip and knee osteoarthritis: a psychometric evaluation. *BMC Musculoskelet Disord*. 2011; 12(1):149.
6. Sepucha K, Feibelman S, Chang Y, Clay CF, Kearing S, Tomek I, Yang TS, Katz JN. Factors associated with high decision quality for treatment of hip and knee osteoarthritis. *J Am Coll Surg* 2013 Oct;217(4):694-701. doi: 10.1016/j.jamcollsurg.2013.06.002.
7. Stacey D, Hawker G, Dervin G, Tugwell P, Boland L, Pomey MP, O'Connor AM, Taljaard M. Decision aid for patients considering total knee arthroplasty with preference report for surgeons: a pilot randomized controlled trial. *BMC Musculoskelet Disord*. 2014 Feb 24;15:54. doi: 10.1186/1471-2474-15-54.

X. Questions or comments? Please contact us at decisions@partners.org or visit our website at <https://www.mghdecisionsciences.org>

DECISION QUALITY WORKSHEET TREATMENTS FOR HIP OSTEOARTHRITIS

Instructions

This survey has questions about what it was like for you to make decisions about treating your hip osteoarthritis.

Please check the box ☒ to answer each item.

Your answers will tell us two important things:

1. What matters most to you?
2. How well did we do our job of giving you information?

Thank you!

Section 1: What Matters Most to You

1.1. Which treatment did you want to have to treat your hip osteoarthritis?

- ☐ Hip replacement surgery
- ☐ Non-surgical treatment options
- ☐ I am not sure

Section 2: Facts About Hip Osteoarthritis

This set of questions asks about some facts doctors think are important for patients to know about hip osteoarthritis. The correct answer to each question is based on medical research. Please do your best to answer each question.

2.1. Which treatment is most likely to provide relief from hip pain caused by osteoarthritis?

- ☐ Surgery
- ☐ Non-surgical treatments
- ☐ Both are about the same

2.2. If 100 people have hip replacement surgery, about how many will need to have the same hip replaced again in less than 20 years?

- ☐ More than half
- ☐ About half
- ☐ Less than half

2.3. If 100 people have hip replacement surgery, about how many will have less hip pain after the surgery?

- ☐ 30
- ☐ 50
- ☐ 70
- ☐ 90

2.4. Serious complications happen after hip replacement surgery including life-threatening blood clots, infections, heart attacks, and even death.

If 100 people have hip replacement surgery, about how many will have a serious complication within 3 months after surgery?

- ☐ 4
- ☐ 10
- ☐ 14
- ☐ 20

2.5. After hip replacement surgery, about how many months does it take most people to get back to doing their usual activities?

- ☐ Less than 2 months
- ☐ 2 to 6 months
- ☐ 7 to 12 months
- ☐ More than 12 months

**The End.
Thank you.**

Copyright Notice

© 2016 The Massachusetts General Hospital. Rights Reserved. This work is distributed under the Creative Commons Attribution-NonCommercial-ShareAlike 4.0 License ("License"), which permits unrestricted sharing of this work, provided that (1) it may not be used for commercial purposes; (2) Adapted Material may be prepared and shall be made freely available under identical terms and conditions of the License; and (3) attribution must be given to The Massachusetts General Hospital.

DECISION QUALITY WORKSHEET

TREATMENTS FOR KNEE OSTEOARTHRITIS

Instructions

This survey has questions about what it was like for you to make decisions about treating your knee osteoarthritis.

Please check the box ☒ to answer each item.

Your answers will tell us two important things:

1. What matters most to you?
2. How well did we do our job of giving you information?

Thank you!

Section 1: What Matters Most to You

1.1. Which treatment did you want to have to treat your knee osteoarthritis?

- ☐ Knee replacement surgery
- ☐ Non-surgical treatment options
- ☐ I am not sure

Section 2: Facts About Knee Osteoarthritis

This set of questions asks about some facts doctors think are important for patients to know about knee osteoarthritis. The correct answer to each question is based on medical research. Please do your best to answer each question.

2.1. Which treatment is most likely to provide relief from knee pain caused by osteoarthritis?

- ☐ Surgery
- ☐ Non-surgical treatments
- ☐ Both are about the same

2.2. If 100 people have knee replacement surgery, about how many will need to have the same knee replaced again in less than 15 years?

- ☐ More than half
- ☐ About half
- ☐ Less than half

2.3. If 100 people have knee replacement surgery, about how many will have less knee pain after the surgery?

- ☐ 20
- ☐ 40
- ☐ 60
- ☐ 80

2.4. Serious complications happen after knee replacement surgery including life-threatening blood clots, infections, heart attacks, and even death.

If 100 people have knee replacement surgery, about how many will have a serious complication within 3 months after surgery?

- ☐ 4
- ☐ 10
- ☐ 14
- ☐ 20

2.5. After knee replacement surgery, about how many months does it take most people to get back to doing their usual activities?

- ☐ Less than 2 months
- ☐ 2 to 6 months
- ☐ 7 to 12 months
- ☐ More than 12 months

**The End.
Thank you.**

Copyright Notice

© 2016 The Massachusetts General Hospital. Rights Reserved. This work is distributed under the Creative Commons Attribution-NonCommercial-ShareAlike 4.0 License ("License"), which permits unrestricted sharing of this work, provided that (1) it may not be used for commercial purposes; (2) Adapted Material may be prepared and shall be made freely available under identical terms and conditions of the License; and (3) attribution must be given to The Massachusetts General Hospital.

Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET)

SUMMARY OF CHANGES TO HEDIS MY 2020 & MY 2021

- Clarified the Episode Date when detoxification occurs during an acute inpatient stay.
- Updated the step 3 instructions for ED and observation visits that result in an inpatient stay, to make them consistent with instructions in the *Definitions* section.
- Added value sets for opioid treatment services that are billed weekly or monthly to the denominator and numerators.
- Updated the continuous enrollment period.

Description

The percentage of adolescent and adult members with a new episode of alcohol or other drug (AOD) abuse or dependence who received the following.

- *Initiation of AOD Treatment.* The percentage of members who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization, telehealth or medication treatment within 14 days of the diagnosis.
- *Engagement of AOD Treatment.* The percentage of members who initiated treatment and who were engaged in ongoing AOD treatment within 34 days of the initiation visit.

Definitions

Intake Period	January 1–November 14 of the measurement year. The Intake Period is used to capture new episodes of AOD abuse and dependence.
Index Episode	<p>The earliest eligible encounter during the Intake Period with a diagnosis of AOD abuse or dependence.</p> <p><i>For ED or observation visits that result in an inpatient stay, the inpatient discharge is the Index Episode.</i></p>
Date of service for services billed weekly or monthly	For an opioid treatment service that bills monthly or weekly (<u>ODU Weekly Non Drug Service Value Set</u> ; <u>ODU Monthly Office Based Treatment Value Set</u> ; <u>ODU Weekly Drug Treatment Service Value Set</u>), 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 IESD, negative diagnosis history and numerator events).
IESD	<p>Index Episode Start Date. The earliest date of service for an eligible encounter during the Intake Period with a diagnosis of AOD abuse or dependence.</p> <p><i>For an outpatient, intensive outpatient, partial hospitalization, observation, telehealth, or ED visit (not resulting in an inpatient stay), the IESD is the date of service.</i></p> <p><i>For an inpatient stay or for detoxification that occurred during an inpatient stay, the IESD is the date of discharge.</i></p> <p><i>For detoxification (other than detoxification that occurred during an inpatient stay), the IESD is the date of service.</i></p>

**Negative
Diagnosis
History**

For ED or observation visits that result in an inpatient stay, the IESD is the date of the inpatient discharge (an AOD diagnosis is not required for the inpatient stay; use the diagnosis from the ED or observation visit to determine the diagnosis cohort).

For direct transfers, the IESD is the discharge date from the last admission (an AOD diagnosis is not required for the transfer; use the diagnosis from the initial admission to determine the diagnosis cohort).

A period of 60 days (2 months) before the IESD when the member had no claims/encounters with a diagnosis of AOD abuse or dependence.

For an inpatient stay, use the admission date to determine the Negative Diagnosis History.

For ED or observation visits that result in an inpatient stay, use the earliest date of service (either the ED/observation date of service or the inpatient admission date) to determine the Negative Diagnosis History.

For direct transfers, use the first admission to determine the Negative Diagnosis History.

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

Note: Members in hospice are excluded from the eligible population. Refer to General Guideline 17: Members in Hospice.

Product lines

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

Age

13 years and older as of December 31 of the measurement year. Report two age stratifications and a total rate:

- 13–17 years.
- 18+ years.
- Total.

The total is the sum of the age stratifications.

