

**Connecticut Quality Council
2023 Aligned Measure Set Annual Review
Measure Specifications**

June 15, 2023 Meeting

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Asthma Medication Ratio (AMR)

SUMMARY OF CHANGES TO HEDIS MY 2023

- Added instructions to report rates stratified by race and ethnicity for each product line.
- Clarified in the “Event/diagnosis” criteria that required exclusions are not a step.
- Added a required exclusion for members who died during the measurement year.
- Removed “Dyphylline Guaifenesin Medications Lists” from the Asthma Controller Medications table.
- Added new data elements tables for race and ethnicity stratification reporting.
- Revised the “Other” criteria in the Nonclinical Components table under *Rules for Allowable Adjustments of HEDIS*.
- Revised the “Required exclusions” criteria in the Clinical Components table under *Rules for Allowable Adjustments of HEDIS*.
- Removed the *Note* from the “Event/diagnosis” criteria in the Clinical Components table under *Rules for Allowable Adjustments of HEDIS*.

Description

The percentage of 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 when the prescription is dispensed.

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 dispensed.

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

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.

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

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

Units of medication

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-days or less supply of an oral medication. For example, two inhaler canisters of the same medication dispensed on the same day counts as two medication units and only one dispensing event.

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.

Eligible Population**Product lines**

Commercial, Medicaid (report each product line separately).

Stratifications

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

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

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

Ages	<p>Ages 5–64 as of December 31 of the measurement year. Report the following age stratifications and a total rate:</p> <ul style="list-style-type: none"> • 5–11 years. • 12–18 years. • 19–50 years. • 51–64 years. • Total. <p>The total is the sum of the age stratifications for each product line.</p>
Continuous enrollment	The measurement year and the year prior to the measurement year.
Allowable gap	No more than one gap in enrollment of up to 45 days during each year of continuous enrollment. To determine continuous enrollment for a Medicaid beneficiary for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage during each year of continuous enrollment.
Anchor date	December 31 of the measurement year.
Benefits	Medical. Pharmacy during the measurement year.
Event/diagnosis	<p>Follow the steps below to identify the eligible population.</p> <p>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.</p> <ul style="list-style-type: none"> • At least one ED visit (<u>ED Value Set</u>), with a principal diagnosis of asthma (<u>Asthma Value Set</u>). • At least one acute inpatient encounter (<u>Acute Inpatient Value Set</u>), with a principal diagnosis of asthma (<u>Asthma 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 principal diagnosis of asthma (<u>Asthma Value Set</u>) on the discharge claim. To identify an acute inpatient discharge: <ol style="list-style-type: none"> 1. Identify all acute and nonacute inpatient stays (<u>Inpatient Stay Value Set</u>). 2. Exclude nonacute inpatient stays (<u>Nonacute Inpatient Stay Value Set</u>). 3. Identify the discharge date for the stay. • At least four outpatient visits (<u>Outpatient Value Set</u>), observation visits (<u>Observation Value Set</u>), telephone visits (<u>Telephone Visits Value Set</u>) or e-visits or virtual check-ins (<u>Online Assessments Value Set</u>), on different dates of service, with any diagnosis of asthma (<u>Asthma Value Set</u>) 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).

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

Administrative Specification

Denominator The eligible population.

Numerator The number of members who have a medication ratio of ≥ 0.50 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.

Units of Controller Medications (step 1)

Units of Total Asthma Medications (step 3)

Step 5 Sum the total number of members who have a ratio of ≥ 0.50 in step 4.

Asthma Controller Medications

Description	Prescriptions	Medication Lists	Route
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
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-A-1/2: Data Elements for Asthma Medication Ratio

Metric	Age	Data Element	Reporting Instructions
AsthmaMedicationRatio	5-11	Benefit	Metadata
	12-18	EligiblePopulation	For each Stratification
	19-50	ExclusionAdminRequired	For each Stratification
	51-64	NumeratorByAdmin	For each Stratification
	Total	NumeratorBySupplemental	For each Stratification
		Rate	(Percent)

Table AMR-B-1/2: Data Elements for Asthma Medication Ratio: Stratifications by Race

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

Table AMR-C-1/2: Data Elements for Asthma Medication Ratio: Stratifications by Ethnicity

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

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

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

Rules for Allowable Adjustments of HEDIS

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

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

Rules for Allowable Adjustments of 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 an area of interest defined by gender, race, ethnicity, socioeconomic or sociodemographic characteristics, geographic region or another characteristic.
CLINICAL COMPONENTS		
Eligible Population	Adjustments Allowed (Yes/No)	Notes
Event/diagnosis	Yes, with limits	Only events or diagnoses that contain (or map to) codes in the medication lists and value sets may be used to identify visits. Medication lists, value sets and logic may not be changed.
Denominator Exclusions	Adjustments Allowed (Yes/No)	Notes
Required exclusions	Yes, with limits	Apply required exclusions according to specified value sets. The hospice and deceased member 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
Medication Ratio of 0.50 or greater	No	Medication lists and logic may not be changed.

Child and Adolescent Well-Care Visits (WCV)

SUMMARY OF CHANGES TO HEDIS MY 2023

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

Description

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

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

Eligible Population

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

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

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

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

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

Administrative Specification

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

Note

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

Data Elements for Reporting

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

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

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

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

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

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

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

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

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

Rules for Allowable Adjustments of HEDIS

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

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

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

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

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

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

SUMMARY OF CHANGES TO HEDIS MY 2023

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

Description

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

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

Eligible Population

Product lines	Commercial, Medicaid, Medicare (report each product line separately).
Ages	6 years and older as of the date of the ED visit. Report three age stratifications and a total rate: <ul style="list-style-type: none"> • 6–17 years. • 18–64 years. • 65 years and older. • Total. <p>The total is the sum of the age stratifications.</p>
Continuous enrollment	Date of the ED visit through 30 days after the ED visit (31 total days).
Allowable gap	None.
Anchor date	None.
Benefit	Medical and mental health.
Event/diagnosis	An ED visit (<u>ED Value Set</u>) 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 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. <p>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</p>

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

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

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

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

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

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

Required exclusions

Exclude members who meet either of the following criteria:

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

Administrative Specification

Denominator The eligible population.

Numerators

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

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

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

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

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

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

Note

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

Data Elements for Reporting

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

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

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

Rules for Allowable Adjustments of HEDIS

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

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

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

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

Follow-Up After Hospitalization for Mental Illness (FUH)

SUMMARY OF CHANGES TO HEDIS MY 2023

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

Description

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

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

Eligible Population

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

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

**Acute
readmission or
direct transfer**

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

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

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

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

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

**Nonacute
readmission or
direct transfer**

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

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

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

**Required
exclusions**

Exclude members who meet either of the following criteria:

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

Administrative Specification

Denominator The eligible population.

Numerators

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

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

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

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

Note

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

Data Elements for Reporting

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

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

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

Rules for Allowable Adjustments of HEDIS

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

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

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

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

Follow-Up Care for Children Prescribed ADHD Medication (ADD)

SUMMARY OF CHANGES TO HEDIS MY 2023

- Added instructions for calculating covered days.
- Replaced “discharge date” with “admission date” in step 4 of the event/diagnosis in both Rate 1 and Rate 2.
- Modified medication lists to make them compatible with digital measure formatting.
- Added a required exclusion for members who died during the measurement year.
- Revised the “Other” criteria in the Nonclinical Components table under *Rules for Allowable Adjustments of HEDIS*.
- Revised the “Required exclusions” criteria in the Clinical Components table under *Rules for Allowable Adjustments of HEDIS*.

Description

The percentage of children newly prescribed attention-deficit/hyperactivity disorder (ADHD) medication who had at least three follow-up care visits within a 10-month period, one of which was within 30 days of when the first ADHD medication was dispensed. Two rates are reported.

1. *Initiation Phase*. The percentage of members 6–12 years of age with a prescription dispensed for ADHD medication, who had one follow-up visit with a practitioner with prescribing authority during the 30-day Initiation Phase.
2. *Continuation and Maintenance (C&M) Phase*. The percentage of members 6–12 years of age with a prescription dispensed for ADHD medication, who remained on the medication for at least 210 days and who, in addition to the visit in the Initiation Phase, had at least two follow-up visits with a practitioner within 270 days (9 months) after the Initiation Phase ended.

Definitions

Intake period	The 12-month window starting March 1 of the year prior to the measurement year and ending the last calendar day of February of the measurement year.
Negative medication history	A period of 120 days (4 months) prior to the IPSD when the member had no ADHD medications dispensed for either new or refill prescriptions.
IPSD	Index prescription start date. The earliest prescription dispensing date for an ADHD medication where the date is in the intake period and there is a negative medication history.
Initiation Phase	The 30 days following the IPSD.
C&M Phase	The 300 days following the IPSD (10 months).
Continuous medication treatment	The number of medication treatment days during the 301-day period must be ≥ 210 days (i.e., 301 treatment days – 91 gap days).
Treatment days (covered days)	The actual number of calendar days covered with prescriptions within the specified 301-day period.

Use the following steps to identify and calculate covered days.

Step 1 Identify dispensing events where multiple prescriptions for the same medication are dispensed with overlapping days supply (i.e., dispensed on the same day or dispensed on different days with overlapping days supply). Sum the days supply for these dispensing events.

Identify the start and end dates: The start date is the date of service of the earliest dispensing event and the end date is the start date plus the summed days supply minus one. The start date through the end date are considered covered days. For example:

- If there are three 7-days supply dispensing events for the same medication on January 1, the start date is January 1 and the end date is January 21. Covered days include January 1–21.
- If there are two 7-days supply dispensing events for the same medication on January 1 and January 5, the start date is January 1 and the end date is January 14. Covered days include January 1–14.
- If there are three 7-days supply dispensing events for the same medication on January 1, a 7-days supply dispensing event on January 20 and a 7-days supply dispensing event on January 28, the start date is January 1 and the end date is February 4. Covered days include January 1–February 4.

Note: This step assumes that the member will take one prescription at a time (and start taking the next prescription after exhausting the previous prescription).

Step 2 For all other dispensing events (multiple prescriptions for the same medication on different days without overlap, multiple prescriptions for different medications on the same or different days, with or without overlap), identify the start and end dates for each dispensing event individually. The start date through the end date are considered covered days.

Note: This step assumes the member will take the different medications concurrently.

Step 3 Count the covered days. Consider each calendar day covered by one or more medications to be one covered day.

Identifying same or different drugs To identify same or different drugs, use the medication lists specified for the measure in the ADHD Medications table. Drugs in different medication lists are considered different drugs. For example, a dispensing event from the [Dexmethylphenidate Medications List](#) is considered a different drug from a dispensing event from the [Methylphenidate Medications List](#).

Eligible Population: Rate 1—Initiation Phase

Product lines	Commercial, Medicaid (report each product line separately).
Ages	6 years as of March 1 of the year prior to the measurement year to 12 years as of the last calendar day of February of the measurement year.
Continuous enrollment	120 days (4 months) prior to the IPSD through 30 days after the IPSD.
Allowable gap	None.

- Anchor date** None.
- Benefits** Medical and pharmacy.
- Event/diagnosis** Follow the steps below to identify the eligible population for the Initiation Phase.
- Step 1** Identify all children in the specified age range who were dispensed an ADHD medication. Use all the medication lists in the ADHD Medications table below to identify ADHD dispensing events.

ADHD Medications

Drug Class	Prescription	Medication Lists
CNS stimulants	<ul style="list-style-type: none"> Dexmethylphenidate Dextroamphetamine Lisdexamfetamine Methylphenidate Methamphetamine 	<ul style="list-style-type: none"> Dexmethylphenidate Medications List Dextroamphetamine Medications List Lisdexamfetamine Medications List Methylphenidate Medications List Methamphetamine Medications List
Alpha-2 receptor agonists	<ul style="list-style-type: none"> Clonidine Guanfacine 	<ul style="list-style-type: none"> Clonidine Medications List Guanfacine Medications List
Miscellaneous ADHD medications	<ul style="list-style-type: none"> Atomoxetine 	<ul style="list-style-type: none"> Atomoxetine Medications List

- Step 2** Test for negative medication history. For each member identified in step 1, test each ADHD prescription for a negative medication history. The IPSD is the dispensing date of the earliest ADHD prescription in the intake period with a negative medication history.
- Step 3** Calculate continuous enrollment. Members must be continuously enrolled for 120 days (4 months) prior to the IPSD through 30 days after the IPSD.
- Step 4** Remove members who had an acute inpatient encounter for a mental, behavioral or neurodevelopmental disorder during the 30 days after the IPSD. Either of the following meets criteria:
- An acute inpatient encounter (Acute Inpatient Value Set) with a principal diagnosis of mental, behavioral or neurodevelopmental disorder (Mental, Behavioral and Neurodevelopmental Disorders Value Set).
 - An acute inpatient admission with a principal diagnosis of mental, behavioral or neurodevelopmental disorder (Mental, Behavioral and Neurodevelopmental Disorders Value Set) on the discharge claim. To identify an acute inpatient admission:
 - Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
 - Exclude nonacute inpatient stays (Nonacute Inpatient Stay Value Set).
 - Identify the admission date for the stay.

Required exclusions	<p>Exclude members who meet any of the following criteria:</p> <ul style="list-style-type: none"> • Members with a diagnosis of narcolepsy (<u>Narcolepsy Value Set</u>) any time during their history through December 31 of the measurement year. • Members in hospice or using hospice services any time during the measurement year. Refer to <i>General Guideline 15: Members in Hospice</i>. • Members who died any time during the measurement year. Refer to <i>General Guideline 16: Deceased Members</i>.
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Administrative Specification: Rate 1—Initiation Phase

Denominator	The Rate 1 eligible population.
Numerator	<p>A follow-up visit with a practitioner with prescribing authority, within 30 days after the IPSD. Any of the following code combinations billed by a practitioner with prescribing authority meet criteria:</p> <ul style="list-style-type: none"> • An outpatient visit (<u>Visit Setting Unspecified Value Set with Outpatient POS Value Set</u>). • An outpatient visit (<u>BH Outpatient Value Set</u>). • An observation visit (<u>Observation Value Set</u>). • A health and behavior assessment or intervention (<u>Health and Behavior Assessment or Intervention Value Set</u>). • An intensive outpatient encounter or partial hospitalization (<u>Visit Setting Unspecified Value Set with Partial Hospitalization POS Value Set</u>). • An intensive outpatient encounter or partial hospitalization (<u>Partial Hospitalization or Intensive Outpatient Value Set</u>). • A community mental health center visit (<u>Visit Setting Unspecified Value Set with Community Mental Health Center POS Value Set</u>). • A telehealth visit (<u>Visit Setting Unspecified Value Set with Telehealth POS Value Set</u>). • A telephone visit (<u>Telephone Visits Value Set</u>).

Note: Do not count a visit on the IPSD as the Initiation Phase visit.

Eligible Population: Rate 2—C&M Phase

Product lines	Commercial, Medicaid (report each product line separately).
Ages	6 years as of March 1 of the year prior to the measurement year to 12 years as of the last calendar day of February of the measurement year.
Continuous enrollment	<p>Members must be continuously enrolled in the organization for 120 days (4 months) prior to the IPSD and 300 days (10 months) after the IPSD.</p> <p>Members who switch product lines or products between the Rate 1 and Rate 2 continuous enrollment periods are only included in Rate 1. However, if an organization reports products combined, then a member who switches between those products (e.g., the products included in the HEDIS reporting entity) is included in both rates. For example, if an organization reports HMO and POS products combined and a member switches from HMO to POS between the</p>

Rate 1 and Rate 2 continuous enrollment period, the member is included in both Rate 1 and Rate 2.

Allowable gap	One 45-day gap in enrollment between 31 days and 300 days (10 months) after the IPSD. 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	None.
Benefits	Medical and pharmacy.
Event/diagnosis	Follow the steps below to identify the eligible population for the C&M Phase. Step 1 Identify all members who meet the eligible population criteria for <i>Rate 1—Initiation Phase</i> . Step 2 Calculate continuous enrollment. Members must be continuously enrolled in the organization for 120 days (4 months) prior to the IPSD and 300 days (10 months) after the IPSD. Step 3 Calculate treatment days (covered days) to determine continuous medication treatment. Using the members in step 2, determine if the member was dispensed a sufficient number of prescriptions to provide continuous treatment for at least 210 days out of the 301-day period, beginning on the IPSD through 300 days after the IPSD. The definition of “continuous medication treatment” allows gaps in medication treatment, up to a total of 91 days during the 301-day (10-month) period. Gaps can include either washout period gaps to change medication or treatment gaps to refill the same medication. Regardless of the number of gaps, the total gap days may be no more than 91. Count any combination of gaps (e.g., one washout gap of 14 days and numerous weekend drug holidays). Step 4 Remove members who had an acute inpatient encounter for a mental, behavioral or neurodevelopmental disorder during the 300 days (10 months) after the IPSD. Either of the following meets criteria: <ul style="list-style-type: none">• An acute inpatient encounter (<u>Acute Inpatient Value Set</u>) with a principal diagnosis of mental, behavioral or neurodevelopmental disorder (<u>Mental, Behavioral and Neurodevelopmental Disorders Value Set</u>).• An acute inpatient admission with a principal diagnosis of mental, behavioral or neurodevelopmental disorder (<u>Mental, Behavioral and Neurodevelopmental Disorders Value Set</u>) on the discharge claim. To identify an acute inpatient admission:<ol style="list-style-type: none">1. Identify all acute and nonacute inpatient stays (<u>Inpatient Stay Value Set</u>).2. Exclude nonacute inpatient stays (<u>Nonacute Inpatient Stay Value Set</u>).3. Identify the admission date for the stay.

Administrative Specification: Rate 2—C&M Phase

Denominator The Rate 2 eligible population.

Numerator Identify all members who meet the following criteria:

- Numerator compliant for Rate 1—Initiation Phase, **and**
- At least two follow-up visits on different dates of service with any practitioner, from 31–300 days (9 months) after the IPSPD.

Any of the following code combinations identify follow-up visits:

- An outpatient visit (Visit Setting Unspecified Value Set **with** Outpatient POS Value Set).
- An outpatient visit (BH Outpatient Value Set).
- An observation visit (Observation Value Set).
- A health and behavior assessment or intervention (Health and Behavior Assessment or Intervention Value Set).
- An intensive outpatient encounter or partial hospitalization (Visit Setting Unspecified Value Set **with** Partial Hospitalization POS Value Set).
- An intensive outpatient encounter or partial hospitalization (Partial Hospitalization or Intensive Outpatient Value Set).
- A community mental health center visit (Visit Setting Unspecified Value Set **with** Community Mental Health Center POS Value Set).
- A telehealth visit (Visit Setting Unspecified Value Set **with** Telehealth POS Value Set).
- A telephone visit (Telephone Visits Value Set).
- An e-visit or virtual check-in (Online Assessments Value Set).

Only one of the two visits (during days 31–300 after the IPSPD) may be an e-visit or virtual check-in (Online Assessments Value Set).

Note

- *For members who have multiple overlapping prescriptions, count the overlap days once toward the days supply (whether the overlap is for the same drug or for a different drug).*
- *Refer to Appendix 3 for the definition of prescribing practitioner.*
- *Organizations may have different methods for billing intensive outpatient encounters 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 period required for the rate (e.g., within 30 days after or from 31–300 days after the IPSPD).*

Data Elements for Reporting

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

Table ADD-1/2: Data Elements for Follow-Up Care for Children Prescribed ADHD Medication

Metric	Data Element	Reporting Instructions
Initiation	Benefit	Metadata
Continuation	EligiblePopulation	For each Metric
	ExclusionAdminRequired	Only for Initiation Metric
	NumeratorByAdmin	For each Metric
	NumeratorBySupplemental	For each Metric
	Rate	(Percent)

Rules for Allowable Adjustments of HEDIS

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

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

Rules for Allowable Adjustments of Follow-Up Care for Children Prescribed ADHD Medication

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	Using a benefit is not required; adjustments are allowed.
Other	Yes	Organizations may use additional eligible population criteria to focus on an area of interest defined by gender, race, ethnicity, socioeconomic or sociodemographic characteristics, geographic region or another characteristic.
CLINICAL COMPONENTS		
Eligible Population	Adjustments Allowed (Yes/No)	Notes
Event/diagnosis	No	Only events or diagnoses that contain (or map to) codes in the medication lists and value sets may be used to identify visits. Medication lists, value sets and logic may not be changed.
Denominator Exclusions	Adjustments Allowed (Yes/No)	Notes
Required exclusions	Yes, with limits	Apply required exclusions according to specified value sets. The hospice and deceased member 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"> • Initiation Phase • C&M Phase 	No	Value sets and logic may not be changed.

Immunizations for Adolescents (IMA)*

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

SUMMARY OF CHANGES TO HEDIS MY 2023

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

Description

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

Eligible Population

Product lines	Commercial, Medicaid (report each product line separately).
Stratifications	<p>For each product line, report the following stratifications by race and total, and stratifications by ethnicity and total:</p> <ul style="list-style-type: none"> • <i>Race:</i> <ul style="list-style-type: none"> – White. – Black or African American. – American Indian or Alaska Native. – Asian. – Native Hawaiian or Other Pacific Islander. – Some Other Race. – Two or More Races. – Asked but No Answer. – Unknown. – Total. • <i>Ethnicity:</i> <ul style="list-style-type: none"> – Hispanic or Latino. – Not Hispanic or Latino. – Asked but No Answer. – Unknown. – Total.

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

Age	Adolescents who turn 13 years of age during the measurement year.
Continuous enrollment	12 months prior to the member's 13th birthday.
Allowable gap	No more than one gap in enrollment of up to 45 days during the 12 months prior to the 13th birthday. To determine continuous enrollment for a Medicaid beneficiary for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage (e.g., a member whose coverage lapses for 2 months [60 days] is not continuously enrolled).
Anchor date	Enrolled on the member's 13th birthday.
Benefit	Medical.
Event/diagnosis	None.
Required exclusions	Exclude members who meet either of the following criteria: <ul style="list-style-type: none"> • Members in hospice or using hospice services any time during the measurement year. Refer to <i>General Guideline 15: Members in Hospice</i>. • Members who died any time during the measurement year. Refer to <i>General Guideline 16: Deceased Members</i>.

Administrative Specification

Denominator The eligible population.

Numerators

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

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

Tdap Any of the following meet criteria:

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

HPV Any of the following meet criteria:

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

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

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

Hybrid Specification

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

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

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

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

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

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

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

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

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

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

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

Note

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

Data Elements for Reporting

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

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

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

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

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

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

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

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

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

Rules for Allowable Adjustments of HEDIS

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

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

Rules for Allowable Adjustments of Immunizations for Adolescents

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

Kidney Health Evaluation for Patients With Diabetes (KED)*

*This measure was developed by NCQA with input from the National Kidney Foundation.

SUMMARY OF CHANGES TO HEDIS MY 2023

- Revised the optional exclusions for polycystic ovarian syndrome, gestational diabetes or steroid-induced diabetes to be required exclusions.
- Added a required exclusion for members who died during the measurement year.
- Added a direct reference code for palliative care.
- Updated the number of occurrences required for the frailty cross-cutting exclusion.
- Revised the “Other” criteria in the Nonclinical Components table under *Rules for Allowable Adjustments of HEDIS*.
- Revised the “Required exclusions” criteria in the Clinical Components table under *Rules for Allowable Adjustments of HEDIS*.

Description

The percentage of members 18–85 years of age with diabetes (type 1 and type 2) who received a kidney health evaluation, defined by an estimated glomerular filtration rate (eGFR) **and** a urine albumin-creatinine ratio (uACR), during the measurement year.

Eligible Population

Product lines	Commercial, Medicaid, Medicare (report each product line separately).
Ages	18–85 years as of December 31 of the measurement year. Report three age stratifications and a total rate: <ul style="list-style-type: none"> • 18–64. • 65–74. • 75–85. • 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	There are two ways to identify members with diabetes: by claim/encounter data and by pharmacy data. The organization must use both methods to identify the eligible population, but a member only needs to be identified by one method to be included in the measure. Members may be identified as having diabetes during the measurement year or the year prior to the measurement year.

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

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

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

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

Diabetes Medications

Description	Prescription		
Alpha-glucosidase inhibitors	• Acarbose	• Miglitol	
Amylin analogs	• Pramlintide		
Antidiabetic combinations	<ul style="list-style-type: none"> • Alogliptin-metformin • Alogliptin-pioglitazone • Canagliflozin-metformin • Dapagliflozin-metformin • Dapagliflozin-saxagliptin • Empagliflozin-linagliptin • Empagliflozin-linagliptin-metformin 	<ul style="list-style-type: none"> • Empagliflozin-metformin • Ertugliflozin-metformin • Ertugliflozin-sitagliptin • Glimepiride-pioglitazone • Glipizide-metformin • Glyburide-metformin • Linagliptin-metformin 	<ul style="list-style-type: none"> • Metformin-pioglitazone • Metformin-repaglinide • Metformin-rosiglitazone • Metformin-saxagliptin • Metformin-sitagliptin

Description	Prescription
Insulin	<ul style="list-style-type: none"> • Insulin aspart • Insulin aspart-insulin aspart protamine • Insulin degludec • Insulin degludec-liraglutide • Insulin detemir • Insulin glargine • Insulin glargine-lixisenatide • Insulin glulisine • Insulin isophane human • Insulin isophane-insulin regular • Insulin lispro • Insulin lispro-insulin lispro protamine • Insulin regular human • Insulin human inhaled
Meglitinides	<ul style="list-style-type: none"> • Nateglinide • Repaglinide
Glucagon-like peptide-1 (GLP1) agonists	<ul style="list-style-type: none"> • Albiglutide • Dulaglutide • Exenatide • Liraglutide (excluding Saxenda®) • Lixisenatide • Semaglutide
Sodium glucose cotransporter 2 (SGLT2) inhibitor	<ul style="list-style-type: none"> • Canagliflozin • Dapagliflozin (excluding Farxiga®) • Ertugliflozin • Empagliflozin
Sulfonylureas	<ul style="list-style-type: none"> • Chlorpropamide • Glimepiride • Glipizide • Glyburide • Tolazamide • Tolbutamide
Thiazolidinediones	<ul style="list-style-type: none"> • Pioglitazone • Rosiglitazone
Dipeptidyl peptidase-4 (DDP-4) inhibitors	<ul style="list-style-type: none"> • Alogliptin • Linagliptin • Saxagliptin • Sitagliptin

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

Required exclusions

Exclude members who meet any of the following criteria:

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

Exclusions

Exclude members who meet any of the following criteria:

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

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

Dementia Medications

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

Administrative Specification

Denominator The eligible population.

Numerator

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

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

Data Elements for Reporting

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

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

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

Rules for Allowable Adjustments of HEDIS

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

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

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

NONCLINICAL COMPONENTS		
Eligible Population	Adjustments Allowed (Yes/No)	Notes
Product lines	Yes	Organizations are not required to use product line criteria; product lines may be combined and all (or no) product line criteria may be used.
Ages	Yes, with limits	Age determination dates may be changed (e.g., select, “age as of June 30”). The denominator age may be changed if the range is within the specified age range (18–85 years).
Continuous enrollment, allowable gap, anchor date	Yes	Organizations are not required to use enrollment criteria; adjustments are allowed.
Benefit	Yes	Organizations are not required to use a benefit; adjustments are allowed.
Other	Yes	Organizations may use additional eligible population criteria to focus on an area of interest defined by gender, race, ethnicity, socioeconomic or sociodemographic characteristics, geographic region or another characteristic.
CLINICAL COMPONENTS		
Eligible Population	Adjustments Allowed (Yes/No)	Notes
Event/diagnosis	No	Only events or diagnoses that contain (or map to) codes in the medication lists and value sets may be used to identify visits. Medication lists, value sets and logic may not be changed.
Denominator Exclusions	Adjustments Allowed (Yes/No)	Notes
Required exclusions	Yes, with limits	Apply required exclusions according to specified value sets. The hospice, deceased member and palliative care exclusions are not required. Refer to Exclusions in the Guidelines for the Rules for Allowable Adjustments.
Exclusions: I-SNP, LTI, frailty or advanced illness	Yes	These exclusions are not required. Refer to <i>Exclusions</i> in the <i>Guidelines for the Rules for Allowable Adjustments</i> .
Numerator Criteria	Adjustments Allowed (Yes/No)	Notes
Kidney Health Evaluation	No	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 2023

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

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

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 (Antipsychotic Medications List ; Antipsychotic Combination Medications List ; Prochlorperazine Medications List) of the same or different medications, on different dates of service during the measurement year.