AOD diagnosis cohorts	<p>Report the following diagnosis cohorts for each age stratification and the total rate:</p> <ul style="list-style-type: none"> • Alcohol abuse or dependence. • Opioid abuse or dependence. • Other drug abuse or dependence. • Total.
Continuous enrollment	60 days (2 months) prior to the IESD through 47 days after the IESD (108 total days).
Allowable gap	None.
Anchor date	None.
Benefits	<p>Medical, pharmacy and chemical dependency (inpatient and outpatient).</p> <p>Note: <i>Members with detoxification-only chemical dependency benefits do not meet these criteria.</i></p>
Event/diagnosis	<p>New episode of AOD abuse or dependence during the Intake Period.</p> <p>Follow the steps below to identify the eligible population, which is the denominator for both rates.</p> <p>Step 1 Identify the Index Episode. Identify all members in the specified age range who during the Intake Period had one of the following:</p> <ul style="list-style-type: none"> • An outpatient visit, telehealth, intensive outpatient visit or partial hospitalization with a diagnosis of AOD abuse or dependence. Any of the following code combinations meet criteria: <ul style="list-style-type: none"> – <u>IET Stand Alone Visits Value Set</u> with one of the following: <u>Alcohol Abuse and Dependence Value Set</u>, <u>Opioid Abuse and Dependence Value Set</u>, <u>Other Drug Abuse and Dependence Value Set</u>. – <u>IET Visits Group 1 Value Set</u> with <u>IET POS Group 1 Value Set</u> and with one of the following: <u>Alcohol Abuse and Dependence Value Set</u>, <u>Opioid Abuse and Dependence Value Set</u>, <u>Other Drug Abuse and Dependence Value Set</u>. – <u>IET Visits Group 2 Value Set</u> with <u>IET POS Group 2 Value Set</u> and with one of the following: <u>Alcohol Abuse and Dependence Value Set</u>, <u>Opioid Abuse and Dependence Value Set</u>, <u>Other Drug Abuse and Dependence Value Set</u>. – <u>ODU Weekly Non Drug Service Value Set</u> with <u>Opioid Abuse and Dependence Value Set</u>. – <u>ODU Monthly Office Based Treatment Value Set</u> with <u>Opioid Abuse and Dependence Value Set</u>. – <u>ODU Weekly Drug Treatment Service Value Set</u> with <u>Opioid Abuse and Dependence Value Set</u>. • A detoxification visit (<u>Detoxification Value Set</u>) with one of the following: <u>Alcohol Abuse and Dependence Value Set</u>, <u>Opioid Abuse and Dependence Value Set</u>, <u>Other Drug Abuse and Dependence Value Set</u>. • An ED visit (<u>ED Value Set</u>) with one of the following: <u>Alcohol Abuse and Dependence Value Set</u>, <u>Opioid Abuse and Dependence Value Set</u>, <u>Other Drug Abuse and Dependence Value Set</u>.

- 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 (ODU Weekly Non Drug Service Value Set; ODU Monthly Office Based Treatment Value Set; ODU Weekly Drug Treatment Service Value Set) with a diagnosis of opioid abuse or dependence (Opioid Abuse and Dependence Value Set).

For members with more than one episode of AOD abuse or dependence, use the first episode.

For members whose first episode was an ED or observation visit that resulted in an inpatient stay, use the diagnosis from the ED or observation visit to determine the diagnosis cohort and use the inpatient discharge date as the IESD.

Step 2 Select the Index Episode and stratify based on age and AOD diagnosis cohort.

- If the member has a diagnosis of alcohol abuse or dependence (Alcohol Abuse and Dependence Value Set), place the member in the alcohol cohort.
- If the member has a diagnosis of opioid abuse or dependence (Opioid Abuse and Dependence Value Set), place the member in the opioid cohort.
- If the member has a drug abuse or dependence that is neither for opioid or alcohol (Other Drug Abuse and Dependence Value Set), place the member in the other drug cohort.

If the member has multiple substance use diagnosis for the visit, report the member in all AOD diagnosis stratifications for which they meet criteria.

The total is not a sum of the diagnosis cohorts. Count members in the total denominator rate if they had at least one alcohol, opioid or other drug abuse or dependence diagnosis during the measurement period. Report member with multiple diagnoses during the Index Episode only once for the total rate for the denominator.

Step 3 Test for Negative Diagnosis History. Exclude members who had a claim/ encounter with a diagnosis of AOD abuse or dependence (AOD Abuse and Dependence Value Set), AOD medication treatment (AOD Medication Treatment Value Set) or an alcohol or opioid dependency treatment medication dispensing event (Alcohol Use Disorder Treatment Medications List; Opioid Use Disorder Treatment Medications List) during the 60 days (2 months) before the IESD.

For an inpatient IESD, use the admission date to determine the 60-day Negative Diagnosis History period.

For ED or observation visits that result in an inpatient stay, use the earliest date of service (either the ED/observation date of service or the inpatient admission date) to determine the Negative Diagnosis History.

Step 4 Calculate continuous enrollment. Members must be continuously enrolled for 60 days (2 months) before the IESD through 47 days after the IESD (108 total days), with no gaps.

Administrative Specification

Denominator The eligible population.

Numerator

Initiation of AOD Treatment Initiation of AOD treatment within 14 days of the IESD.

If the Index Episode was an inpatient discharge (or an ED/observation visit that resulted in an inpatient stay), the inpatient stay is considered initiation of treatment and the member is compliant.

If the Index 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 member is compliant.

If the Index Episode was not an inpatient discharge, the member must initiate treatment on the IESD or in the 13 days after the IESD (14 total days). Any of the following code combinations meet criteria for initiation:

- An acute or nonacute inpatient admission **with** a diagnosis (on the discharge claim) matching the IESD diagnosis cohort using 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.
- IET Stand Alone Visits Value Set **with** a diagnosis matching the IESD diagnosis cohort using 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** a diagnosis matching the IESD diagnosis cohort using one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.

- IET Visits Group 1 Value Set **with** IET POS Group 1 Value Set **and** a diagnosis matching the IESD diagnosis cohort using one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- IET Visits Group 2 Value Set **with** IET POS Group 2 Value Set **and** a diagnosis matching the IESD diagnosis cohort using 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 Visit Value Set) **with** a diagnosis matching the IESD diagnosis cohort using 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** a diagnosis matching the IESD diagnosis cohort using one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- If the Index Episode was for a diagnosis of opioid abuse or dependence (Opioid Abuse and Dependence Value Set) an opioid treatment service (ODU Weekly Non Drug Service Value Set).
- If the Index Episode was for a diagnosis of opioid abuse or dependence (Opioid Abuse and Dependence Value Set) an opioid treatment service (ODU Monthly Office Based Treatment Value Set).
- If the Index Episode was for a diagnosis of alcohol abuse or dependence (Alcohol Abuse and Dependence Value Set) a medication treatment dispensing event (Alcohol Use Disorder Treatment Medications List) or medication treatment during a visit (AOD Medication Treatment Value Set).
- If the Index Episode was for a diagnosis of opioid abuse or dependence (Opioid Abuse and Dependence Value Set) a medication treatment dispensing event (Opioid Use Disorder Treatment Medications List) or medication treatment during a visit (AOD Medication Treatment Value Set; ODU Weekly Drug Treatment Service Value Set).

For all initiation events except medication treatment (AOD Medication Treatment Value Set; Alcohol Use Disorder Treatment Medications List; Opioid Use Disorder Treatment Medications List), initiation on the same day as the IESD must be with different providers in order to count.

If a member is compliant for the Initiation numerator for any diagnosis cohort (alcohol, opioid, other drug) or for multiple cohorts, count the member only once in the Total Initiation numerator. The "Total" column is not the sum of the diagnosis columns.

Exclude the member from the denominator for both indicators (*Initiation of AOD Treatment* and *Engagement of AOD Treatment*) if the initiation of treatment event is an inpatient stay with a discharge date after November 27 of the measurement year.

Engagement of AOD Treatment

Step 1 Identify all members compliant for the Initiation of AOD Treatment numerator.

For members who initiated treatment via an inpatient admission, the 34-day period for engagement begins the day after discharge.

Step 2 Identify members who had an opioid treatment service that bills monthly (ODU Monthly Office Based Treatment Value Set) or who had a visit that included medication administration (ODU Weekly Drug Treatment Service Value Set) beginning on the day after the initiation encounter through 34 days after the initiation event.

For these members, if the IESD Diagnosis cohort was a diagnosis of opioid abuse or dependence (Opioid Abuse and Dependence Value Set), the member is numerator compliant for Engagement of AOD Treatment.

Step 3 Identify members whose initiation of AOD treatment was a medication treatment event (Alcohol Use Disorder Treatment Medications List; Opioid Use Disorder Treatment Medications List; AOD Medication Treatment Value Set).

These members are numerator compliant if they have two or more engagement events, where only one can be an engagement medication treatment event, beginning on the day after the initiation encounter through 34 days after the initiation event (total of 34 days).

Step 4 Identify the remaining members whose initiation of AOD treatment was *not* a medication treatment event (members not identified in step 3).

These members are numerator compliant if they meet *either* of the following:

- At least one engagement medication treatment event.
- At least two engagement visits.

Two engagement visits can be on the same date of service but they must be with different providers in order 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 beginning on the day after the initiation encounter through 34 days after the initiation event (total of 34 days) meet criteria for an engagement visit:

- An acute or nonacute inpatient admission with a diagnosis (on the discharge claim) matching the IESD diagnosis cohort using 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.

- IET Stand Alone Visits Value Set **with** a diagnosis matching the IESD diagnosis cohort using 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** a diagnosis matching the IESD diagnosis cohort using one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- IET Visits Group 1 Value Set **with** IET POS Group 1 Value Set **with** a diagnosis matching the IESD diagnosis cohort using one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- IET Visits Group 2 Value Set **with** IET POS Group 2 Value Set **with** a diagnosis matching the IESD diagnosis cohort using 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** a diagnosis matching the IESD diagnosis cohort using 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** a diagnosis matching the IESD diagnosis cohort using one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- If the IESD Diagnosis cohort was a diagnosis of opioid abuse or dependence (Opioid Abuse and Dependence Value Set) an opioid treatment service (ODU Weekly Non Drug Service Value Set).

**Engagement
medication
treatment events**

Either of the following meets criteria for an engagement medication treatment event:

- If the IESD diagnosis was a *diagnosis of alcohol abuse or dependence* (Alcohol Abuse and Dependence Value Set), one or more medication treatment dispensing events (Alcohol Use Disorder Treatment Medications List) or medication treatment during a visit (AOD Medication Treatment Value Set), beginning on the day after the initiation encounter through 34 days after the initiation event (total of 34 days), meets criteria for Alcohol Abuse and Dependence Treatment.
- If the IESD diagnosis was a *diagnosis of opioid abuse or dependence* (Opioid Abuse and Dependence Value Set), one or more medication dispensing events (Opioid Use Disorder Treatment Medications List) or medication treatment during a visit (AOD Medication Treatment Value Set), beginning on the day after the initiation encounter through 34 days after the initiation event (total of 34 days), meets criteria for Opioid Abuse and Dependence Treatment.

If the member is compliant for multiple cohorts, only count the member once for the Total Engagement numerator. The Total column is not the sum of the Diagnosis columns.

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
Antagonist	• Naltrexone (oral and injectable)
Partial agonist	• Buprenorphine (sublingual tablet, injection, implant) • Buprenorphine/naloxone (sublingual tablet, buccal film, sublingual film)

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.
- For members in the “other drug abuse or dependence” cohort, medication treatment does not meet numerator criteria for Initiation of AOD Treatment or Engagement of AOD Treatment.
- Methadone is not included in the medication lists for this measure. Methadone for opioid use disorder is only administered or dispensed by federally certified opioid treatment programs and does not show up in pharmacy claims data. A pharmacy claim for methadone would be more indicative of treatment for pain than treatment for an opioid use disorder; therefore they are not included in the medication lists. The AOD Medication Treatment Value Set includes some codes that identify methadone treatment because these codes are used on medical claims, not pharmacy claims.

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 Alcohol and Other Drug Dependence Treatment

	Administrative
Measurement year	✓
Eligible population	For each age stratification, diagnosis stratification and total
Numerator events by administrative data	Each rate, for each age stratification, diagnosis stratification and total
Reported rate	Each rate, for each age stratification, diagnosis stratification and total

Rules for Allowable Adjustments of HEDIS

This section *may not* be used for reporting health plan 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.

Rules for Allowable Adjustments for Initiation and Engagement of Alcohol and Other Drug Dependence 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.
AOD 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.
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: This measure uses new episodes of AOD abuse and dependence; modifying the Intake period can affect the Index Episode and other dates; however, the order and relationship of the events may not be changed.
Denominator Exclusions	Adjustments Allowed (Yes/No)	Notes
Exclusions	NA	There are no exclusions for this measure.
Numerator Criteria	Adjustments Allowed (Yes/No)	Notes
<ul style="list-style-type: none"> Initiation of AOD Treatment Engagement of AOD Treatment 	No	Medication lists, value sets and logic may not be changed.

Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)*

***Developed with financial support from the Agency for Healthcare Research and Quality (AHRQ) and Centers for Medicare & Medicaid Services (CMS) under the CHIPRA Pediatric Quality Measures Program Centers of Excellence grant number U18 HS020503.**

SUMMARY OF CHANGES TO HEDIS MY 2020 & MY 2021

- Clarified in the *Rules for Allowable Adjustments of HEDIS* that when adjusting ages, the upper age range may be expanded or there may be no upper age limit.

Description

The percentage of children and adolescents 1–17 years of age who had two or more antipsychotic prescriptions and had metabolic testing. Three rates are reported:

1. The percentage of children and adolescents on antipsychotics who received blood glucose testing.
2. The percentage of children and adolescents on antipsychotics who received cholesterol testing.
3. The percentage of children and adolescents on antipsychotics who received blood glucose and cholesterol testing.

Eligible Population

Note: *Members in hospice are excluded from the eligible population. Refer to General Guideline 17: Members in Hospice.*

Product lines	Commercial, Medicaid (report each product line separately).
Ages	1–17 years as of December 31 of the measurement year. Report two age stratifications and a total rate for each of the three indicators: <ul style="list-style-type: none">• 1–11 years.• 12–17 years.• Total. <p>The total is the sum of the age stratifications.</p>
Continuous enrollment	The measurement year.
Allowable gap	No more than one gap in enrollment of up to 45 days during the measurement year.
Anchor date	December 31 of the measurement year.
Benefit	Medical and pharmacy.
Event/diagnosis	At least two antipsychotic medication dispensing events (<u>Antipsychotic Medications List</u> ; <u>Antipsychotic Combination Medications List</u> ; <u>Prochlorperazine</u>

Medications List) of the same or different medications, on different dates of service during the measurement year.

Antipsychotic Medications

Description	Prescription		
Miscellaneous antipsychotic agents	<ul style="list-style-type: none"> • Aripiprazole • Asenapine • Brexpiprazole • Cariprazine • Clozapine • Haloperidol 	<ul style="list-style-type: none"> • Iloperidone • Loxapine • Lurasidone • Molindone • Olanzapine • Paliperidone 	<ul style="list-style-type: none"> • Pimozide • Quetiapine • Risperidone • Ziprasidone
Phenothiazine antipsychotics	<ul style="list-style-type: none"> • Chlorpromazine • Fluphenazine • Perphenazine 	<ul style="list-style-type: none"> • Thioridazine • Trifluoperazine 	
Thioxanthenes	<ul style="list-style-type: none"> • Thiothixene 		
Long-acting injections	<ul style="list-style-type: none"> • Aripiprazole • Fluphenazine decanoate • Haloperidol decanoate 	<ul style="list-style-type: none"> • Olanzapine • Paliperidone palmitate • Risperidone 	

Antipsychotic Combination Medications

Description	Prescription	
Psychotherapeutic combinations	<ul style="list-style-type: none"> • Fluoxetine-olanzapine 	<ul style="list-style-type: none"> • Perphenazine-amitriptyline

Prochlorperazine Medications

Description	Prescription
Phenothiazine antipsychotics	<ul style="list-style-type: none"> • Prochlorperazine

Administrative Specification

Denominator The eligible population.

Numerator

Blood Glucose Members who received at least one test for blood glucose (Glucose Lab Test Value Set; Glucose Test Result or Finding Value Set) or HbA1c (HbA1c Lab Test Value Set; HbA1c Test Result or Finding Value Set) during the measurement year.

Cholesterol Members who received at least one test for LDL-C (LDL-C Lab Test Value Set; LDL-C Test Result or Finding Value Set) or cholesterol (Cholesterol Lab Test Value Set; Cholesterol Test Result or Finding Value Set) during the measurement year.

Blood Glucose and Cholesterol Members who received both of the following during the measurement year on the same or different dates of service.

- At least one test for blood glucose (Glucose Lab Test Value Set, Glucose Test Result or Finding Value Set) or HbA1c (HbA1c Lab Test Value Set, HbA1c Test Result or Finding Value Set).
- At least one test for LDL-C (LDL-C Lab Test Value Set; LDL-C Test Result or Finding Value Set) or cholesterol (Cholesterol Lab Test Value Set; Cholesterol Test Result or Finding Value Set).

Data Elements for Reporting

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

Table APM-1/2: Data Elements for Metabolic Monitoring for Children and Adolescents on Antipsychotics

	Administrative
Measurement year	✓
Eligible population	<i>For each age stratification and total</i>
Numerator events by administrative data	<i>Each indicator, for each age stratification and total</i>
Numerator events by supplemental data	<i>Each indicator, for each age stratification and total</i>
Reported rate	<i>Each indicator, for each age stratification and total</i>

Rules for Allowable Adjustments of HEDIS

This section *may not* be used for reporting health plan 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.

Guidance for Allowable Adjustments for Metabolic Monitoring for Children and Adolescents on Antipsychotics

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 within a specified age range (ages 1–17+ years). Additionally, the upper age range may be expanded, or no upper age limit may be used.
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 dispensing events that contain (or map to) codes in the medication lists and value sets may be used to identify antipsychotic medication events. Medication lists, value sets and logic may not be changed.
Denominator Exclusions	Adjustments Allowed (Yes/No)	Notes
Exclusions	NA	There are no exclusions for this measure.
Numerator Criteria	Adjustments Allowed (Yes/No)	Notes
Metabolic monitoring	No	Value sets and logic may not be changed.

Prenatal and Postpartum Care (PPC)

SUMMARY OF CHANGES TO HEDIS MY 2020 & MY 2021

- Revised the definition of last enrollment segment.
- Clarified that visits that occur prior to the enrollment start date (during the pregnancy) meet criteria.
- Added telephone visits (Telephone Visits Value Set) e-visits and virtual check-ins (Online Assessments Value Set) to the Timeliness of Prenatal Care rate (administrative specification) and clarified in the *Notes* that services provided via telephone, e-visit or virtual check-in are eligible for use in reporting both rates.
- Updated the Hybrid specification to indicate that sample size reduction is allowed using only the current year's administrative rate for MY 2020; for MY 2021, organizations may reduce the sample size using the current year's administrative rate or the prior year's audited, product line-specific rate.
- Added examples of "pregnancy diagnosis" in the Hybrid specification of the Timeliness of Prenatal Care indicator.

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).
Last enrollment segment	The period of continuous enrollment (with no gaps in enrollment) during the pregnancy with the start date that is closest to the delivery date. Use guideline "Members Who Switch Products/Product Lines" in the <i>General Guidelines for Data Collection and Reporting</i> to determine continuous enrollment.

Eligible Population

Note: Members in hospice are excluded from the eligible population. If an organization reports this measure using the Hybrid method, and a member is found to be in hospice or using hospice services during medical record review, the member is removed from the sample and replaced by a member from the oversample. Refer to General Guideline 17: Members in Hospice.

Product lines	Commercial, Medicaid (report each product line separately).
Age	None specified.
Continuous enrollment	43 days prior to delivery through 60 days after delivery.