Required exclusions

Exclude members who meet either of the following criteria:

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

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 • Aripiprazole lauroxil • 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

Metric	Age	Data Element	Reporting Instructions
BloodGlucoseTesting	1-11	Benefit	Metadata
CholesterolTesting	12-17	EligiblePopulation	For each Stratification, repeat per Metric
BloodGlucoseCholesterolTesting	Total	ExclusionAdminRequired	For each Stratification, repeat per Metric
		NumeratorByAdmin	For each Metric and Stratification
		NumeratorBySupplemental	For each Metric and Stratification
		Rate	(Percent)

Rules for Allowable Adjustments of HEDIS

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

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

Guidance for Allowable Adjustments of 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 an area of interest defined by gender, race, ethnicity, socioeconomic or sociodemographic characteristics, geographic region or another characteristic.
CLINICAL COMPONENTS		
Eligible Population	Adjustments Allowed (Yes/No)	Notes
Event/diagnosis	No	Only 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
Required exclusions	Yes	The hospice and deceased member 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
Metabolic Monitoring	No	Value sets and logic may not be changed.

Supplemental Patient-Centered Medical Home Items for the CAHPS® Clinician & Group Survey 3.0

Population Version: Adult
Language: English

Read about the [Patient-Centered Medical Home Item Set](#).

Users of the CAHPS® Clinician & Group Survey are free to incorporate supplemental items in order to meet the needs of their organizations, local markets, and/or audiences. Some items cover events that occur with low frequency in the general population. You should include them only if your sample design is likely to yield a sufficient number of responses to those questions for statistical analysis and reporting.

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

Supplemental Patient-Centered Medical Home Items for the CAHPS[®] Clinician & Group Survey 3.0

Population Version: Child
Language: English

Read about the [Patient-Centered Medical Home Item Set](#).

Users of the CAHPS[®] Clinician & Group Survey are free to incorporate supplemental items in order to meet the needs of their organizations, local markets, and/or audiences. Some items cover events that occur with low frequency in the general population. You should include them only if your sample design is likely to yield a sufficient number of responses to those questions for statistical analysis and reporting.

Questions	Placement and Other Instructions
<p>PCMH1. Did this provider’s office give you information about what to do if your child needed care during evenings, weekends, or holidays?</p> <p>¹ <input type="checkbox"/> Yes ² <input type="checkbox"/> No</p>	<p>After core question 15</p>
<p>PCMH2. Specialists are doctors like surgeons, heart doctors, allergy doctors, skin doctors, and other doctors who specialize in one area of health care. In the last 6 months, did your child see a specialist for a particular health problem?</p> <p>¹ <input type="checkbox"/> Yes ² <input type="checkbox"/> No → If No, go to PCMH4</p>	<p>After core question 25</p>
<p>PCMH3. In the last 6 months, how often did the provider named in Question 1 seem informed and up-to-date about the care your child got from specialists?</p> <p>¹ <input type="checkbox"/> Never ² <input type="checkbox"/> Sometimes ³ <input type="checkbox"/> Usually ⁴ <input type="checkbox"/> Always</p>	<p>After PCMH2</p> <p>Note: Use with PCMH2</p>
<p>PCMH4. Please answer these questions about the provider named in Question 1 of this survey.</p> <p>In the last 6 months, did you and someone from this provider’s office talk about the kinds of behaviors that are normal for your child at this age?</p> <p>¹ <input type="checkbox"/> Yes ² <input type="checkbox"/> No</p>	<p>After PCMH3</p>
<p>PCMH5. In the last 6 months, did you and someone from this provider’s office talk about how your child’s body is growing?</p> <p>¹ <input type="checkbox"/> Yes ² <input type="checkbox"/> No</p>	<p>After PCMH4</p>
<p>PCMH6. In the last 6 months, did you and someone from this provider’s office talk about your child’s moods and emotions?</p> <p>¹ <input type="checkbox"/> Yes ² <input type="checkbox"/> No</p>	<p>After PCMH5</p>

Questions	Placement and Other Instructions
<p>PCMH7. In the last 6 months, did you and someone from this provider’s office talk about things you can do to keep your child from getting injured?</p> <p>¹ <input type="checkbox"/> Yes ² <input type="checkbox"/> No</p>	<p>After PCMH6</p>
<p>PCMH8. In the last 6 months, did you and someone from this provider’s office talk about how much or what kind of food your child eats?</p> <p>¹ <input type="checkbox"/> Yes ² <input type="checkbox"/> No</p>	<p>After PCMH7</p>
<p>PCMH9. In the last 6 months, did you and someone from this provider’s office talk about how much or what kind of exercise your child gets?</p> <p>¹ <input type="checkbox"/> Yes ² <input type="checkbox"/> No</p>	<p>After PCMH8</p>
<p>PCMH10. In the last 6 months, did you and someone from this provider’s office talk about how your child gets along with others?</p> <p>¹ <input type="checkbox"/> Yes ² <input type="checkbox"/> No</p>	<p>After PCMH9</p>

Prenatal and Postpartum Care (PPC)

SUMMARY OF CHANGES TO HEDIS MY 2023

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

Description

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

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

Definitions

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

Eligible Population

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

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

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

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

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

Age	None specified.
Continuous enrollment	43 days prior to delivery through 60 days after delivery.
Allowable gap	None.
Anchor date	Date of delivery.
Benefit	Medical.
Event/diagnosis	<p>Delivered a live birth on or between October 8 of the year prior to the measurement year and October 7 of the measurement year. Include members who delivered in any setting.</p> <p>Multiple births. Members who had two separate deliveries (different dates of service) between October 8 of the year prior to the measurement year and October 7 of the measurement year count twice. Members who had multiple live births during one pregnancy count once.</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 Members 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: 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.</p> <p>Step 2 Remove 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>
Required exclusions	<p>Exclude members who meet either of the following criteria:</p> <ul style="list-style-type: none"> • Members in hospice or using hospice services any time during the measurement year. Refer to <i>General Guideline 15: Members in Hospice</i>. • Members who died any time during the measurement year. Refer to <i>General Guideline 16: Deceased Members</i>.

Administrative Specification

Denominator The eligible population.

Numerator

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

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

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

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

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

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

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

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

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

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

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

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

Hybrid Specification

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

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

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

Numerator

Timeliness of Prenatal Care

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

Administrative

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

Medical record

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

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

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

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

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

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

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

Note

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

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

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

Data Elements for Reporting

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

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

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

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

Metric
TimelinessPrenatalCare
PostpartumCare

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

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

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

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

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

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

Rules for Allowable Adjustments of HEDIS

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

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

Rules for Allowable Adjustments of Prenatal and Postpartum Care

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

Quality ID #134: Preventive Care and Screening: Screening for Depression and Follow-Up Plan

2023 COLLECTION TYPE:

MIPS CLINICAL QUALITY MEASURES (CQMS)

MEASURE TYPE:

Process

DESCRIPTION:

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

INSTRUCTIONS:

This measure is to be submitted a minimum of **once per measurement period** for patients seen during the measurement period. The most recent screening submitted will be used for performance calculation. This measure may be submitted by Merit-based Incentive Payment System (MIPS) eligible clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding. The follow-up plan must be related to a positive depression screening, example: "Patient referred for psychiatric evaluation due to positive depression screening."

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

Measure Submission Type:

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

DENOMINATOR:

All patients aged 12 years and older at the beginning of the measurement period with at least one qualifying encounter during the measurement period

Definition:

Not Eligible for Depression Screening or Follow-Up Plan (Denominator Exclusions) –

- **Patients who have been diagnosed with depression**
 - The following codes would be sufficient to define the Denominator Exclusion of depression: F01.51, F01.511, F01.518, F01.52, F01.53, F01.54, F01.A0, F01.A11, F01.A18, F01.A2, F01.A3, F01.A4, F01.B0, F01.B11, F01.B18, F01.B2, F01.B3, F01.B4, F01.C0, F01.C11, F01.C18, F01.C2, F01.C3, F01.C4, F32.A, F32.0, F32.1, F32.2, F32.3, F32.4, F32.5, F32.89, F32.9, F33.0, F33.1, F33.2, F33.3, F33.40, F33.41, F33.42, F33.8, F33.9, F34.1, F34.81, F34.89, F43.21, F43.23, F53.0, F53.1, O90.6, O99.340, O99.341, O99.342, O99.343, O99.345
 - For historical reference purposes these ICD-9 codes if documented would be sufficient to define the Denominator Exclusion of depression: 290.13, 290.21, 290.43, 296.20, 296.21, 296.22, 296.23, 296.24, 296.25, 296.26, 296.30, 296.31, 296.32, 296.33,

296.34, 296.35, 296.36, 296.81, 296.82, 298.0, 300.4, 301.12, 309.0, 309.1, 309.28, 311

- **Patients who have been diagnosed with bipolar disorder**
 - The following codes would be sufficient to define the Denominator Exclusion of bipolar disorder: F30.2, F30.3, F30.4, F30.8, F30.9, F30.10, F30.11, F30.12, F30.13, F31.0, 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
 - For historical reference purposes these ICD-9 codes if documented would be sufficient to define the Denominator Exclusion of bipolar disorder: 296.00, 296.01, 296.02, 296.03, 296.04, 296.05, 296.06, 296.40, 296.41, 296.42, 296.43, 296.44, 296.45, 296.46, 296.50, 296.51, 296.52, 296.53, 296.54, 296.55, 296.56, 296.60, 296.61, 296.62, 296.63, 296.64, 296.65, 296.66, 296.7, 296.80, 296.81, 296.82, 296.89

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

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

Denominator Criteria (Eligible Cases):

Patients aged ≥ 12 years at the beginning of the measurement period

AND

Patient encounter during the performance period (CPT or HCPCS): 59400, 59510, 59610, 59618, 90791, 90792, 90832, 90834, 90837, 92625, 96105, 96110*, 96112, 96116, 96125, 96136, 96138, 96156, 96158, 97161, 97162, 97163, 97164, 97165, 97166, 97167, 98966, 98967, 98968, 99078, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99315, 99316, 99341, 99342, 99344, 99345, 99347, 99348, 99349, 99350, 99401*, 99402*, 99403*, 99424, 99441, 99442, 99443, 99483, 99484, 99491, 99492, 99493, 99384*, 99385*, 99386*, 99387*, 99394*, 99395*, 99396*, 99397*, G0101, G0402, G0438, G0439, G0444

WITHOUT

Place of Service (POS): 12

AND NOT

DENOMINATOR EXCLUSION:

Documentation stating the patient has had a diagnosis of depression or has had a diagnosis of bipolar disorder: G9717

NUMERATOR:

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

Definitions:

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

Standardized Depression Screening Tool – A normalized and validated depression screening tool developed for the patient population in which it is being utilized.

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

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

Patient Health Questionnaire for Adolescents (PHQ-A), Beck Depression Inventory-Primary Care

Version (BDI-PC), Mood Feeling Questionnaire (MFQ), Center for Epidemiologic Studies Depression Scale (CES-D), Patient Health Questionnaire (PHQ-9), Pediatric Symptom Checklist (PSC-17), and PRIME MD-PHQ-2

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

Patient Health Questionnaire (PHQ-9), Beck Depression Inventory (BDI or BDI-II), Center for Epidemiologic Studies Depression Scale (CES-D), Depression Scale (DEPS), Duke Anxiety-Depression Scale (DADS), Geriatric Depression Scale (GDS), Cornell Scale for Depression in Dementia (CSDD), PRIME MD-PHQ-2, Hamilton Rating Scale for Depression (HAM-D), Quick Inventory of Depressive Symptomatology Self-Report (QID-SR), Computerized Adaptive Testing Depression Inventory (CAT-DI), and Computerized Adaptive Diagnostic Screener (CAD-MDD)

- **Perinatal Screening Tools**

Edinburgh Postnatal Depression Scale, Postpartum Depression Screening Scale, Patient Health Questionnaire 9 (PHQ-9), Beck Depression Inventory, Beck Depression Inventory-II, Center for Epidemiologic Studies Depression Scale, and Zung Self-rating Depression Scale

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

- Referral to a provider for additional evaluation and assessment to formulate a follow-up plan for a positive depression screen
- Pharmacological interventions
- Other interventions or follow-up for the diagnosis or treatment of depression

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

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

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

Patient Reason(s):

Patient refuses to participate

OR

Medical Reason(s):

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

Numerator Instructions:

A depression screen is completed on the date of the encounter or up to 14 calendar 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 or up to two calendar days after the date of the encounter, such as referral to a provider for additional evaluation, pharmacological interventions, or other interventions for the treatment of depression. An example to illustrate the follow-up plan documentation timing: if the encounter is on a Monday from 3-4 pm (day 0) and the patient screens positive, the clinician has through anytime on Wednesday (day 2) to complete follow-up plan documentation.