Allowable gap	No allowable gap during the continuous enrollment period.
Anchor date	Date of delivery.
Benefit	Medical.
Event/diagnosis	<p><i>Delivered a live birth on or between October 8 of the year prior to the measurement year and October 7 of the measurement year.</i> Include women who delivered in any setting.</p> <p><i>Multiple births.</i> 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.</p> <p>Follow the steps below to identify the eligible population, which is the denominator for both rates.</p> <p>Step 1 Identify deliveries. Identify all women with a delivery (<u>Deliveries Value Set</u>) on or between October 8 of the year prior to the measurement year and October 7 of the measurement year.</p> <p>Note: <i>The intent is to identify the date of delivery (the date of the “procedure”). If the date of delivery cannot be interpreted on the claim, use the date of service or, for inpatient claims, the date of discharge.</i></p> <p>Step 2 Exclude non-live births (<u>Non-live Births Value Set</u>).</p> <p>Step 3 Identify continuous enrollment. Determine if enrollment was continuous 43 days prior to delivery through 60 days after delivery, with no gaps.</p>

Administrative Specification

Denominator	The eligible population.
Numerator	
Timeliness of Prenatal Care	<p>A prenatal visit during the required timeframe. Follow the steps below to identify numerator compliance.</p> <p>Step 1 Identify women whose last enrollment segment started before, on or between 280 and 219 days before delivery (or EDD).</p> <p>These women must have a prenatal visit during the first trimester.</p> <p>Step 2 Identify women whose last enrollment segment started less than 219 days before delivery (or EDD).</p> <p>These women must have a prenatal visit any time during the period that begins 280 days prior to delivery and ends 42 days after enrollment start date.</p> <p>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.</p> <p>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:</p>

- 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	<p>A systematic sample drawn from the eligible population for each product line.</p> <p>For MY 2020 reporting, the organization may reduce the sample size using the current year's administrative rate. The prior year's reported rate may not be used when reducing the sample size for MY 2020 reporting.</p> <p>For MY 2021 reporting, organizations may reduce the sample size using the current year's administrative rate or the prior year's audited, product line-specific rate.</p> <p>Refer to the <i>Guidelines for Calculations and Sampling</i> for information on reducing the sample size.</p>
Numerator	
<i>Timeliness of Prenatal Care</i>	A prenatal visit during the required timeframe. Refer to the Administrative Specification to identify the required timeframe for each woman based on the date of enrollment in the organization and the gaps in enrollment during the pregnancy.
<u>Administrative</u>	Refer to <i>Administrative Specification</i> 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 continuously enrolled during the first trimester allow more flexibility than criteria for women who were continuously enrolled.*
 - *For women whose last enrollment segment started before, on or between 280 and 219 days before delivery, the organization has sufficient opportunity to provide prenatal care by the end of the first trimester.*
 - *For women whose last enrollment segment started less than 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, 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-1/2: Data Elements for Prenatal and Postpartum Care

	Administrative	Hybrid
Measurement year	✓	✓
Data collection methodology (Administrative or Hybrid)	<i>For each of the 2 rates</i>	<i>For each of the 2 rates</i>
Eligible population	<i>For each of the 2 rates</i>	<i>For each of the 2 rates</i>
Number of numerator events by administrative data in eligible population (before exclusions)		<i>For each of the 2 rates</i>
Current year's administrative rate (before exclusions)		<i>For each of the 2 rates</i>
Minimum required sample size (MRSS)		<i>For each of the 2 rates</i>
Oversampling rate		<i>For each of the 2 rates</i>
Number of oversample records		<i>For each of the 2 rates</i>
Number of medical records excluded because of valid data errors		<i>For each of the 2 rates</i>
Number of employee/dependent medical records excluded		<i>For each of the 2 rates</i>
Records added from the oversample list		<i>For each of the 2 rates</i>
Denominator		<i>For each of the 2 rates</i>
Numerator events by administrative data	<i>For each of the 2 rates</i>	<i>For each of the 2 rates</i>
Numerator events by medical records		<i>For each of the 2 rates</i>
Reported rate	<i>For each of the 2 rates</i>	<i>For each of the 2 rates</i>

Rules for Allowable Adjustments of HEDIS

This section *may not* be used for reporting health plan 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.

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
Exclusions	NA	There are no exclusions for this measure.
Numerator Criteria	Adjustments Allowed (Yes/No)	Notes
<ul style="list-style-type: none"> 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.

Health Equity: Race, Ethnicity, and Language Stratification Measure

Steward: MA EOHHS Quality Measure Alignment Taskforce
As of June 16, 2021

SUMMARY OF CHANGES FOR 2022

- New measure for 2022.

Background

The Massachusetts Quality Measure Alignment Taskforce (Taskforce) is adopting a Health Equity measure for 2022 focused on stratifying performance for select measures from the Massachusetts Aligned Measure Set.¹ The Taskforce prioritized stratification of measures in the Core Set, which are expected to be used by payers and providers in their global budget-based risk contracts. The Taskforce added a pediatric-focused measure from the Menu Set.

The Health Equity measure will initially focus on stratifying performance by race, ethnicity, and language (REL) to encourage provider organizations to collect REL data and use REL data to stratify measure performance. The Taskforce aims to include a Health Equity measure focused on reducing disparities in performance in the future once provider organizations have more robust REL data.

Description

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

- Measure #1: Comprehensive Diabetes Care: HbA1c Poor Control
- Measure #2: Controlling High Blood Pressure
- Measure #3: Screening for Clinical Depression and Follow-up Plan
- Measure #4: Child and Adolescent Well-Care Visits

General Guidelines

Organizations Responsible and Data Source Used for Reporting Performance	<p>Provider organizations should use their own EHR-based clinical data, patient age and sex data, and REL data to report stratified performance for Measures #1 - #3.</p> <p>Because Measure #4 uses only administrative data, provider organizations should leverage payer-provided data for measure performance and their own REL data to report stratified performance for Measure #4. For example, payers could share a spreadsheet with information on which patients meet the numerator for the measure. Provider organizations could use this information to update data in their EHRs and report performance on the measure.</p>
---	--

¹ For more information on the Massachusetts Quality Measure Alignment Taskforce and the Massachusetts Aligned Measure Set, see: <https://www.mass.gov/info-details/eohhs-quality-measure-alignment-taskforce>.

	Alternatively, provider organizations could report performance for Measure #4 using data from their EHRs if it includes information on whether a patient had a well-care visit. The limitation of this approach, however, is that EHR data likely would not contain information on whether a patient received a well-care visit from another provider organization.
Overall Parameters for Stratification	<p>Provider organizations should report stratified performance:</p> <ul style="list-style-type: none"> • for each race, ethnicity, and language stratification category separately (e.g., within race, report measure performance separately for White, Black or African American, etc.; within ethnicity, report measure performance separately for Hispanic/Latino and non-Hispanic/Latino; within language, report measure performance separately for English, Spanish, etc.); • using patient self-reported data gathered by the provider organization wherever possible rather than imputing a patient's REL; • for their entire patient population meeting each measure's specifications, across health plans and lines of business, and • only for measures relevant to the population served by the provider organization (e.g., a pediatric provider organization will not be expected to report performance for Measure #1 and Measure #2).
Data Completeness Threshold	There is no data completeness threshold for reporting performance stratified by REL. Organizations should report on all patients for whom they have REL data.
Required REL Reporting Categories	<p>Organizations should report stratified performance for the REL categories that the provider organization is currently using. Provider organizations are not expected to modify their REL categories for the purpose of reporting performance.²</p> <p><i>Note: If the categories within each race, ethnicity and language stratification are mutually exclusive, the sum of all stratifications should equal the total population (e.g., if an organization uses five race categories for stratification, the sum of all five race stratifications should equal the total population).</i></p>

Measure #1: Comprehensive Diabetes Care: HbA1c Poor Control (CMS122v9)³

Measure #1 – Description

Percentage of patients 18-75 years of age with diabetes who had hemoglobin A1c >9.0% during the measurement year

Measure #1 – Denominator

Initial Population	Patients 18-75 years of age with diabetes with a visit during the measurement period
---------------------------	--

² The language category does not distinguish whether the organization is collecting data for patient's preferred language versus language spoken.

³ Source: CMS 2021 eCQM specifications for Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%).
<https://ecqi.healthit.gov/ecqm/ep/2021/cms122v9>.

Denominator Statement	Equals Initial Population
Denominator Exclusions	<ul style="list-style-type: none"> • Exclude patients whose hospice care overlaps the measurement period. • Exclude patients 66 and older who are living long term in an institution for more than 90 consecutive days during the measurement period. • Exclude patients 66 and older with advanced illness and frailty because it is unlikely that patients will benefit from the services being measured.
Denominator Exceptions	None
Rate 1	The denominator statement.
Rate 2	The denominator statement. Separately report the percentage of patients in the denominator statement for which the provider organization has complete race data.
Rate 3	The denominator statement. Separately report the percentage of patients in the denominator statement for which the provider organization has complete ethnicity data.
Rate 4	The denominator statement. Separately report the percentage of patients in the denominator statement for which the provider organization has complete language data.

Measure #1 – Numerator

Numerator Statement	Patients whose most recent HbA1c level (performed during the measurement period) is >9.0%
Numerator Exclusions	None
Guidance	<p>Patient is numerator compliant if most recent HbA1c level >9%, the most recent HbA1c result is missing, or if there are no HbA1c tests performed and results documented during the measurement period. If the HbA1c test result is in the medical record, the test can be used to determine numerator compliance.</p> <p>Only patients with a diagnosis of Type 1 or Type 2 diabetes should be included in the denominator of this measure; patients with a diagnosis of secondary diabetes due to another condition should not be included.</p>
Rate 1	The numerator statement.
Rate 2	The numerator statement, stratified by race.
Rate 3	The numerator statement, stratified by ethnicity.
Rate 4	The numerator statement, stratified by language.

Measure #2: Controlling High Blood Pressure (CMS165v9)⁴

Measure #2 – Description

⁴ Source: CMS 2021 eCQM specifications. <https://ecqi.healthit.gov/ecqm/ep/2021/cms165v9>.

Percentage of patients 18-85 years of age who had a diagnosis of hypertension overlapping the measurement period or the year prior to the measurement period, and whose most recent blood pressure was adequately controlled (<140/90mmHg) during the measurement period

Measure #2 – Denominator

Initial Population	Patients 18-85 years of age who had a visit and diagnosis of essential hypertension overlapping the measurement period or the year prior to the measurement period
Denominator Statement	Equals Initial Population
Denominator Exclusions	<ul style="list-style-type: none"> • Patients with evidence of end stage renal disease (ESRD), dialysis or renal transplant before or during the measurement period. Also exclude patients with a diagnosis of pregnancy during the measurement period. • Exclude patients whose hospice care overlaps the measurement period. • Exclude patients 66 and older who are living long term in an institution for more than 90 consecutive days during the measurement period. • Exclude patients 66 and older with advanced illness and frailty because it is unlikely that patients will benefit from the services being measured.
Denominator Exceptions	None
Rate 1	The denominator statement.
Rate 2	The denominator statement. Separately report the percentage of patients in the denominator statement for which the provider organization has complete race data.
Rate 3	The denominator statement. Separately report the percentage of patients in the denominator statement for which the provider organization has complete ethnicity data.
Rate 4	The denominator statement. Separately report the percentage of patients in the denominator statement for which the provider organization has complete language data.

Measure #2 – Numerator

Numerator Statement	Patients whose most recent blood pressure is adequately controlled (systolic blood pressure < 140 mmHg and diastolic blood pressure < 90 mmHg) during the measurement period
Numerator Exclusions	None
Guidance	<p>In reference to the numerator element, only blood pressure readings performed by a clinician or a remote monitoring device are acceptable for numerator compliance with this measure.</p> <p>Do not include BP readings:</p> <ul style="list-style-type: none"> • 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

	<p>blood tests.</p> <ul style="list-style-type: none"> Reported by or taken by the patient <p>If no blood pressure is recorded during the measurement period, the patient's blood pressure is assumed "not controlled."</p> <p>If there are multiple blood pressure readings on the same day, use the lowest systolic and the lowest diastolic reading as the most recent blood pressure reading.</p>
Rate 1	The numerator statement.
Rate 2	The numerator statement, stratified by race.
Rate 3	The numerator statement, stratified by ethnicity.
Rate 4	The numerator statement, stratified by language.

Measure #3: Screening for Depression and Follow-up Plan (CMS2v10)⁵

Measure #3 – 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

Measure #3 – Denominator

Initial Population	All patients aged 12 years and older at the beginning of the measurement period with at least one eligible encounter during the measurement period
Denominator Statement	Equals Initial Population
Denominator Exclusions	Patients who have been diagnosed with depression or with bipolar disorder
Denominator Exceptions	<ul style="list-style-type: none"> Patient Reason(s) Patient refuses to participate Medical Reason(s) <p><i>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)</i></p>
Rate 1	The denominator statement.
Rate 2	The denominator statement. Separately report the percentage of patients in the denominator statement for which the provider organization has complete race data.
Rate 3	The denominator statement. Separately report the percentage of patients in the denominator statement for which the provider organization has complete ethnicity data.

⁵ Source: CMS 2021 eCQM specifications. <https://ecqi.healthit.gov/ecqm/ep/2021/cms002v10>.

Rate 4	The denominator statement. Separately report the percentage of patients in the denominator statement for which the provider organization has complete language data.
---------------	--

Measure #3 – Numerator

Numerator Statement	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
Numerator Exclusions	None
Guidance	<p>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.</p> <p>This eCQM is a patient-based measure. Depression screening is required once per measurement period, not at all encounters.</p> <p>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.</p> <p>Screening Tools:</p> <ul style="list-style-type: none"> • 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, filing the code, 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.

	<p>Follow-Up Plan: The follow-up plan must be related to a positive depression screening, for example: "Patient referred for psychiatric evaluation due to positive depression screening."</p> <p>Examples of a follow-up plan include but are not limited to:</p> <ul style="list-style-type: none"> 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 <p>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.</p>
Rate 1	The numerator statement.
Rate 2	The numerator statement, stratified by race.
Rate 3	The numerator statement, stratified by ethnicity.
Rate 4	The numerator statement, stratified by language.

Measure #4: Child and Adolescent Well-Care Visits⁶

Measure #4 – Description

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

Measure #4 – Denominator

Initial Population	Patients 3-21 years of age during the measurement period
Denominator Statement	Equals Initial Population
Denominator Exclusions	None
Denominator Exceptions	None
Rate 1	The denominator statement.
Rate 2	The denominator statement. Separately report the percentage of patients in the denominator statement for which the provider organization has complete race data.

⁶ Source: Adapted from NCQA HEDIS MY 2021 specifications.

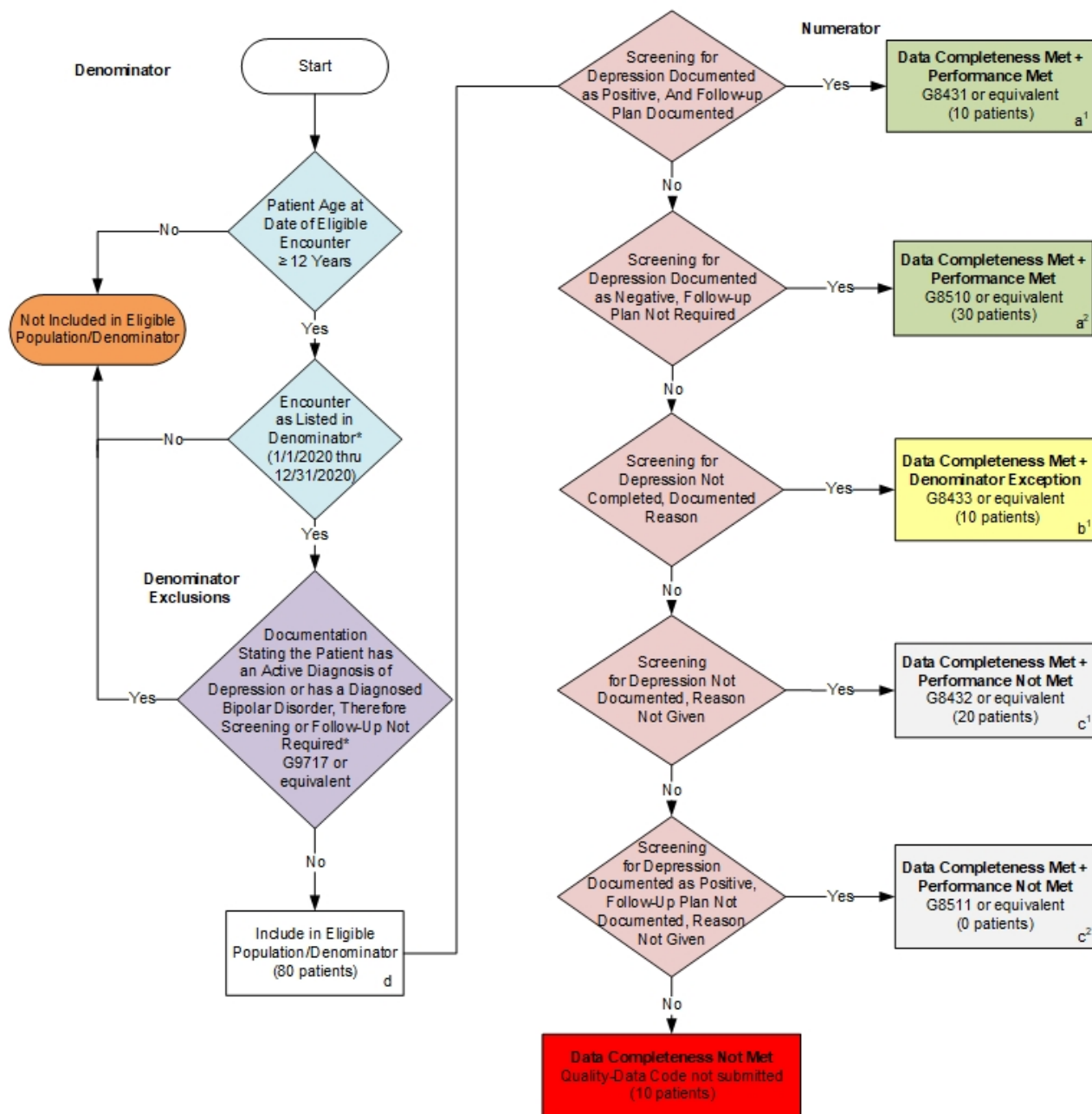
Rate 3	The denominator statement. Separately report the percentage of patients in the denominator statement for which the provider organization has complete ethnicity data.
Rate 4	The denominator statement. Separately report the percentage of patients in the denominator statement for which the provider organization has complete language data.

Measure #4 – Numerator

Numerator Statement	<p>Patients who received one or more well-care visits during the measurement year</p> <p>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</p>
Numerator Exclusions	None
Guidance	<p>This measure requires use of administrative data to identify well-care visits. Provider organizations should leverage payer-provided data for measure performance. For example, payers could share a spreadsheet with information on which patients meet the numerator for the measure. Provider organizations could use this information to update data in their EHRs and report performance on the measure.</p> <p>Alternatively, provider organizations could report performance for this measure using data from their EHRs if it includes information on whether a patient had a well-care visit. The limitation of this approach, however, is that EHR data likely would not contain information on whether a patient received a well-care visit from another provider organization.</p>
Codes to Identify Well-Care Visits	<p>99381-99385; 99391-99395; 99461; G0438-G0439; S0302; Z00.00-Z00.01; Z00.110-Z00.111; Z00.121; Z00.129; Z00.2; Z00.3; Z02.5; Z76.1; Z76.2; 103740001; 170099002; 170107008; 170114005; 170123008; 170132005; 170141000; 170150003; 170159002; 170168000; 170250008; 170254004; 170263002; 170272005; 170281004; 170290006; 170300004; 170309003; 171387006; 171394009; 171395005; 171409007; 171410002; 171416008; 171417004; 243788004; 268563000; 270356004; 401140000; 410620009; 410621008; 410622001; 410623006; 410624000; 410625004; 410626003; 410627007; 410628002; 410629005; 410630000; 410631001; 410632008; 410633003; 410634009; 410635005; 410636006; 410637002; 410638007; 410639004; 410640002; 410641003; 410642005; 410643000; 410644006; 410645007; 410646008; 410647004; 410648009; 410649001; 410650001; 442162000; 783260003; 444971000124105; 446301000124108; 446381000124104; 669251000168104; 669261000168102; 669271000168108; 669281000168106</p>
Rate 1	The numerator statement.
Rate 2	The numerator statement, stratified by race.
Rate 3	The numerator statement, stratified by ethnicity.
Rate 4	The numerator statement, stratified by language.