This is a patient-based measure. Depression screening is required once per measurement period, not at all

encounters. An age-appropriate, standardized, and validated depression screening tool must be used for numerator compliance. The name of the age-appropriate standardized depression screening tool utilized must be documented in the medical record. This measure does not require documentation of a specific score, just whether results of the normalized and validated depression screening tool used are considered positive or negative. Each standardized screening tool provides guidance on whether a particular score is considered positive for depression. The depression screening must be reviewed and addressed by the provider on the date of the encounter. Positive pre-screening results indicating a patient is at high risk for self-harm should receive more urgent intervention as determined by the provider practice. The screening should occur during a qualifying encounter or up to 14 calendar days prior to the date of the qualifying encounter.

The measure assesses the most recent depression screening completed either during the qualifying encounter or within the 14 calendar 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.

The follow-up plan **MUST** still be provided for and discussed with the patient during the qualifying encounter used to evaluate the numerator. However, documentation of the follow-up plan can occur up to two calendar days after the qualifying encounter, in accordance with the policies of an eligible clinician or provider's practice or health system. All services should be documented during, or as soon as practicable, after the qualifying encounter in order to maintain an accurate medical record.

Should a patient screen positive for depression, a clinician should:

- Only order pharmacological intervention when appropriate and after sufficient diagnostic evaluation. However, for the purposes of this measure, additional screening and assessment during the qualifying encounter will not qualify as a follow-up plan.
- Opt to complete a suicide risk assessment when appropriate and based on individual patient characteristics. However, for the purposes of this measure, a suicide risk assessment or additional screening using a standardized tool, will not qualify as a follow-up plan.

Numerator Options:

Performance Met:

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

OR

Performance Met:

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

OR

Denominator Exception:

Screening for depression not completed, documented patient or medical reason (**G8433**)

OR

Performance Not Met:

Depression screening not documented, reason not given (**G8432**)

OR

Performance Not Met:

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

RATIONALE:

Depression is a serious medical illness associated with higher rates of chronic disease, increased health care utilization, and impaired functioning [1]. Results from a 2016 U.S. survey data indicated that 12.8 percent of adolescents (3.1 million adolescents) had a major depressive episode (MDE) in the past year, with nine percent of adolescents (2.2 million adolescents) having one MDE with severe impairment [2]. The odds of a diagnosis of depression are believed to be 2.6 times

greater for children and adolescents exposed to trauma as compared to those unexposed or less exposed [3]. Children and teens with major depressive disorder (MDD) have been found to have difficulty carrying out their daily activities, relating to others, growing up healthy, and are at an increased risk of suicide [4].

The same 2016 study indicated that 6.7 percent of adults aged 18 or older (16.2 million adults) had at least one MDE with 4.3 percent of adults (10.3 million adults) having one MDE with severe impairment in the past year [2]. Moreover, it is estimated 22.9 percent of adult patients with chronic pain (2.2 million adults) were diagnosed with comorbid depression from 2011 to 2015, with an upward trend of prevalence among Black Americans, patients aged 65 to 84 years old, Medicare and Medicaid insured patients, and patients from zip code areas with low annual household incomes [5].

Depression and other mood disorders, such as bipolar disorder and anxiety disorders, especially during the perinatal period, can have devastating effects on women, infants, and families [6]. It's estimated that the global prevalence of antenatal (or perinatal) depression ranges from 15 to 65 percent, with current or previous exposure to abuse and violence, lack of social support, and family history of mental disorders being risk factors. Depressive symptoms measured during pregnancy have been shown to influence the quality of the postpartum mother-infant relationship [7]. Additionally, the risk of low birth weight and preterm birth is higher among infants born from depressed mothers [8].

Negative outcomes associated with depression make it crucial to screen in order to identify and treat depression in its early stages. Data indicates that as the severity of depressive symptoms increase, rates of having difficulty with work, home, or social activities related to depressive symptoms increase. For those twelve and older with mild depressive symptoms, 45.7 percent reported difficulty with activities, and for those with severe depressive symptoms, 88 percent reported difficulty [1]. Depression also imposes significant economic burden through direct and indirect costs, supporting the need for regular depression screening. "In the United States, an estimated \$22.8 billion was spent on depression treatment in 2009, and lost productivity cost an additional estimated \$23 billion in 2011" [9].

Numerous studies have found significant disparities in depression prevalence and treatment among racial/ethnic minorities. One study revealed that Indigenous adults are at a high risk for posttraumatic stress disorder, depression, suicide, substance use disorder, and concurrent behavioral health disorders secondary to these initial health problems [10]. Additionally, though rates of depression are lower among Blacks and Hispanics than among whites, depression among Blacks and Hispanics is likely to be more recurrent. Furthermore, 48 percent of whites receive mental health services, compared to just 31 percent of Blacks and Hispanics, and 22 percent of Asians [11]. Asian Americans and Black Americans are also significantly more likely to utilize emergency rooms for depression treatment, which contributes to inconsistent follow-up care [12].

While primary care providers (PCPs) serve as the first line of defense in the detection of depression, studies show that PCPs fail to recognize up to 46 percent of depressed patients [13]. "In nationally representative U.S. surveys, about eight percent of adolescents reported having major depression in the past year. Only 36 percent to 44 percent of children and adolescents with depression receive treatment, suggesting that the majority of depressed youth are undiagnosed and untreated" [4]. Furthermore, evidence supports that screening for depression in pregnant and postpartum women is of moderate net benefit and treatment options for positive depression screening should be available for patients twelve and older including pregnant and postpartum women.

This measure seeks to align with clinical guideline recommendations as well as the Healthy People 2020 recommendation for routine screening for mental health problems as a part of primary care for both children and adults and makes an important contribution to the quality domain of community and population health [14].

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CLINICAL RECOMMENDATION STATEMENTS:

Adolescent Recommendation (12-18 years):

“The USPSTF recommends screening for MDD in adolescents aged 12 to 18 years. Screening should be implemented with adequate systems in place to ensure accurate diagnosis, effective treatment, and appropriate follow-up (B recommendation)” [1].

Adult Recommendation (18 years and older):

“The USPSTF recommends screening for depression in the general adult population, including pregnant and postpartum women. Screening should be implemented with adequate systems in place to ensure accurate diagnosis, effective treatment, and appropriate follow-up (B recommendation)” [2].

“The USPSTF recommends that clinicians provide or refer pregnant and postpartum persons who are at increased risk of perinatal depression to counseling interventions. (B recommendation)” [3].

The American College of Obstetricians and Gynecologists (ACOG) provides the following recommendation: "All obstetrician–

gynecologists and other obstetric care providers should complete a full assessment of mood and emotional well-being (including screening for postpartum depression and anxiety with a validated instrument) during the comprehensive postpartum visit for each patient." [4].

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

1. "Clinicians should routinely screen all adults for depression using a standardized instrument."
2. "Clinicians should establish and maintain follow-up with patients."
3. "Clinicians should screen and monitor depression in pregnant and post-partum women." [5]

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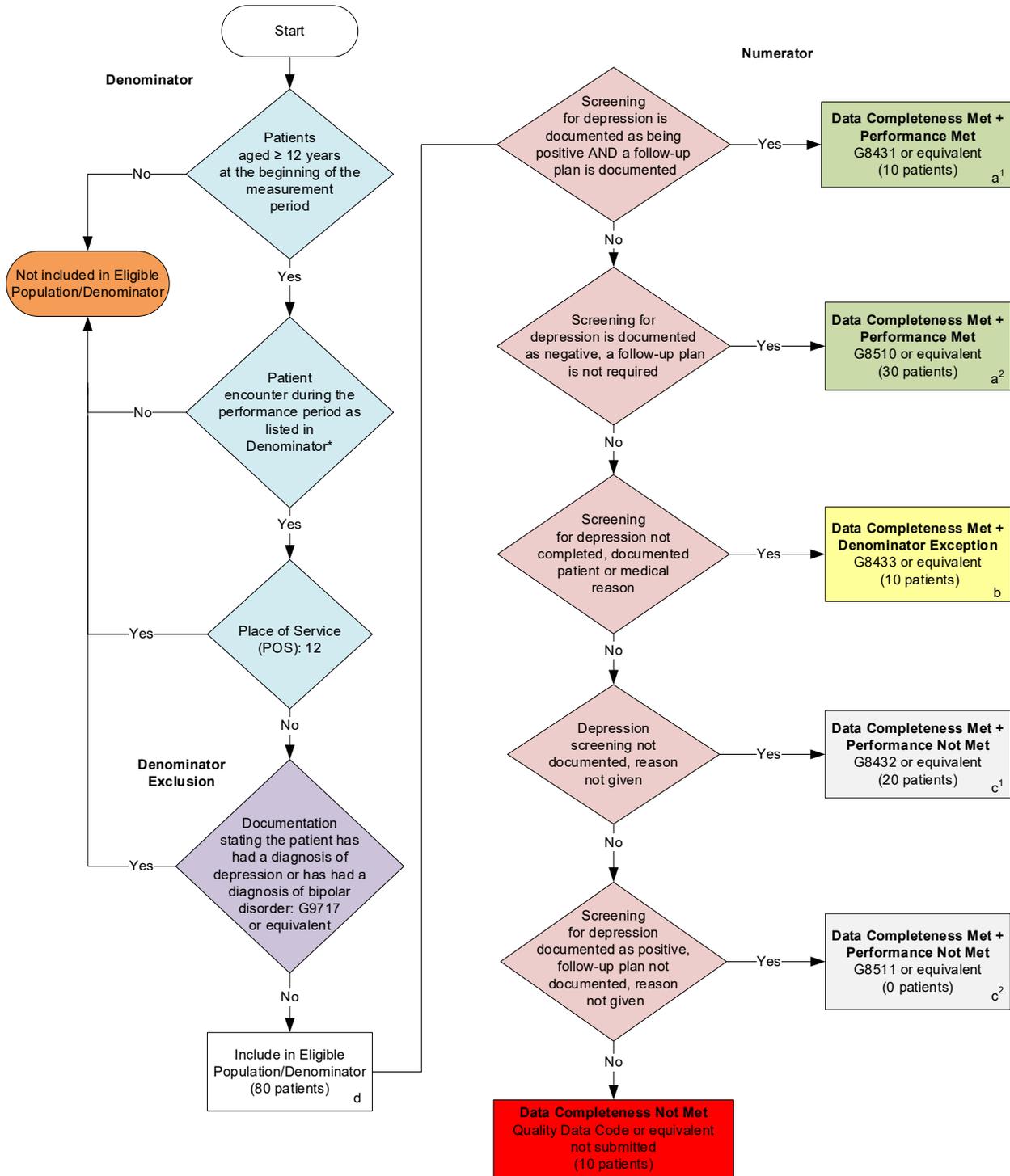
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**2023 Clinical Quality Measure Flow for Quality ID #134:
Preventive Care and Screening: Screening for Depression and Follow-Up Plan**

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



SAMPLE CALCULATIONS

Data Completeness Rate=

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

Performance Rate=

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

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

NOTE: Submission Frequency: Patient-Intermediate

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**2023 Clinical Quality Measure Flow Narrative for Quality ID #134:
Preventative Care and Screening: Screening for Depression and Follow-Up Plan**

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

1. Start with Denominator
2. Check *Patients aged greater than or equal to 12 years at the beginning of the measurement period*:
 - a. If *Patients aged greater than or equal to 12 years at the beginning of the measurement period* equals No, do not include in *Eligible Population/Denominator*. Stop processing.
 - b. If *Patients aged greater than or equal to 12 years at the beginning of the measurement period* equals Yes, proceed to check *Patient encounter during the performance period as listed in Denominator**.
3. Check *Patient encounter during the performance period as listed in Denominator**:
 - a. If *Patient encounter during the performance period as listed in Denominator** equals No, do not include in *Eligible Population/Denominator*. Stop processing.
 - b. If *Patient encounter during the performance period as listed in Denominator** equals Yes, proceed to check *Place of Service (POS)*.
4. Check *Place of Service (POS)*:
 - a. If *Place of Service (POS)* equals Yes, do not include in *Eligible Population/Denominator*. Stop processing.
 - b. If *Place of Service (POS)* equals No, proceed to check *Documentation stating the patient has had a diagnosis of depression or has had a diagnosis of bipolar disorder*.
5. Check *Documentation stating the patient has had a diagnosis of depression or has had a diagnosis of bipolar disorder*:
 - a. If *Documentation stating the patient has had a diagnosis of depression or has had a diagnosis of bipolar disorder* equals Yes, do not include in *Eligible Population/Denominator*. Stop processing.
 - b. If *Documentation stating the patient has had a diagnosis of depression or has had a diagnosis of bipolar disorder* equals No, include in *Eligible Population/Denominator*.
6. Denominator Population:
 - Denominator Population is all Eligible Patients in the Denominator. Denominator is represented as Denominator in the Sample Calculation listed at the end of this document. Letter d equals 80 patients in the Sample Calculation.
7. Start Numerator
8. Check *Screening for depression is documented as being positive AND a follow-up plan is documented*:
 - a. If *Screening for depression is documented as being positive AND a follow-up plan is documented* equals Yes, include in *Data Completeness Met and Performance Met*.
 - *Data Completeness Met and Performance Met* letter is represented in the 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.
 - b. If *Screening for depression is documented as being positive AND a follow-up plan is documented* equals

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

9. Check *Screening for depression is documented as negative, a follow-up plan is not required*:
 - a. If *Screening for depression is documented as negative, a follow-up plan is not required* equals Yes, include in *Data Completeness Met and Performance Met*.
 - *Data Completeness Met and Performance Met* letter is represented in the 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.
 - b. If *Screening for depression is documented as negative, a follow-up plan is not required* equals No, proceed to check *Screening for depression not completed, documented patient or medical reason*.
10. Check *Screening for depression not completed, documented patient or medical reason*:
 - a. If *Screening for depression not completed, documented patient or medical reason* equals Yes, include in *Data Completeness Met and Denominator Exception*.
 - *Data Completeness Met and Denominator Exception* letter is represented in the Data Completeness and Performance Rate in the Sample Calculation listed at the end of this document. Letter b equals 10 patients in the Sample Calculation.
 - b. If *Screening for depression not completed, documented patient or medical reason* equals No, proceed to check *Depression screening not documented, reason not given*.
11. Check *Depression screening not documented, reason not given*:
 - a. If *Depression screening not documented, reason not given* equals Yes, include in *Data Completeness Met and Performance Not Met*.
 - *Data Completeness Met and Performance Not Met* letter is represented in the Data Completeness in the Sample Calculation listed at the end of this document. Letter c¹ equals 20 patients in the Sample Calculation.
 - b. If *Depression screening not documented, reason not given* equals No, proceed to check *Screening for depression documented as positive, follow-up plan not documented, reason not given*.
12. 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 *Data Completeness Met and Performance Not Met*.
 - *Data Completeness Met and Performance Not Met* letter is represented in the Data Completeness in the Sample Calculation listed at the end of this document. Letter c² equals 0 patients in the Sample Calculation.
 - b. If *Screening for depression documented as positive, follow-up plan not documented, reason not given* equals No, proceed to check *Data Completeness Not Met*.
13. Check *Data Completeness Not Met*:
 - If *Data Completeness Not Met*, the Quality Data Code or equivalent was not submitted. 10 patients have been subtracted from the Data Completeness Numerator in the Sample Calculation.