**2020 Clinical Quality Measure Flow for Quality ID #134 NQF #0418:
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=

$$\frac{\text{Performance Met (a}^1\text{+a}^2\text{=40 patients) + Denominator Exception (b}^1\text{=10 patients) + Performance Not Met (c}^1\text{+c}^2\text{=20 patients)}}{\text{Eligible Population / Denominator (d=80 patients)}} = \frac{70 \text{ patients}}{80 \text{ patients}} = 87.50\%$$

Performance Rate=

$$\frac{\text{Performance Met (a}^1\text{+a}^2\text{=40 patients)}}{\text{Data Completeness Numerator (70 patients) - Denominator Exception (b}^1\text{=10 patients)}} = \frac{40 \text{ patients}}{60 \text{ patients}} = 66.67\%$$

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

NOTE: Submission Frequency: Patient-Process

CPT only copyright 2019 American Medical Association. All rights reserved.
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. v4

**2020 Clinical Quality Measure Flow Narrative for Quality ID #134 NQF #0418:
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 Patient Age:
 - a. If the Patient Age is greater than or equal to 12 Years on Date of Eligible Encounter equals No during the measurement period, do not include in Eligible Population. Stop Processing.
 - b. If the Patient Age is greater than or equal to 12 Years on Date of Eligible Encounter equals Yes during the measurement period, proceed to check Encounter Performed.
3. Check Encounter Performed:
 - a. If Encounter as Listed in the Denominator equals No, do not include in Eligible Population. Stop Processing.
 - b. If Encounter as Listed in the Denominator equals Yes, proceed to check Documentation Stating the Patient has an Active Diagnosis of Depression or has a Diagnosed Bipolar Disorder, Therefore Screening or Follow-Up Not Required*.
4. Check Documentation Stating the Patient has an Active Diagnosis of Depression or has a Diagnosed Bipolar Disorder, Therefore Screening or Follow-Up Not Required*:
 - a. If Documentation Stating the Patient has an Active Diagnosis of Depression or has a Diagnosed Bipolar Disorder, Therefore Screening or Follow-up Not Required equals Yes, do not include in Eligible Population.
Stop Processing
 - b. If Documentation Stating the Patient has an Active Diagnosis of Depression or has a Diagnosed Bipolar Disorder, Therefore Screening or Follow-up Not Required equals No, include in Eligible Population.
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 Documented as Positive, And Follow-up Plan Documented:
 - a. If Screening for Depression Documented as Positive, And Follow-up Plan Documented equals Yes, include in Data Completeness Met and Performance Met.
 - b. 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 a¹ equals 10 patients in the Sample Calculation.
 - c. If Screening for Depression Documented as Positive, And Follow-up Plan Documented equals No, proceed to check Screening for Depression Documented as Negative, Follow-up Plan Not Required.
8. Check Screening for Depression Documented as Negative, Follow-up Plan Not Required:

- a. If Screening for Depression Documented as Negative, Follow-up Plan Not Required equals Yes, include in Data Completeness Met and Performance Met.
 - b. 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 a² equals 30 patients in the Sample Calculation.
 - c. If Screening for Depression Documented as Negative, Follow-up Plan 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.
 - b. 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 b¹ equals 10 patients in the Sample Calculation.
 - c. If Screening for Depression Not Completed, Documented Reason equals No, proceed to check Screening for Depression Not Documented, Reason Not Given.
10. Check Screening for Depression Not Documented, Reason Not Given:
- a. If Screening for Depression Not Documented, Reason Not Given equals Yes, include in the Data Completeness Met and Performance Not Met.
 - b. 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 c¹ equals 20 patients in the Sample Calculation.
 - c. If Screening for Depression 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.
 - b. 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 c² equals 0 patients in the Sample Calculation.
 - c. 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=

$$\frac{\text{Performance Met (a}^1\text{+a}^2\text{=40 patients)} + \text{Denominator Exception (b}^1\text{=10 patients)} + \text{Performance Not Met (c}^1\text{+c}^2\text{=20 patients)}}{\text{Eligible Population / Denominator (d=80 patients)}} = \frac{70 \text{ patients}}{80 \text{ patients}} = 87.50\%$$

Performance Rate=

$$\frac{\text{Performance Met (a}^1\text{+a}^2\text{=40 patients)}}{\text{Data Completeness Numerator (70 patients) - Denominator Exception (b}^1\text{=10 patients)}} = \frac{40 \text{ patients}}{60 \text{ patients}} = 66.67\%$$

MassHealth ACO Quality Measurement Program
ACO#5: Screening for Depression and Follow-Up Plan

Source	Year	Steward
Hybrid	2019	CMS



Overview

Measure Name	Screening for Depression and Follow-Up Plan
Steward	CMS
NQF Number	NQF 0418
2019 Benchmark	Reporting Only
Data Source	Hybrid

Population Health Impact

Depression is a common behavioral health condition and one of the leading causes of disability in adolescents and adults. Screening should be implemented with adequate systems in place to ensure accurate diagnosis, effective treatment, and appropriate plan for follow-up

Measure Summary

Description	The percentage of ACO attributed members 12 to 64 years of age on the date of the encounter, with an outpatient visit during the measurement year AND screened for clinical depression using a standardized tool during the measurement year AND, if screened positive, a follow-up plan is documented on the date of the positive screen
Numerator	ACO attributed members 12 to 64 years of age on the date of the encounter, with an outpatient visit during the measurement year AND screened for clinical depression using a standardized tool during the measurement year, AND, if screened positive, a follow-up plan is documented on the date of the positive screen
Denominator	ACO attributed members 12 to 64 years of age on the date of the encounter, with an outpatient visit during the measurement year

Eligible Population

Age	ACO attributed members 12 to 64 years of age on the date of the encounter		
Continuous Enrollment	--		
Allowable Gap	--		
Anchor Date	--		
Event/Diagnosis	At least one eligible encounter during the measurement period <table><tr><th>Depression Screening Eligible Encounter Value Set - CPT/HCPCS Codes</th></tr><tr><td>59400, 59510, 59610, 59618, 90791, 90792, 90832, 90834, 90837, 92625, 96116, 96118, 96150, 96151, 97165, 97166, 97167, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99384, 99385, 99386, 99387, 99394, 99395, 99396, 99397, G0101, G0402, G0438, G0439, G0444, G0502, G0503, G0504, G0505, G0507, T1015</td></tr></table>	Depression Screening Eligible Encounter Value Set - CPT/HCPCS Codes	59400, 59510, 59610, 59618, 90791, 90792, 90832, 90834, 90837, 92625, 96116, 96118, 96150, 96151, 97165, 97166, 97167, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99384, 99385, 99386, 99387, 99394, 99395, 99396, 99397, G0101, G0402, G0438, G0439, G0444, G0502, G0503, G0504, G0505, G0507, T1015
Depression Screening Eligible Encounter Value Set - CPT/HCPCS Codes			
59400, 59510, 59610, 59618, 90791, 90792, 90832, 90834, 90837, 92625, 96116, 96118, 96150, 96151, 97165, 97166, 97167, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99384, 99385, 99386, 99387, 99394, 99395, 99396, 99397, G0101, G0402, G0438, G0439, G0444, G0502, G0503, G0504, G0505, G0507, T1015			
Exclusions	Exclude members with a diagnosis and/or documentation of any of the following: <ul style="list-style-type: none">Members with an active diagnosis* of 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, F53.1, O90.6, O99.340, O99.341, O99.342, O99.343, O99.345		

- Members with an active diagnosis* of 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
 - Members in Hospice (Hospice Value Set)
 - Member refuses to participate
 - Member is in an urgent or emergent situation where time is of the essence and to delay treatment would jeopardize the beneficiary's health status
 - Situations where the member's functional capacity or motivation to improve may impact the accuracy of results of standardized depression assessment tools. For example: certain court appointed cases or cases of delirium
- *Note:** The term "active diagnosis" is defined as a diagnosis that is either on the patient's problem list, a diagnosis code listed on the encounter, or is documented in a progress note indicating that the patient is being treated or managed for the disease or condition during the denominator identification measurement period

Definitions

Screening with a standardized tool

A normalized and validated depression screening tool developed for the patient population in which it is being utilized. Examples of depression screening tools include but are not limited to:

☐ **Adolescent Screening Tools (12-17 years)**

Patient Health Questionnaire for Adolescents (PHQ-A), Beck Depression Inventory-Primary Care Version (BDI-PC), Mood Feeling Questionnaire (MFQ), Center for Epidemiologic Studies Depression Scale (CES-D), and PRIME MD-PHQ2

☐ **Adult Screening Tools (18 years and older)**

Patient Health Questionnaire (PHQ-9), Beck Depression Inventory (BDI or BDI-II), Center for Epidemiologic Studies Depression Scale (CES-D), Depression Scale (DEPS), Duke Anxiety-Depression Scale (DADS), Geriatric Depression Scale (GDS), Cornell Scale Screening, and PRIME MD-PHQ2

Administrative Specification

Denominator

The eligible population

Numerator

Follow-up plan may be documented with administrative data, if available, using the following HCPCS codes (note: date of service delivery for which codes were billed for must match the date of the identified eligible encounter).

Code	Description
G8431	Screening for clinical depression is documented as being positive and a follow-up plan is documented
G8510	Screening for clinical depression is documented as negative, a follow-up plan is not required

Hybrid Specification

Denominator	A systematic sample drawn from the eligible population.
Numerator	<p>Members who were screened for clinical depression using an age-appropriate standardized tool, AND, if screened positive, a follow-up plan is documented on the date of the positive screen.</p> <p>Follow-Up Plan: Documented follow-up for a positive depression screening must include one or more of the following:</p> <ul style="list-style-type: none"> • Additional evaluation for depression • Suicide Risk Assessment • 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 <p>GUIDANCE:</p> <p>A depression screen is completed on 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 positive screen. If more than one depression screenings are administered to a member during the measurement period, use the most recent screening.</p> <p>Screening Tools:</p> <ul style="list-style-type: none"> • 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 filing the code, on the date of the encounter • The screening and encounter must occur on the same date • Standardized Depression Screening Tools should be normalized and validated for the age appropriate patient population in which they are used and must be documented in the medical record <p>Follow-Up Plan:</p> <ul style="list-style-type: none"> • The follow-up plan must be related to a positive depression screening, example: "Patient referred for psychiatric evaluation due to positive depression screening."

Additional Measure Information

Risk Adjustment	None
NCQA HEDIS® Measure ID	N/A
Summary of Modifications	<ul style="list-style-type: none"> • Defined the population as MassHealth members in the ACO. • Combined Adult Core and Child Core age requirements into a single measure (limiting age range to 12-64).

MassHealth ACO Quality Measurement Program	Source	Year	Steward
ACO#5: Screening for Depression and Follow-Up Plan	Hybrid	2019	CMS



	<ul style="list-style-type: none"> Added T1015 code as an eligible encounter.
HEDIS Version	--
HEDIS Value Set: Inclusion Criteria	--
HEDIS Value Set: Exclusion Criteria	<ul style="list-style-type: none"> <u>Hospice Value Set*</u>

Measure Specific Notification:

Prior to the clinical data collection timeframe for hybrid measures, MassHealth will provide additional guidance to ACOs regarding the appropriate identification and application of denominator exclusions for ACO #5, Screening for Depression and Follow Up Plan.

Note: Where appropriate, national quality measure stewards, including NCQA, incorporate the use of LOINC, SNOMED, and CVX codes within measure value sets. EOHHS does not capture these codes in claims/encounter submission and data storage processes, and as such, cannot utilize these codes as part of denominator/numerator inclusionary logic for ACO quality measure calculation.

*HEDIS® Value Set used with permission from NCQA.

*Certain HEDIS Value Sets developed by the National Committee for Quality Assurance ("NCQA") are being used by EOHHS in association with third party non-NCQA measures. Proprietary coding is contained in the HEDIS Value Sets. Users of the proprietary code sets should obtain all necessary licenses from the owners of these code sets. NCQA disclaims all liability for use of the HEDIS Value Sets or accuracy of any coding contained in the HEDIS Value Sets.

HEDIS®

The Healthcare Effectiveness Data and Information Set (HEDIS®) is a registered trademark of NCQA.

Measure Specification Updated 12/13/2019

Shared Decision Making Process Survey

NQF Measure 2962

User Guide

I. Purpose:

To measure the extent to which patients are involved in the decision-making process.

II. Versions:

Shared Decision Making Process_4: 4 item version of the shared decision making process survey. The survey is able to be adapted to specific conditions and options. As shown in the Table, Item 3 varies depending on whether there are two options or more than two options.

III. Timing

The SDM Process_4 survey should be administered after a consult with a health care provider where a decision was discussed. The items were written assuming that the choice is known (e.g. that the patient is having or had surgery, taking medication, having the screening test, etc).

Modifications may be required if it is to be used before the choice is known.

IV. Scoring:

Each response is scored 0 or 1 according to the labels in the Table. Participants receive 1 point for a response of "yes" or "a lot" or "some." The total points are summed and result in total scores from 0 -4, with higher scores indicating more shared decision making. Surveys with one or more missing items do not get a total score.

Table: Shared Decision Making Process_4 survey

Instructions	TALKING WITH YOUR HEALTH CARE PROVIDERS Please answer these questions about what happened when you talked with health care providers including doctors, nurses and other health care professionals about [tests or treatments] for your [condition].
Items	1. How much did you and your health care providers talk about the reasons you might want to have [test/intervention]? <input type="checkbox"/> ₁ A lot <input type="checkbox"/> ₁ Some <input type="checkbox"/> ₀ A little <input type="checkbox"/> ₀ Not at all

	<p>2. How much did you and your health care providers talk about the reasons you might not want to have [test/intervention]?</p> <p><input type="checkbox"/>₁ A lot</p> <p><input type="checkbox"/>₁ Some</p> <p><input type="checkbox"/>₀ A little</p> <p><input type="checkbox"/>₀ Not at all</p> <p>3. Did any of your health care providers talk about [an alternative to intervention, e.g. non-surgical treatments/not testing] as something that you should seriously consider?</p> <p>[Version for situations with more than two options: Did any of your health care providers explain that there were choices in what you could do to treat your [condition]?]</p> <p><input type="checkbox"/>₁ Yes</p> <p><input type="checkbox"/>₀ No</p> <p>4. Did any of your health care providers ask if you wanted to have [test/intervention]?</p> <p><input type="checkbox"/>₁ Yes</p> <p><input type="checkbox"/>₀ No</p>
--	--

III. NQF PRO-PM Measure #2962 specifications:

The SDMP_4 is used as the basis for a patient-reported outcome performance measure (PRO-PM). The following describes calculation for that measure.

- **Numerator Statement:** The numerator is the sum of the total scores (0-4) for all those responding.
- **Denominator Statement:** The denominator includes the number of respondents from the target population of adults who have undergone a procedure for one of the target conditions and completed the survey.
- **Denominator Exclusions:** Respondents who are missing 1 or more items do not get a total score and are excluded. No other exclusions as long as the respondent has the procedure for the designated condition.
- **Sampling:** Patients of a particular surgeon or at a particular clinical site (which could be a group of providers or a hospital or other surgical site) who had a one of the procedures are identified from medical records, claims or in some other way. Sampling should allow time for immediate recovery, while attempting to survey shortly after the procedure, for example, by sampling eligible patients 1- 6 months after the procedure. Patients can be sampled sequentially, or a pool of such patients who had the procedure in a particular time period (e.g. in the last 3 months) can be created and sampled at a rate that produces the desired number of potential respondents.

The measure can also be calculated from a population-based sample, such as a sample of a population in a geographic area. Eligible respondents could be identified from claims (such as Medicare claims files) or based on patient self-reports of having had the procedures within some time frame.

- Proxy respondents are not permitted. The patients who receive the test or intervention for the target condition should answer the survey questions.

VI. Development Process:

In 2007, a team of researchers at the University of Michigan developed several items to be used in the DECISIONS survey, the first national survey of how common medical decisions were being made in the United States [1,2]. One key goal was to develop items that would assess the extent to which shared decision making happened across 10 different medical decisions. The SDM Process Survey is based on four questions from that survey.

The survey items were derived from the shared decision making model (SDM), a conceptual framework that was first outlined by Mulley in the late 1980s [3] and extended by Mulley and Sepucha [4-5]. The model takes a systems approach to understanding and improving clinical decision making that focuses on two key participants: patients (and family) and clinicians. The model emphasizes the fundamentally social nature of the decision making task, and the fact that it cannot be completed by the clinicians or patients alone, but rather requires interactions between them. The guiding principles behind the items included: 1) patients should have adequate knowledge and experience to answer; 2) minimize need for judgment or evaluation; 3) cover the key elements necessary for a shared decision process; 4) be short and easy to adapt to a variety of settings. Although the items do not cover all possible SDM behaviors, these four elements (discussion of options, pros, cons and preferences) are foundational components in widely accepted definitions [5-7].

VII. Psychometric Properties:

Feasibility: The survey is feasible and typically has very low missing data (1-3%). [e.g. see 8]

Acceptability: The survey is acceptable with high response rates when administered by mail, online or by phone, and takes < 2 minutes to complete.

Floor and ceiling effects: The SDMP_4 has not shown floor or ceiling effects. In a national study of 10 different medical conditions, mean scores varied widely, with lowest for mammography (mean = 1.5 out of 4), and the highest for surgery for low back pain (mean = 3.2 out of 4). [8]

Reliability:

- Internal consistency: the score is technically a composite and as a result, Cronbach's alpha may not be an appropriate measure of reliability, however we have calculated it for some samples and found Cronbach alphas of 0.77 for breast cancer surgery [9], 0.78 for hip and knee osteoarthritis [10], 0.54 for spine [11], 0.87 for hip and knee osteoarthritis [11]
- Retest reliability: short term (~4 week) retest reliability ICC=0.64 (95% CI 0.67, 0.86) [9]
- Practice level reliability: When we drew random samples of patients from the same sites who had made decisions, the correlations of the SDMP_4 scores averaged .61 [13]

Validity

- Content validity was confirmed through the extensive feedback from patients and providers in the development process as well as in the field tests.
- Construct validity: Those who had higher SDMP scores reported
 - better decision quality, [10]
 - were less likely to think they made the wrong decision, [9] and
 - reported less dissonance (conflict between what was important to them and the decision that was made). [12]
 - clinical sites that made an effort to implement SDM (with patient decision aids and/or coaching) had higher scores than usual care sites [11, 13]

VIII. Sample size considerations

The standard deviations for the measure vary by topic and sample (ranging from 0.83-1.25). We have observed a 0.3SD-0.5SD difference between sites that do and do not make an effort to do shared decision making. A sample size of about 50-60 would be needed to detect differences in proportions of .5 SD for the measure with 80% power assuming standard deviation of about 1.

IX. Appropriate Use

The SDM Process_4 is protected by copyright. It is available to use at no cost, provided that you:

- Cite the reference in any questionnaires or publications
- Do not charge for or profit from it
- Do not alter items except for customization for a specific condition/interventions and reformatting

X. Suggested Citation for the SDM Process_4 User Guide:

Sepucha KR and Fowler FJ. Shared Decision Making Process_4 User Guide v.1.0. ©Massachusetts General Hospital, 2018.

XI. References:

1. Zikmund-Fisher BJ, Couper MP, Singer E, Levin C, Fowler Jr. FJ, Ziniel S, et al. The DECISIONS study: a nationwide survey of U.S. adults regarding nine common medical decisions. *Medical Decision Making*. September/October 2010; 30: 20S- 34S.
2. Zikmund-Fisher B, Couper M, Singer E, Ubel P, Fowler F, Levin C, Ziniel S, Fagerlin A. Deficits and variations in patients' experience with making 9 common medical decisions: The DECISIONS survey. *Medical Decision Making*. September/October 2010; 30: 85S-95S.
3. Mulley, A. J. (1990). Methodological issues in the application of effectiveness and outcomes research to clinical practice. *Effectiveness and Outcomes in Health Care*. Washington D.C., National Academy Press.
4. Sepucha K and Mulley A. Extending Decision Support: Preparation and Implementation. *Patient Education and Counseling* 2003; 50 (3):269-271.
5. Sepucha K and Mulley A. A Perspective on the Patient's Role in Treatment Decisions. *Medical Care Research and Review* 2009 66:54S-74S.