Sample Calculations:

Data Completeness Rate equals Performance Met (a^1 plus a^2 equals 40 patients) plus Denominator Exception (b equals 10 patients) plus Performance Not Met (c^1 plus c^2 equals 20 patients) divided by Eligible Population/Denominator (d equals 80 patients). All equals 70 patients divided by 80 patients. All equals 87.50 percent.

Performance Rate equals Performance Met (a^1 plus a^2 equals 40 patients) divided by Data Completeness Numerator (70 patients) minus Denominator Exception (b equals 10 patients). All equals 40 patients divided by 60 patients. All equals 66.67 percent.

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

NOTE: Submission Frequency: Patient-Intermediate

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

SDOH Screening Measure Specifications

**Social Determinants of Health (SDOH) Screening
Steward: Connecticut Office of Health Strategy¹
As of July 7, 2022**

Description

Social Determinants of Health are the “conditions in the places where people live, learn, work, and play that affect a wide range of health and quality-of life-risks and outcomes.”²

The percentage of attributed patients who were screened for Social Determinants of Health using a screening tool once per measurement year, where the primary care clinician has documented the completion of the screening and the results.

Eligible Population

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

Product lines	Medicaid, Commercial
Stratification	None
Ages	All ages
Continuous enrollment	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 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.
Lookback period	12 months
Benefit	Medical
Event/diagnosis	<ul style="list-style-type: none"> • The patient has been seen by an Advanced Network-affiliated primary care clinician anytime within the last 12 months • For the purpose of this measure “primary care clinician” is any provider defined by the reporting payer as a primary care clinician and holding a patient panel. • Follow the below to determine a primary care visit: <ul style="list-style-type: none"> ○ The following are the eligible CPT/HCPCS office visit codes for determining a primary care visit: 98970-98972; 99201-99205; 99212-99215; 99324-99337; 99341-99350; 99381 – 99387; 99391-99397; 99417;

¹ This measure was developed based on the Rhode Island Executive Office of Health and Human Services (EOHHS) SDOH Screening measure and the Massachusetts EOHHS Health-Related Social Needs Screening measure.

² Definition from the CDC: www.cdc.gov/socialdeterminants/index.htm. Last accessed on 5/22/22.

	<p>99421-99423; 99439; 99490; 99495-99496; G2212</p> <ul style="list-style-type: none"> ○ The following are the eligible telephone visit, e-visit or virtual check-in codes for determining a primary care visit: <ul style="list-style-type: none"> ▪ CPT/HCPCS/SNOMED codes: 98966-98968, 98969-98972, 99421-99423, 99441-99443, 99444, 11797002, 185317003, 314849005, 386472008, 386473003, 386479004 ▪ Any of the above CPT/HCPCS office visit codes for determining a primary care visit with the following POS codes: 02 ▪ Any of the above CPT/HCPCS office visit codes for determining a primary care visit with the following modifiers: 95, GT
Exclusions	<ul style="list-style-type: none"> ● Patients in hospice care (see Code List below) ● Refused to participate

Electronic Data Specifications

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

Denominator	A systematic sample drawn from the eligible population
Numerator	<p>Individuals attributed to the primary care clinician who were screened for Social Determinants of Health once per measurement year and for whom results are in the primary care clinician’s health record.</p> <p>Notes:</p> <ul style="list-style-type: none"> ● Screens may be rendered asynchronously, i.e., at a time and through a modality other than a visit with a primary care clinician that triggered inclusion in the denominator. ● Screens rendered during a telephone visit, e-visit or virtual check-in meet numerator criteria. <p>Advanced Networks can, but are not required to, use ICD-10 Z codes to track performance for this measure electronically.</p>
Unit of measurement	Individual
Documentation requirements	<p>All screenings must be documented in the attributed primary care clinician’s patient health record, regardless of if the primary care clinician screened the individual or if the screen was performed by anyone else, including: another provider, the insurer or a community partner.</p> <p>The screening results must either be a) embedded in an EHR, or b) a PDF of the screening results must be accessible in the EHR, i.e., the</p>

	<p>primary care clinician must not be required to leave the EHR to access a portal or other electronic location to view the screening results, or c) a hard copy of the screening results are in a paper health record.</p> <p>Results for at least one question per required domain must be included for a screen to be considered numerator complaint.</p>
<p>Required domains</p>	<ol style="list-style-type: none"> 1. Housing insecurity; 2. Food insecurity; 3. Transportation; 4. Interpersonal violence; and 5. Utility assistance <p>Note: If primary care clinicians are conducting the screen during a telephone visit, e-visit or virtual check-in or independent of a visit, they may use their discretion whether to ask questions related to interpersonal violence. The interpersonal violence domain must, however, be included for screens administered during in-person visits.</p>

Code List

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

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

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

Substance Use Assessment in Primary Care

Steward: Inland Empire Health Plan

NQF #: N/A

SUMMARY OF CHANGES FOR 2023

- Added ages 11-17 years to the measure.
- Removed HCPCS codes G0396 and G0397 from the list of qualifying numerator codes and added code H0001.
- Added an example list of qualifying screening tools.

Description

The percentage of members 11 years and older who were screened for substance use during the measurement year.

Definitions

Screening Tools	<p>Examples of Substance Use Assessment in Primary Care screening tools include but are not limited to:</p> <ul style="list-style-type: none">• Cut Down-Annoyed-Guilty-Eye-Opener Adapted to Include Drugs (CAGE-AID)• Tobacco, Alcohol, Prescription medication, and other Substances (TAPS)• National Institute on Drug Abuse (NIDA) Quick Screen for adults<ul style="list-style-type: none">○ The single NIDA Quick Screen alcohol-related question can be used for alcohol use screening• Drug Abuse Screening Test (DAST-10)• Alcohol Use Disorders Identification Test (AUDIT-C)• Parents, Partner, Past and Present (4Ps) for pregnant women and adolescents• Car, Relax, Alone, Forget, Friends, Trouble (CRAFFT) for non-pregnant adolescents• Michigan Alcoholism Screening Test Geriatric (MAST-G) alcohol screening for geriatric population
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Eligible Population

Product lines	Commercial, Medicaid, Medicare (report each product line separately).
Stratification	None.

Ages	11 years and older during the measurement year. Report two age stratifications and total rate: <ul style="list-style-type: none"> • 11-17 years. • 18 years and older. • Total.
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 st of the measurement year.
Lookback period	12 months prior.
Benefit	Medical.
Event/diagnosis	None.
Exclusions	None.

Specifications

Data Source	Claims.
Denominator	All Members aged 18 years and older during the measurement year. Member counted only once in the denominator.
Numerator	Members who were screened for substance use at least once during the measurement year.

Numerator Codes

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 15 to 30 minutes

Substance Use Assessment in Primary Care	HCPS	G0442	Annual Alcohol Misuse Screening 15 minutes
Substance Use Assessment in Primary Care	HCPS	G0443	Brief face-to-face behavioral counseling for alcohol misuse, 15 minutes
Substance Use Assessment in Primary Care	HCPS	H0001	Alcohol and/or Drug Assessment
Substance Use Assessment in Primary Care	HCPS	H0049	Alcohol and/or Drug Screening
Substance Use Assessment in Primary Care	HCPS	H0050	Alcohol and/or Drug Service Brief Intervention Per 15 Minutes

Transitions of Care (TRC)

SUMMARY OF CHANGES TO HEDIS MY 2023

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

Description

The percentage of discharges for members 18 years of age and older who had each of the following. Four rates are reported:

- *Notification of Inpatient Admission*. Documentation of receipt of notification of inpatient admission on the day of admission through 2 days after the admission (3 total days).
- *Receipt of Discharge Information*. Documentation of receipt of discharge information on the day of discharge through 2 days after the discharge (3 total days).
- *Patient Engagement After Inpatient Discharge*. Documentation of patient engagement (e.g., office visits, visits to the home, telehealth) provided within 30 days after discharge.
- *Medication Reconciliation Post-Discharge*. Documentation of medication reconciliation on the date of discharge through 30 days after discharge (31 total days).

Definitions

Medication reconciliation	A type of review in which the discharge medications are reconciled with the most recent medication list in the outpatient medical record.
Medication list	A list of medications in the medical record. The medication list may include medication names only or may include medication names, dosages and frequency, over-the-counter (OTC) medications and herbal or supplemental therapies.

Eligible Population

Product lines	Medicare.
Ages	18 years and older as of December 31 of the measurement year. Report two age stratifications and a total rate: <ul style="list-style-type: none"> • 18–64 years. • 65 years and older. • Total.
Continuous enrollment	The date of discharge through 30 days after discharge (31 total days).
Allowable gap	None.

Anchor date	None.
Benefit	Medical.
Event/diagnosis	<p>An acute or nonacute inpatient discharge on or between January 1 and December 1 of the measurement year. To identify acute and nonacute inpatient discharges:</p> <ol style="list-style-type: none"> 1. Identify all acute and nonacute inpatient stays (<u>Inpatient Stay Value Set</u>). 2. Identify the discharge date for the stay. <p>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.</p>
Observation visits that precede the inpatient stay	Do not adjust the admit date if the discharge is preceded by an observation stay; use the admit date from the acute or nonacute inpatient stay.
Readmission or direct transfer	<p>If the discharge is followed by a readmission or direct transfer to an acute or nonacute inpatient care setting on the date of discharge through 30 days after discharge (31 days total), use the admit date from the first admission and the discharge date from the last discharge. To identify readmissions and direct transfers during the 31-day period:</p> <ol style="list-style-type: none"> 1. Identify all acute and nonacute inpatient stays (<u>Inpatient Stay Value Set</u>). 2. Identify the admission date for the stay (the admission date must occur during the 31-day period). 3. Identify the discharge date for the stay (the discharge date is the event date). <p>Exclude both the initial and the readmission/direct transfer discharge if the last discharge occurs after December 1 of the measurement year.</p> <p>If the admission date and the discharge date for an acute inpatient stay occur between the admission and discharge dates for a nonacute inpatient stay, include only the nonacute inpatient discharge. To identify acute inpatient discharges:</p> <ol style="list-style-type: none"> 1. Identify all acute and nonacute inpatient stays (<u>Inpatient Stay Value Set</u>). 2. Exclude nonacute inpatient stays (<u>Nonacute Inpatient Stay Value Set</u>). 3. Identify the admission date for the stay. 4. Identify the discharge date for the stay. <p>To identify nonacute inpatient discharges:</p> <ol style="list-style-type: none"> 1. Identify all acute and nonacute inpatient stays (<u>Inpatient Stay Value Set</u>). 2. Confirm the stay was for nonacute care based on the presence of a nonacute code (<u>Nonacute Inpatient Stay Value Set</u>). 3. Identify the admission date for the stay. 4. Identify the discharge date for the stay.

Note: If a member remains in an acute or nonacute facility through December 1 of the measurement year, a discharge is not included in the measure for this member, but the organization must have a method for identifying the member's status for the remainder of the measurement year, and may not assume the member remained admitted based only on the absence of a discharge before December 1.

If the organization is unable to confirm the member remained in the acute or nonacute care setting through December 1, disregard the readmission or direct transfer and use the initial discharge date.

Required exclusions

Members who meet either of the following criteria:

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

Administrative Specification

Denominator The eligible population.

Numerators

Notification of Inpatient Admission Administrative reporting is not available for this indicator.

Receipt of Discharge Information Administrative reporting is not available for this indicator.

Patient Engagement After Inpatient Discharge Patient engagement provided within 30 days after discharge. Do not include patient engagement that occurs on the date of discharge. The following meet criteria for patient engagement:

- An outpatient visit (Outpatient Value Set).
- A telephone visit (Telephone Visits Value Set).
- Transitional care management services (Transitional Care Management Services Value Set).
- An e-visit or virtual check-in (Online Assessments Value Set).

Medication Reconciliation Post-Discharge Medication reconciliation (Medication Reconciliation Encounter Value Set; Medication Reconciliation Intervention Value Set) conducted by a prescribing practitioner, clinical pharmacist, physician assistant or registered nurse on the date of discharge through 30 days after discharge (31 total days).

Hybrid Specification

Denominator A systematic sample drawn from the eligible population.

The denominator is based on discharges, not on members. Members may appear more than once in the sample.

Organizations may reduce the sample size based only on the prior year's audited, product line-specific rate for the lowest rate of all TRC indicators.

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

Identifying the medical record

Documentation in any outpatient medical record that is accessible to the PCP or ongoing care provider is eligible for use in reporting.

Numerators

Notification of Inpatient Admission

Documentation of receipt of notification of inpatient admission on the day of admission or on the day of admission through 2 days after the admission (3 total days).

Administrative

Administrative reporting is not available for this indicator.

Medical record

Documentation in the outpatient medical record must include evidence of receipt of notification of inpatient admission on the day of admission through 2 days after the admission (3 total days).

Documentation in the outpatient medical record must include evidence of receipt of notification of inpatient admission that includes evidence of the date when the documentation was received. Any of the following examples meet criteria:

- Communication between inpatient providers or staff and the member's PCP or ongoing care provider (e.g., phone call, email, fax).
- Communication about admission between emergency department and the member's PCP or ongoing care provider (e.g., phone call, email, fax).
- Communication about admission to the member's PCP or ongoing care provider through a health information exchange; an automated admission, or discharge and transfer (ADT) alert system.
- Communication about admission with the member's PCP or ongoing care provider through a shared electronic medical record (EMR) system. When using a shared EMR system, documentation of a "received date" is not required to meet criteria. Evidence that the information was filed in the EMR and is accessible to the PCP or ongoing care provider on the day of admission through 2 days after the admission (3 total days) meets criteria.
- Communication about admission to the member's PCP or ongoing care provider from the member's health plan.
- Indication that the member's PCP or ongoing care provider admitted the member to the hospital.
- Indication that a specialist admitted the member to the hospital and notified the member's PCP or ongoing care provider.
- Indication that the PCP or ongoing care provider placed orders for tests and treatments any time during the member's inpatient stay.
- Documentation that the PCP or ongoing care provider performed a preadmission exam or received communication about a planned inpatient admission. The time frame that the planned inpatient admission must be communicated is not limited to the day of admission through 2 days after the admission (3 total days); documentation that the PCP or ongoing care provider performed a preadmission exam or received notification of a planned admission prior to the admit date also meets criteria. The planned admission documentation or preadmission exam must clearly pertain to the denominator event.

Note: When an ED visit results in an inpatient admission, notification that a provider sent the member to the ED does not meet criteria. Evidence that the PCP or ongoing care provider communicated with the ED about the admission meets criteria.

Receipt of Discharge Information Documentation of receipt of discharge information on the day of discharge through 2 days after the discharge (3 total days).

Administrative Administrative reporting is not available for this indicator.

Medical record Documentation in the outpatient medical record must include evidence of receipt of discharge information on the day of discharge through 2 days after the discharge (3 total days) with evidence of the date when the documentation was received. Discharge information may be included in, but not limited to, a discharge summary or summary of care record or be located in structured fields in an EHR. At a minimum, the discharge information must include all of the following:

- The practitioner responsible for the member's care during the inpatient stay.
- Procedures or treatment provided.
- Diagnoses at discharge.
- Current medication list.
- Testing results, or documentation of pending tests or no tests pending.
- Instructions for patient care post-discharge.

Note: If the PCP or ongoing care provider is the discharging provider, the discharge information must be documented in the medical record on the day of discharge through 2 days after the discharge (3 total days).

When using a shared EMR system, documentation of a "received date" in the EMR is not required to meet criteria. Evidence that the information was filed in the EMR and is accessible to the PCP or ongoing care provider on the day of discharge through 2 days after the discharge (3 total days) meets criteria.

Patient Engagement After Inpatient Discharge Documentation of patient engagement (e.g., office visits, visits to the home, or telehealth) provided within 30 days after discharge. Do not include patient engagement that occurs on the date of discharge.

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

Medical record Documentation in the outpatient medical record must include evidence of patient engagement within 30 days after discharge. Any of the following meet criteria:

- An outpatient visit, including office visits and home visits.
- A telephone visit.
- A synchronous telehealth visit where real-time interaction occurred between the member and provider using audio and video communication.
- An e-visit or virtual check-in (asynchronous telehealth where two-way interaction, which was not real-time, occurred between the member and provider).

Note: If the member is unable to communicate with the provider, interaction between the member's caregiver and the provider meets criteria.

Medication Reconciliation Post-Discharge Medication reconciliation conducted by a prescribing practitioner, clinical pharmacist, physician assistant or registered nurse, as documented through either administrative data or medical record review on the date of discharge through 30 days after discharge (31 total days).

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

Medical record Documentation in the outpatient medical record must include evidence of medication reconciliation and the date when it was performed. Any of the following meet criteria:

- Documentation of the current medications with a notation that the provider reconciled the current and discharge medications.
- Documentation of the current medications with a notation that references the discharge medications (e.g., no changes in medications since discharge, same medications at discharge, discontinue all discharge medications).
- Documentation of the member's current medications with a notation that the discharge medications were reviewed.
- Documentation of a current medication list, a discharge medication list and notation that both lists were reviewed on the same date of service.
- Documentation of the current medications with evidence that the member was seen for post-discharge hospital follow-up with evidence of medication reconciliation or review. Evidence that the member was seen for post-discharge hospital follow-up requires documentation that indicates the provider was aware of the member's hospitalization or discharge.
- Documentation in the discharge summary that the discharge medications were reconciled with the most recent medication list in the outpatient medical record. There must be evidence that the discharge summary was filed in the outpatient chart on the date of discharge through 30 days after discharge (31 total days).
- Notation that no medications were prescribed or ordered upon discharge.

Note

- The following notations or examples of documentation do not count as numerator compliant:
 - Notification of Inpatient Admission and Notification of Inpatient Discharge:
 - Documentation that the member or the member's family notified the member's PCP or ongoing care provider of the admission or discharge.
 - Documentation of notification that does not include a time frame or date when the documentation was received.
 - Medication Reconciliation Post-Discharge:
 - Documentation of "post-op/surgery follow-up" without a reference to "hospitalization," "admission" or "inpatient stay" does not imply a hospitalization and is not considered evidence that the provider was aware of a hospitalization.
- The Medication Reconciliation Post-Discharge numerator assesses whether medication reconciliation occurred. It does not attempt to assess the quality of the medication list documented in the medical record or the process used to document the most recent medication list in the medical record.

- *The denominator is based on the discharge date found in administrative/claims data, but organizations may use other systems (including data found during medical record review) to identify data errors and make corrections.*
 - *If a different discharge date is found in the medical record, and the organization chooses to use that date, the organization must assess all indicators using the updated discharge date, including those that were previously compliant based on administrative data.*
- *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 (i.e., within 30 days after discharge).*
- *Refer to Appendix 3 for the definition of PCP and ongoing care provider.*
- *A medication reconciliation performed without the member present meets criteria.*

Data Elements for Reporting

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

Table TRC-3: Data Elements for Transitions of Care

Metric	Age	Data Element	Reporting Instructions	A
MedicationReconciliationPostDischarge	18-64	CollectionMethod	For each Metric, repeat per Stratification	✓
PatientEngagementAfterInpatientDischarge	65+	EligiblePopulation*	For each Metric and Stratification	✓
NotificationInpatientAdmission	Total	ExclusionAdminRequired**†	For each Metric and Stratification	✓
ReceiptDischargeInformation		NumeratorByAdminElig†	For each Metric and Stratification	
		CYAR†	Only for Total (Percent)	
		MinReqSampleSize	For each Metric, repeat per Stratification	
		OversampleRate	For each Metric, repeat per Stratification	
		OversampleRecordsNumber	(Count)	
		ExclusionValidDataErrors	For each Metric, repeat per Stratification	
		ExclusionEmployeeOrDep	For each Metric, repeat per Stratification	
		OversampleRecsAdded	For each Metric, repeat per Stratification	
		Denominator	For each Stratification, repeat per Metric	
		NumeratorByAdmint	For each Metric and Stratification	✓
		NumeratorByMedicalRecords	For each Metric and Stratification	
		NumeratorBySupplemental	For each Metric and Stratification	✓
		Rate	(Percent)	✓

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

†These data elements are only reported or calculated for the MedicationReconciliationPostDischarge and PatientEngagementAfterInpatientDischarge Metrics.

Rules for Allowable Adjustments of HEDIS

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

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

Rules for Allowable Adjustments of Transitions of 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	Age determination dates may be changed (e.g., select, “age as of June 30”). Changing the denominator age range is allowed.
Continuous enrollment, allowable gap, anchor date	Yes	Organizations are not required to use enrollment criteria; adjustments are allowed.
Benefits	Yes	Organizations are not required to use a benefit; adjustments are allowed.
Other	Yes	Organizations may use additional eligible population criteria to focus on an area of interest defined by gender, race, ethnicity, socioeconomic or sociodemographic characteristics, geographic region or another characteristic.
CLINICAL COMPONENTS		
Eligible Population	Adjustments Allowed (Yes/No)	Notes
Event/diagnosis	Yes, with limits	Only events that contain (or map to) codes in the value sets may be used to identify the eligible population for each rate. The value sets and logic may not be changed. Note: Organizations may choose alternate measurement-period date ranges. Organizations may assess at the member level (vs. discharge level) by applying measure logic appropriately (i.e., percentage of members with documentation of medication reconciliation after each discharge).
Denominator Exclusions	Adjustments Allowed (Yes/No)	Notes
Required exclusions	Yes	The hospice and deceased member 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"> • Notification of Inpatient Admission • Receipt of Discharge Information 	No	Allowable adjustments are not permitted for these components of the Transitions of Care measure.
<ul style="list-style-type: none"> • Patient Engagement After Inpatient Discharge • Medication Reconciliation Post-Discharge 	No	Value sets and logic may not be changed.

MEASURE OUD-AD: USE OF PHARMACOTHERAPY FOR OPIOID USE DISORDER

Centers for Medicare & Medicaid Services

A. DESCRIPTION

Percentage of Medicaid beneficiaries ages 18 to 64 with an opioid use disorder (OUD) who filled a prescription for or were administered or dispensed an FDA-approved medication for the disorder during the measurement year. Five rates are reported:

- A total (overall) rate capturing any medications used in medication assisted treatment of opioid dependence and addiction (Rate 1)
- Four separate rates representing the following types of FDA-approved drug products:
 - Buprenorphine (Rate 2)
 - Oral naltrexone (Rate 3)
 - Long-acting, injectable naltrexone (Rate 4)
 - Methadone (Rate 5)

Data Collection Method: Administrative

Guidance for Reporting:

- The measure includes a total rate (Rate 1) and four separate rates for the following four types of FDA-approved drug products:
 - Buprenorphine (Rate 2)
 - Oral naltrexone (Rate 3)
 - Long-acting, injectable naltrexone (Rate 4)
 - Methadone (Rate 5).
- Tables OUD-A and OUD-B are available at <https://www.medicaid.gov/medicaid/quality-of-care/downloads/2022-adult-non-hedis-value-set-directory.zip>. Table OUD-B designates which medications are assigned to the separate rates. Filter on the 'Numerator' column to identify which NDC codes are assigned to each rate.
- The measure uses inpatient, outpatient, residential, long-term care, and pharmacy claims and encounters.
- The numerator for the total rate is not a sum of the numerators for the four medication cohorts. Count beneficiaries in the numerator for the total rate if they had at least one of the four FDA-approved drug products for OUD during the measurement year. Report beneficiaries with multiple drug products only once for the numerator for the total rate.
- Only formulations with an OUD indication (not pain management) are included in value sets for measure calculation.

This measure includes the following coding systems: HCPCS, NDC, ICD-10-CM, and ICD-10-PCS. Refer to the Acknowledgments section at the beginning of the manual for copyright information.

B. DEFINITIONS

Measurement year	January 1 to December 31 of the measurement year.
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C. ELIGIBLE POPULATION

Age	Ages 18 to 64 years. Age is calculated as of January 1 of the measurement year.
Continuous enrollment	The measurement year.
Allowable gap	No allowable gap during the continuous enrollment period.
Anchor date	None.
Benefit	Medical and chemical dependency (inpatient, residential, and outpatient).
Event/ Diagnosis	Beneficiaries who had at least one encounter with a diagnosis of opioid abuse, dependence, or remission (primary or other) at any time during the measurement year. ICD-10 codes for OUD are provided in Table OUD-A available at https://www.medicare.gov/medicare/quality-of-care/downloads/2022-adult-non-hedis-value-set-directory.zip .
Care settings	Inpatient/hospital, outpatient, emergency department.

D. ADMINISTRATIVE SPECIFICATION**Denominator**

The eligible population as defined above.

Numerators

For each beneficiary in the denominator population, follow the steps below to identify beneficiaries for the total numerator and the numerator for each rate.

Numerator 1: Total

Identify beneficiaries with evidence of at least one prescription filled, or who were administered or dispensed an FDA-approved medication for OUD during the measurement year through use of pharmacy claims (relevant NDC code) or through relevant HCPCS coding of medical service. See Table OUD-B, available at <https://www.medicare.gov/medicare/quality-of-care/downloads/2022-adult-non-hedis-value-set-directory.zip>.

Note: The numerator for the total rate is not a sum of the numerators for the four medication cohorts. Count beneficiaries in the numerator for the total rate if they had at least one of the four FDA-approved drug products for OUD during the measurement year. Report beneficiaries with multiple drug products only once for the numerator for the total rate.

Numerator 2: Buprenorphine

Identify beneficiaries with evidence of at least one prescription for buprenorphine at any point during the measurement year. See Table OUD-B, available at <https://www.medicaid.gov/medicaid/quality-of-care/downloads/2022-adult-non-hedis-value-set-directory.zip>. Include NDC codes assigned to Numerator 2 in the Numerator column in Table OUD-B.

Numerator 3: Oral Naltrexone

Identify beneficiaries with evidence of at least one prescription for oral naltrexone at any point during the measurement year. See Table OUD-B, available at <https://www.medicaid.gov/medicaid/quality-of-care/downloads/2022-adult-non-hedis-value-set-directory.zip>. Include NDC codes assigned to Numerator 3 in the Numerator column in Table OUD-B.

Numerator 4: Long-Acting, Injectable Naltrexone

Identify beneficiaries with evidence of at least one prescription for long-acting, injectable naltrexone at any point during the measurement year. See Table OUD-B, available at <https://www.medicaid.gov/medicaid/quality-of-care/downloads/2022-adult-non-hedis-value-set-directory.zip>. Include NDC codes assigned to Numerator 4 in the Numerator column in Table OUD-B.

Numerator 5: Methadone

Identify beneficiaries with evidence of at least one dose of methadone at any point during the measurement year. See Table OUD-B, available at <https://www.medicaid.gov/medicaid/quality-of-care/downloads/2022-adult-non-hedis-value-set-directory.zip>. This rate includes HCPCS codes only. There are no NDC codes assigned to this rate.