6. Charles, C, Gafni, A and Whelan, T. Decision- making in the physician-patient encounter: revising the shared decision –making model. *Soc Sci and Med*, 491 (1999) 65, 651-661.
7. Makoul, G and Clayman, ML An integrative model of shared decision making in medical encounters. *Patient Educ and Couns.* (2006), 60, 301-312.
8. Fowler, FJ, Gerstein, BS, Barry, MJ How patient centered are medical decisions? *JAMA Internal Medicine* 2013 173 (13) 1215-1221.
9. Sepucha K, Feibelman S, Chang Y, Hewitt S, Ziogas A. Measuring the quality of surgical decisions for Latina breast cancer patients. *Health Expect* 2014 May 12 [Epub ahead of print].
10. Sepucha K, Feibelman S, Chang Y, Clay CF, Kearing S, Tomek I, Yang TS, Katz JN. Factors associated with high decision quality for treatment of hip and knee osteoarthritis. *J Am Coll Surg* 2013 Oct;217(4):694-701. doi: 10.1016/j.jamcollsurg.2013.06.002. Epub 2013 Jul 25.
11. Sepucha K, Atlas SJ, Chang Y, Dorrwachter J, Freiberg A, Mangla M, Rubash HE, Simmons LH, Cha T. Patient Decision Aids Improve Decision Quality and Patient Experience and Reduce Surgical Rates in Routine Orthopaedic Care: A Prospective Cohort Study. *J Bone Joint Surg Am.* 2017 Aug 2;99(15):1253-1260. doi: 10.2106/JBJS.16.01045. PubMed PMID: 28763411.
12. Fowler FJ, Gallagher PM, Drake KM, Sepucha K. Decision Dissonance: Evaluation of an Approach to Measuring the Quality of Surgical Decision Making. *Jt Comm J Qual Patient Saf* 2013 Mar;39(3):136-44.
13. Fowler FJ and Sepucha K. National Quality Forum Measure Testing Attachment for Measure 2962. Available from <http://www.qualityforum.org/> using the Find Measures application.

Shared Decision Making Process Survey: SDM Process_4

For situations with two main options insert condition (e.g. knee osteoarthritis) and chosen option (e.g. surgery) and alternative option (e.g. non surgical treatment):

TALKING WITH YOUR HEALTH CARE PROVIDERS

Please answer these questions about what happened when you talked with health care providers including doctors, nurses and other health care professionals about [tests or treatments] for your [condition].

1. How much did you and your health care providers talk about the reasons you might want to have [test/intervention]?

- ☐₁ A lot
☐₁ Some
☐₀ A little
☐₀ Not at all

2. How much did you and your health care providers talk about the reasons you might **not** want to have [test/intervention]?

- ☐₁ A lot
☐₁ Some
☐₀ A little
☐₀ Not at all

3. Did any of your health care providers talk about [an alternative to intervention, e.g. non-surgical treatments/not testing] as something that you should seriously consider?

- ☐₁ Yes
☐₀ No

4. Did any of your health care providers ask if you wanted to have [test/intervention]?

- ☐₁ Yes
☐₀ No

For situations with **more than** two main options insert condition (e.g. prostate cancer) and chosen option (e.g. surgery):

TALKING WITH YOUR HEALTH CARE PROVIDERS

Please answer these questions about what happened when you talked with health care providers including doctors, nurses and other health care professionals about [tests or treatments] for your [condition].

1. How much did you and your health care providers talk about the reasons you might want to have [test/intervention]?

- ☐₁ A lot
☐₁ Some
☐₀ A little
☐₀ Not at all

2. How much did you and your health care providers talk about the reasons you might **not** want to have [test/intervention]?

- ☐₁ A lot
☐₁ Some
☐₀ A little
☐₀ Not at all

3. Did any of your health care providers explain that there were choices in what you could do to treat your [condition]?

- ☐₁ Yes
☐₀ No

4. Did any of your health care providers ask if you wanted to have [test/intervention]?

- ☐₁ Yes
☐₀ No

Definitions:

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

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

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

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

Substance Use Assessment in Primary Care

Methodology: IEHP-Defined Quality Measure

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

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

CODES TO IDENTIFY SUBSTANCE USE ASSESSMENT IN PRIMARY CARE:

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

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

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

Population: Women

Breast Cancer Screening (BCS)

Methodology: HEDIS®

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

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

Use of Imaging Studies for Low Back Pain (LBP)

SUMMARY OF CHANGES TO HEDIS MY 2020 & MY 2021

- In the *Rules for Allowable Adjustments* section, clarified that the numerator criteria may be adjusted with limits.

Description

The percentage of members with a primary 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 $[1 - (\text{numerator} / \text{eligible population})]$. 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 primary 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

Note: Members in hospice are excluded from the eligible population. Refer to General Guideline 17: Members in Hospice.

Product line	Commercial, Medicaid (report each product line separately).
Ages	18 years as of January 1 of the measurement year to 50 years as of December 31 of the measurement year.
Continuous enrollment	180 days (6 months) prior to the IESD through 28 days after the IESD.
Allowable gap	No gaps in enrollment during the continuous enrollment period.
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: Exclude any member who had a diagnosis for which imaging is clinically appropriate. Any of the following meet criteria:
Required exclusions

- *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-day prescription dispensed on June 1 and a 30-day prescription dispensed on June 26, there are 60 covered calendar days (June 1–July 30).

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-day 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

Step 5 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: Data Elements for Use of Imaging Studies for Low Back Pain

	Administrative
Measurement year	✓
Eligible population	✓
Number of required exclusions	✓
Numerator events by administrative data	✓
Reported rate	✓

Rules for Allowable Adjustments of HEDIS

This section *may not* be used for reporting health plan 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.

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	No	Apply required exclusions according to specified medication lists and value sets.
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.

Well-Child Visits in the First 30 Months of Life (W30)

SUMMARY OF CHANGES TO HEDIS MY 2020 & MY 2021

- Revised the measure name to *Well-Child Visits in the First 30 Months of Life*.
- Retired the 0, 1, 2, 3, 4 and 5 well-child visit rates.
- Added Rate 2 for children who turned 30 months old during the measurement year and had two or more well-child visits in the last 15 months.
- Removed the Hybrid Data Collection Method.
- Removed the telehealth exclusion.
- Revised the Data Elements for Reporting table.
- Revised the Ages criteria in the *Rules for Allowable Adjustments* section to only allow ranges within the specified age range of the measure.

Description

The percentage of members who had the following number of well-child visits with a PCP during the last 15 months. The following rates are reported:

1. *Well-Child Visits in the First 15 Months*. Children who turned 15 months old during the measurement year: Six or more well-child visits.
2. *Well-Child Visits for Age 15 Months–30 Months*. Children who turned 30 months old during the measurement year: Two or more well-child visits.

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: Rate 1—Well-Child Visits in the First 15 Months

Note: Members in hospice are excluded from the eligible population. Refer to General Guideline 17: Members in Hospice.

Product lines	Commercial, Medicaid (report each product line separately).
Ages	Children who turn 15 months old during the measurement year. Calculate the 15-month birthday as the child's first birthday plus 90 days.
Continuous enrollment	31 days–15 months of age. Calculate 31 days of age by adding 31 days to the date of birth.
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	The date when the child turns 15 months old.

Benefit	Medical.
Event/diagnosis	None.

Administrative Specification: *Rate 1—Well-Child Visits in the First 15 Months*

Denominator	The Rate 1 eligible population.
Numerator	Six or more well-child visits (<u>Well-Care Value Set</u>) on different dates of service on or before the 15-month birthday. The well-child visit must occur with a PCP, but the PCP does not have to be the practitioner assigned to the child.

Eligible Population: *Rate 2—Well-Child Visits for Age 15 Months–30 Months*

Note: Members in hospice are excluded from the eligible population. Refer to General Guideline 17: Members in Hospice.

Product lines	Commercial, Medicaid (report each product line separately).
Ages	Children who turn 30 months old during the measurement year. Calculate the 30-month birthday as the second birthday plus 180 days.
Continuous enrollment	15 months plus 1 day–30 months of age. Calculate the 15-month birthday plus 1 day as the first birthday plus 91 days.
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	The date when the child turns 30 months old.
Benefit	Medical.
Event/diagnosis	None.

Administrative Specification: *Rate 2—Well-Child Visits for Age 15 Months–30 Months*

Denominator	The Rate 2 eligible population.
Numerator	Two or more well-child visits (<u>Well-Care Value Set</u>) on different dates of service between the child's 15-month birthday plus 1 day and the 30-month birthday. The well-child visit must occur with a PCP, but the PCP does not have to be the practitioner assigned to the child.

Note

- Refer to Appendix 3 for the definition of PCP.
- 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 W30-1/2: Data Elements for Well-Child Visits in the First 30 Months of Life

	Administrative
Measurement year	✓
Eligible population	<i>Each of the 2 rates</i>
Numerator events by administrative data	<i>Each of the 2 rates</i>
Numerator events by supplemental data	<i>Each of the 2 rates</i>
Reported rate	<i>Each of the 2 rates</i>

Rules for Allowable Adjustments of HEDIS

This section *may not* be used for reporting health plan 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.

Rules for Allowable Adjustments for Well-Child Visits in the First 30 Months of Life

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 15 months 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.
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
Exclusions	NA	There are no exclusions for this measure.
Numerator Criteria	Adjustments Allowed (Yes/No)	Notes
<ul style="list-style-type: none"> Well Care Visits in the First 15 Months Well Care Visits for Age 15 Months–30 Months 	No	Value sets and logic may not be changed.