Rates

The total rate is calculated by dividing the number of beneficiaries with evidence of at least one prescription (Numerator 1) by the number of beneficiaries with at least one encounter associated with a diagnosis of opioid abuse, dependence, or remission (i.e., the Denominator).

To calculate the separate rates for each of the four FDA-approved medications for OUD, divide the Numerator for the medication by the Denominator. For example, to calculate the buprenorphine rate, divide the number of beneficiaries with evidence of at least one prescription for buprenorphine during the measurement year (Numerator 2) by the number of beneficiaries with at least one encounter associated with a diagnosis of opioid abuse, dependence, or remission (i.e., the Denominator).

E. ADDITIONAL NOTES

None.

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

SUMMARY OF CHANGES TO HEDIS MY 2023

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

Description

The percentage of 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

Product lines	Commercial, Medicaid (report each product line separately).
Stratifications	For each product line, report the following stratifications by race and total, and stratifications by ethnicity and total: <ul style="list-style-type: none"> • <i>Race:</i> <ul style="list-style-type: none"> – White. – Black or African American. – American Indian or Alaska Native. – Asian. – Native Hawaiian or Other Pacific Islander. – Some Other Race. – Two or More Races. – Asked but No Answer. – Unknown. – Total. • <i>Ethnicity:</i>

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

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

Ages	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.
Required exclusions	Exclude members who meet either of the following criteria: <ul style="list-style-type: none"> • Members in hospice or using hospice services any time during the measurement year. Refer to <i>General Guideline 15: Members in Hospice</i>. • Members who died any time during the measurement year. Refer to <i>General Guideline 16: Deceased Members</i>.

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

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.
Required exclusions	Exclude members who meet either of the following criteria: <ul style="list-style-type: none"> • Members in hospice or using hospice services any time during the measurement year. Refer to <i>General Guideline 15: Members in Hospice</i>. • Members who died any time during the measurement year. Refer to <i>General Guideline 16: Deceased Members</i>.

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-A-1/2: Data Elements for Well-Child Visits in the First 30 Months of Life

Metric	Data Element	Reporting Instructions
Age15Months	EligiblePopulation	For each Metric
Age15To30Months	ExclusionAdminRequired	For each Metric
	NumeratorByAdmin	For each Metric
	NumeratorBySupplemental	For each Metric
	Rate	(Percent)

Table W30-B-1/2: Data Elements for Well-Child Visits in the First 30 Months of Life: Stratifications by Race

Metric	Race	Source	Data Element	Reporting Instructions
Age15Months	White	Direct	EligiblePopulation	For each Metric and Stratification
Age15To30Months	BlackOrAfricanAmerican	Indirect	Numerator	For each Metric and Stratification
	AmericanIndianOrAlaskaNative	Total	Rate	(Percent)
	Asian			
	NativeHawaiianOrOtherPacificIslander			
	SomeOtherRace			
	TwoOrMoreRaces			
	AskedButNoAnswer*			
	Unknown**			

Table W30-C-1/2: Data Elements for Well-Child Visits in the First 30 Months of Life: Stratifications by Ethnicity

Metric	Ethnicity	Source	Data Element	Reporting Instructions
Age15Months	HispanicOrLatino	Direct	EligiblePopulation	For each Metric and Stratification
Age15To30Months	NotHispanicOrLatino	Indirect	Numerator	For each Metric and Stratification
	AskedButNoAnswer*	Total	Rate	(Percent)
	Unknown**			

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

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

Rules for Allowable Adjustments of HEDIS

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

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

Rules for Allowable Adjustments of 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 an area of interest defined by gender, race, ethnicity, socioeconomic or sociodemographic characteristics, geographic region or another characteristic.
CLINICAL COMPONENTS		
Eligible Population	Adjustments Allowed (Yes/No)	Notes
Event/diagnosis	NA	There is no event/diagnosis for this measure.
Denominator Exclusions	Adjustments Allowed (Yes/No)	Notes
Required exclusions	Yes	The hospice and deceased member exclusion are not required. Refer to <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"> • 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.
Stratifications	Adjustments Allowed (Yes/No)	Notes
Well-Care Visits	Yes, with limits	Organizations may stratify the count of visits for the numerator of both rates. Value sets and logic may not be changed.

Quality ID #336: Maternity Care: Postpartum Follow-up and Care Coordination

2023 COLLECTION TYPE:

MIPS CLINICAL QUALITY MEASURES (CQMS)

MEASURE TYPE:

Process – High Priority

DESCRIPTION:

Percentage of patients, regardless of age, who gave birth during a 12-month period who were seen for postpartum care before or at 12 weeks of giving birth and received the following at a postpartum visit: breast-feeding evaluation and education, postpartum depression screening, postpartum glucose screening for gestational diabetes patients, family and contraceptive planning counseling, tobacco use screening and cessation education, healthy lifestyle behavioral advice, and an immunization review and update.

INSTRUCTIONS:

This measure is to be submitted a minimum of **once per performance period** for all patients seen for postpartum care before or at 12 weeks of giving birth during the performance period. This measure may be submitted by Merit-based Incentive Payment System (MIPS) eligible clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

Measure Submission Type:

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

DENOMINATOR:

All patients, regardless of age, who gave birth during a 12-month period and were seen for postpartum care at a visit before or at 12 weeks of giving birth

Denominator Criteria (Eligible Cases):

All patients, regardless of age

AND

Patient procedure during performance period (CPT): 59400, 59410, 59430, 59510, 59515, 59610, 59614, 59618, 59622

WITHOUT

Telehealth Modifier (including but not limited to): GQ, GT, 95, POS 02

AND

Postpartum care visit before or at 12 weeks of giving birth

NUMERATOR:

Patients receiving the following at a postpartum visit:

- Breast-feeding evaluation and education, including patient-reported breast-feeding
- Postpartum depression screening
- Postpartum glucose screening for gestational diabetes patients
- Family and contraceptive planning counseling
- Tobacco use screening and cessation education

- Healthy lifestyle behavioral advice
- Immunization review and update

Definitions:

Breast-Feeding Evaluation and Education – Patients who were evaluated for and educated about breast-feeding before or at 12 weeks postpartum.

Postpartum Depression Screening – Patients who were screened for postpartum depression before or at 12 weeks postpartum. Questions may be asked either directly by a health care provider or in the form of self-completed paper- or computer-administered questionnaires, and results should be documented in the medical record. Depression screening should include a self-reported validated depression screening tool (e.g., PHQ-2, Beck Depression Inventory, Beck Depression Inventory for Primary Care, Edinburgh Postnatal Depression Scale (EPDS)).

Postpartum Glucose Screening for Gestational Diabetes – Patients who were diagnosed with gestational diabetes during pregnancy and were screened with a glucose screen before or at 12 weeks postpartum.

Family and Contraceptive Planning Counseling – Patients who were provided family and contraceptive planning counseling (*including contraception, if necessary*) before or at 12 weeks postpartum.

Tobacco Use Screening and Cessation Education – Patients who were screened for tobacco use before or at 12 weeks postpartum. Patients who used any type of tobacco who were given brief counseling (3 minutes or less) and/or pharmacotherapy.

Healthy Lifestyle Behavioral Advice – Clinicians should use discretion to determine which patients they deem appropriate for healthy lifestyle counseling. Clinicians may take into account the number of weeks that have passed since childbirth, whether the mother is breast-feeding, the degree to which the mother’s body mass index (BMI) exceeds the normal range, whether postpartum depression is present, and the mother’s own feelings and perceptions of her body weight. Counseling should include suggestions around healthy eating and staying active. If deemed necessary by the clinician, the conversation about healthy lifestyle choices could include a follow-up plan, including a referral to a specialist such as a registered dietitian nutritionist, primary care provider, or mental health professional for lifestyle/behavioral therapy, pharmacological interventions, dietary supplements, exercise counseling or nutrition counseling.

Immunization Review and Update – Patients whose immunization records were reviewed and who were provided with indicated immunizations, including completing series initiated antepartum or postpartum, at or before 12 weeks postpartum.

Numerator Instructions:

To satisfactorily meet the numerator ALL components (breast-feeding evaluation and education, postpartum depression screening, postpartum glucose screening for patients with gestational diabetes, family and contraceptive planning counseling, tobacco use screening and cessation education, healthy lifestyle behavioral advice, and immunization review and update) must be performed according to the definitions provided above.

NUMERATOR OPTIONS:

Performance Met:

Postpartum screenings, evaluations, and education performed (**G9357**)

OR

Performance Not Met:

Postpartum screenings, evaluations and education not performed (**G9358**)

RATIONALE:

Managing and ensuring concrete postpartum follow-up after delivery is a critical challenge to the health care system impacting the quality of care mothers receive. The American College of Obstetricians and Gynecologists (ACOG) sees the weeks following birth as a critical period for a woman and her child that sets the stage for long-term health and well-being. As such, this “fourth trimester” should include a comprehensive postpartum visit with a full assessment of physical, social, and psychological well-being.

Postpartum follow-up for depression screening, breast-feeding evaluation and education, family and contraceptive planning counseling, glucose screening for gestational diabetes, tobacco use screening and cessation education, healthy lifestyle behavioral advice, and immunization review and update are important risk factors to evaluate after childbirth. Maternal depression is one of the most common perinatal complications; however, the disorder remains under recognized, underdiagnosed, and undertreated. The various maternal depression disorders are defined by the severity of the depression and the timing and length of the episode. Studies report that 3 to 25 percent of women experience major depression during the year following childbirth.

Establishing the diagnosis of gestational diabetes mellitus offers an opportunity not only to improve pregnancy outcomes, but also to decrease risk factors associated with the subsequent development of type 2 diabetes. The ACOG Committee on Obstetric Practice recommends that all women with gestational diabetes mellitus be screened at 6–12 weeks postpartum and managed appropriately.

Tobacco and nicotine use is still a major contributor to morbidity and mortality in women and men. Women who stop using tobacco and nicotine receive an immediate health and financial benefit.

ACOG acknowledges that unintended pregnancies are common and that pregnancy spacing is important for healthy families. In addition, the greatest risk of low birth weight and preterm birth occurs when the interconception interval is less than 6 months. The ACOG sees the weeks following birth as a critical period for a woman and her child that set the stage for long-term health and well-being.

The ACOG 2018 Postpartum Toolkit states that immunization in the postpartum period is a simple and effective way to protect the woman and her child from certain infections, particularly when the woman was not immunized during pregnancy. Although obstetrician–gynecologists encourage women of childbearing age to be current with their immunizations before the peripartum period, postpartum maternal immunization can prevent acute maternal infection and potential spread of illness from the woman to her newborn. Infants of breast-feeding women acquire maternal antibodies through breast milk.

This measure is a measure of the adequacy of the care provided for those that come for postpartum care, as patients who do not have postpartum visits are excluded from this measure.

Although certain postpartum conditions, such as depression, remain an underrecognized and undertreated condition for all low-income women, this is especially the case for those from racial and ethnic minority groups. A retrospective study of New Jersey’s Medicaid program found that Black and Latina women had particularly low treatment initiation rates for postpartum depression [1]. Postpartum care disparities similarly existed for general postpartum care, postpartum glucose screening, and family and contraceptive planning counseling among racial and ethnic minority groups [2,3]. Access to care barriers, health literacy variations, and care coordination challenges may also play a role in postpartum care disparities [4]. Potential solutions to improve postpartum testing rates included proactively contacting patients, establishing educational programs, and distributing mailings [5]. These studies suggest that successful implementation of this measure’s intent may have positive downstream impacts on disparities in postpartum care and maternal and children’s outcomes overall.

References

1. Kozhimannil, K.B., Trinacty, C.M., Busch, A.B., Huskamp, H.A., Adams, A.S. (2011). Racial and ethnic disparities in postpartum depression care among low-income women. *Psychiatric Services*, 62(6), 619-625. https://doi.org/10.1176/ps.62.6.pss6206_0619
2. Howell, E.A., Padrón, N.A., Beane, S.J. *et al.* (2017). Delivery and payment redesign to reduce disparities in high risk postpartum care. *Maternal Child Health J*, 21(3), 432–438. <https://doi.org/10.1007/s10995-016-2221-8>
3. Mathieu, I.P., Song, Y., Jagasia, S.M. (2014). Disparities in postpartum follow-up in women with gestational diabetes mellitus, *Clinical Diabetes*, 32(4), 178-182. <https://doi.org/10.2337/diaclin.32.4.178>
4. Parekh, N., Jarlenski, M., Kelley, D. (2018). Prenatal and postpartum care disparities in a large Medicaid

program. *Matern Child Health J*, 22, 429–437. <https://doi.org/10.1007/s10995-017-2410-0>

5. Carson, M.P., Frank, M.I., Keely, E. (2013). Original research: Postpartum testing rates among women with a history of gestational diabetes—Systematic review, *Primary Care Diabetes*, 7(3), 177-186. <https://doi.org/10.1016/j.pcd.2013.04.007>.

CLINICAL RECOMMENDATION STATEMENTS:

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

Postpartum Care

The comprehensive postpartum visit should include a full assessment of physical, social, and psychological well-being, including the following domains [1]:

- Mood and emotional well-being
- Infant care and feeding
- Sexuality, contraception, and birth spacing
- Sleep and fatigue
- Physical recovery from birth
- Chronic disease management
- Health maintenance

Breast-Feeding Evaluation and Education

The USPSTF recommends interventions during pregnancy and after birth to support breast-feeding (Grade B recommendation) [2].

This recommendation applies to pregnant women, new mothers, and young children. In rare circumstances involving health issues in mothers or infants, such as human immunodeficiency virus (HIV) infection or galactosemia, breast-feeding may be contraindicated, and interventions to promote breast-feeding may not be appropriate.

Interventions to promote and support breast-feeding may also involve a woman's partner, other family members, and friends.

Postpartum Depression Screening

A screening for postpartum depression should be included in the postpartum visit [3,4]. The 10-question Edinburgh Postnatal Depression Scale (EPDS) is a valuable and efficient way of identifying patients at risk for “perinatal” depression. The EPDS is easy to administer and has proven to be an effective screening tool. Mothers who score above 13 are likely to be suffering from a depressive illness of varying severity. The EPDS score should not override clinical judgment. A careful clinical assessment should be carried out to confirm the diagnosis. The scale indicates how the mother has felt during the previous week. In doubtful cases it may be useful to repeat the tool after 2 weeks.

Postpartum Glucose Screening for Gestational Diabetes Patients

Up to one-third of women who experienced GDM will have impaired glucose metabolism postpartum and 15% to 50% of women will develop type 2 diabetes within the decades following the affected pregnancy [5]. Postpartum follow-up with treatment has been proven to postpone or prevent this occurrence. Glucose testing should be included in the postpartum visit for patients who had pregnancies complicated by gestational diabetes [3]. ACOG recommends either a 75 g, 2-hour oral glucose tolerance test, or a fasting plasma glucose test [1]. Refer to the VA/DoD Clinical Practice Guideline for the Management of Diabetes Mellitus in Primary Care (2017) for more information regarding glucose screening techniques [6].

Family and Contraceptive Planning Counseling

Women should be advised to avoid interpregnancy intervals shorter than 6 months and should be counseled about the risks and benefits of repeat pregnancy sooner than 18 months. Short interpregnancy intervals also are associated with reduced vaginal birth after cesarean success for women undergoing trial of labor after cesarean [1]. Family planning and contraception should be discussed at the postpartum visit [3].

A woman's future pregnancy intentions provide a context for shared decision making regarding contraceptive options. Shared decision making brings two experts to the table: the patient and the health care provider. The health care provider is an expert in the clinical evidence, and the patient is an expert in her experiences and values. As affirmed by the World Health Organization (WHO), when making choices regarding the timing of the next pregnancy, "Individuals and couples should consider health risks and benefits along with other circumstances such as their age, fecundity, fertility aspirations, access to health services, child-rearing support, social and economic circumstances, and personal preferences." Given the complex history of sterilization abuse and fertility control among marginalized women, care should be taken to ensure that every woman is provided information on the full range of contraceptive options so that she can select the method best suited to her needs [1].

Tobacco Screening and Cessation Education

One component of postpartum care be assessing mood and emotional well-being, which includes screening for tobacco use and counseling regarding relapse risk in the postpartum period [1]. An ACOG Work Group created a Tobacco and Nicotine Cessation Toolkit to support clinicians in discussing tobacco and smoking cessation with patients.

Healthy Lifestyle Behavioral Advice

Approximately 65% of reproductive-aged women are overweight or obese at the time of pregnancy and are at risk of postpartum weight retention and chronic obesity [7].

Risk factors for being overweight or obese include a sedentary lifestyle, high caloric dietary intake, family history, genetics, and individual metabolism. Regular physical activity during an uncomplicated pregnancy and the postpartum period can improve cardiorespiratory fitness and reduce the risk and downstream health consequences (e.g., heart disease, diabetes) of being overweight or obese. Postpartum women should follow the national guidelines for physical activity, which is 150 minutes of moderate exercise each week. Recommendations include a target of 20–30 minutes of exercise on most days of the week. Providing lifestyle recommendations to promote maternal health for long-term reduction in the risk of chronic obesity and its downstream sequelae of diabetes and cardiovascular disease is a key objective of the postpartum visit. Such recommendations will also result in improved health in the interpregnancy period, if further childbearing is desired [6].

The postpartum period is an opportune time for obstetrician–gynecologists and other obstetric care providers to recommend and reinforce a healthy lifestyle. Resuming exercise or incorporating new exercise routines after delivery is important in supporting lifelong healthy habits. Exercise routines may be resumed gradually after pregnancy as soon as medically safe, depending on the mode of delivery (vaginal or cesarean birth) and the presence or absence of medical or surgical complications. Some women are capable of resuming physical activities within days of delivery. Pelvic floor exercises can be initiated in the immediate postpartum period. Abdominal strengthening exercises, including abdominal crunch exercises and the drawing-in exercise, a maneuver that increases abdominal pressure by pulling in the abdominal wall muscles, have been shown to decrease the incidence of diastasis recti abdominus and decrease the inter-rectus distance in women who gave birth vaginally or by cesarean birth [7].

Immunization Review and Update

One component of postpartum care includes reviewing vaccination history and providing indicated immunizations, including completing series initiated antepartum or postpartum [1]. The postpartum visit should include a review of current vaccination status in accordance with CDC Pregnancy and Maternal Vaccination guidance, including a review of immunization status against pertussis, influenza, varicella, and rubella [3]. The influenza vaccine is an essential element of pre-pregnancy, prenatal, and postpartum care since influenza can result in serious illness, and has a higher chance of progressing to pneumonia when it occurs during the antepartum or postpartum period [8]. Likewise, women are at high risk of serious complications of seasonal and pandemic influenza infection [9].

References

1. ACOG Committee Opinion No. 736: Optimizing Postpartum Care (2018, reaffirmed 2021)
2. USPSTF Final Recommendation Statement: Breastfeeding: Primary Care Interventions (2016)

3. VA/DoD Clinical Practice Guideline for the Management of Pregnancy Version 3.0 (2018)
4. ACOG Committee Opinion No. 757: Screening for Perinatal Depression (2018)
5. ACOG Tool for Postpartum Gestational Diabetes Mellitus (GDM) Follow-up
6. VA/DoD Clinical Practice Guideline for the Management of Diabetes Mellitus in Primary Care (2017)
7. ACOG Postpartum Toolkit (2018)
8. ACOG Committee Opinion No. 732: Influenza Vaccination During Pregnancy (2018)
9. ACOG Committee Opinion No. 753: Assessment and Treatment of Pregnant Women With Suspected or Confirmed Influenza (2018)

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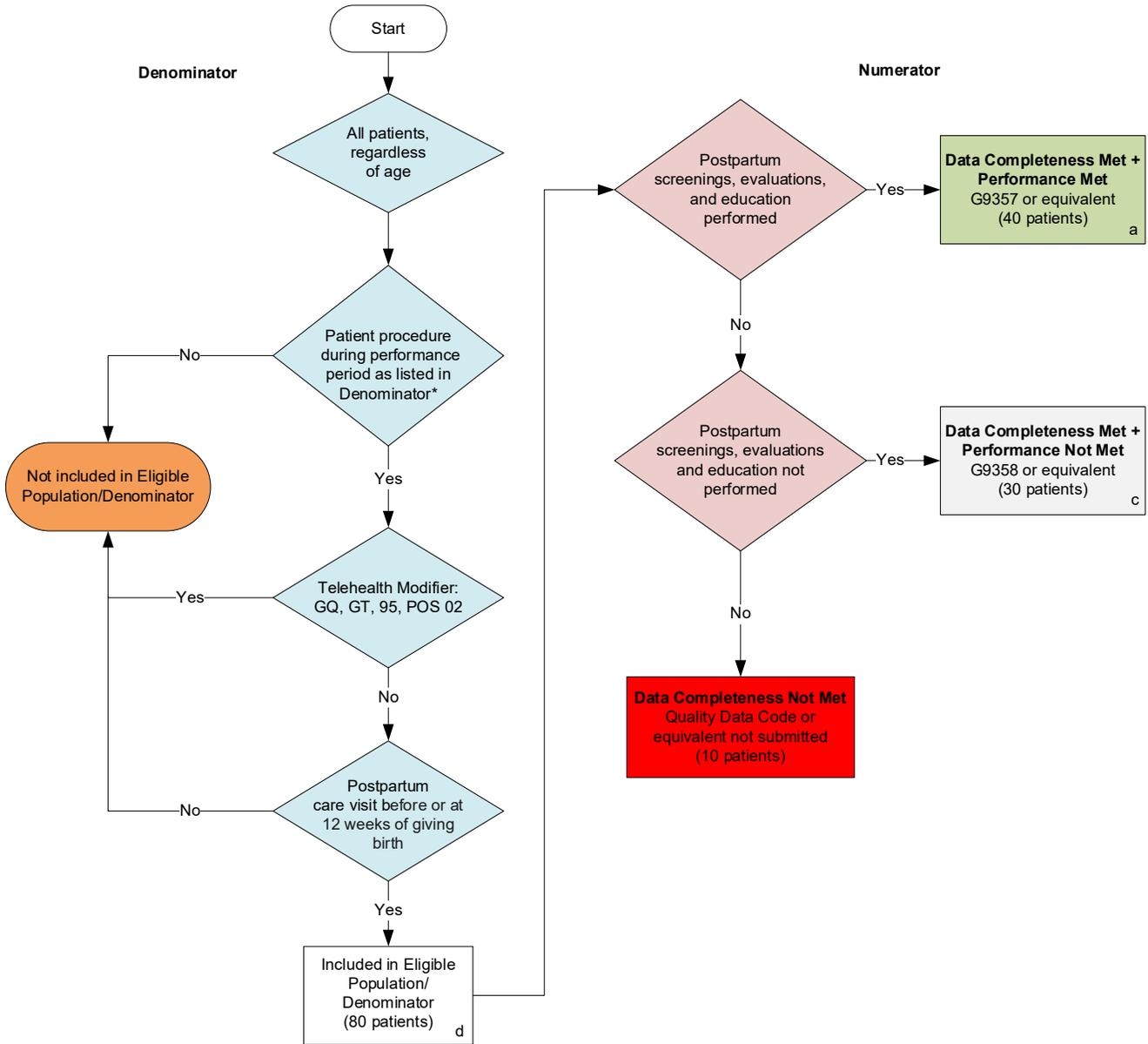
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2023 Clinical Quality Measure Flow for Quality ID #336: Maternity Care: Postpartum Follow-up and Care Coordination

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



SAMPLE CALCULATIONS			
Data Completeness=			
Performance Met (a=40 patients) + Performance Not Met (c=30 patients)	=	70 patients	= 87.50%
Eligible Population / Denominator (d=80 patients)	=	80 patients	
Performance Rate=			
Performance Met (a=40 patients)	=	40 patients	= 57.14%
Data Completeness Numerator (70 patients)	=	70 patients	

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

NOTE: Submission Frequency: Patient-Process

NOTE: Telehealth modifiers include **but are not limited to:** GQ, GT, 95, POS 02

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v7

**2023 Clinical Quality Measure Flow Narrative for Quality ID #336:
Maternity Care: Postpartum Follow-up and Care Coordination**

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

1. Start with Denominator.
2. All patients, regardless of age.
3. Check *Patient procedure during performance period as listed in Denominator**:
 - a. If *Patient procedure during performance period as listed in Denominator** equals No, do not include in *Eligible Population/Denominator*. Stop processing.
 - b. If *Patient procedure during performance period as listed in Denominator** equals Yes, proceed to check *Telehealth Modifier*.
4. Check *Telehealth Modifier*:
 - a. If *Telehealth Modifier* equals Yes, do not include in *Eligible Population/Denominator*. Stop processing.
 - b. If *Telehealth Modifier* equals No, proceed to check *Postpartum care visit before or at 12 weeks of giving birth*.
5. Check *Postpartum care visit before or at 12 weeks of giving birth*:
 - a. If *Postpartum care visit before or at 12 weeks of giving birth* equals No, do not include in *Eligible Population/Denominator*. Stop processing.
 - b. If *Postpartum care visit before or at 12 weeks of giving birth* equals Yes, include in *Eligible Population/Denominator*.
6. Denominator Population:
 - a. Denominator Population is all Eligible Patients in the Denominator. Denominator is represented as Denominator in the Sample Calculation listed at the end of this document. Letter d equals 80 patients in the Sample Calculation.
7. Start Numerator
8. Check *Postpartum screenings, evaluations, and education performed*:
 - a. If *Postpartum screenings, evaluations, and education performed* equals Yes, include in *Data Completeness Met and Performance Met*.
 - *Data Completeness Met and Performance Met* letter is represented in the Data Completeness and Performance Rate in the Sample Calculation listed at the end of this document. Letter a equals 40 patients in the Sample Calculation.
 - b. If *Postpartum screenings, evaluations, and education performed* equals No, proceed to *Postpartum screenings, evaluations, and education not performed*.
9. Check *Postpartum screenings, evaluations, and education not performed*:
 - a. If *Postpartum screenings, evaluations, and education not performed* equals Yes, include in *Data Completeness Met and Performance Not Met*.

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

b. If *Postpartum screenings, evaluations, and education not performed* equals No, proceed to check *Data Completeness Not Met*.

10. Check *Data Completeness Not Met*:

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

Sample Calculations:

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

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

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

NOTE: Submission Frequency: Patient-Process

NOTE: Telehealth modifiers include **but are not limited to**: GQ, GT, 95, POS 02

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

Use of Opioids at High Dosage (HDO)*

*Adapted with financial support from CMS and with permission from the measure developer, Pharmacy Quality Alliance (PQA).

SUMMARY OF CHANGES TO HEDIS MY 2023

- Clarified that the measure is reported as the “percentage” of members.
- Added a direct reference code for palliative care.
- Added a required exclusion for members who died during the measurement year.
- Revised the “Other” criteria in the Nonclinical Components table under *Rules for Allowable Adjustments of HEDIS*.
- Revised the “Required exclusions” criteria in the Clinical Components table under *Rules for Allowable Adjustments of HEDIS*.

Description

The percentage of members 18 years of age and older who received prescription opioids at a high dosage (average morphine milligram equivalent dose [MME] ≥ 90) for ≥ 15 days during the measurement year.

Note: A lower rate indicates better performance.

Definitions

Calculating number of days covered for the denominator

Use the following steps to identify and calculate covered days for the denominator.

- Step 1** Identify dispensing events where multiple prescriptions for the same medication are dispensed with overlapping days supply (i.e., dispensed on the same day *or* dispensed on different days with overlapping days supply). Sum the days supply for these dispensing events.

Identify the start and end dates: The start date is the date of service of the earliest dispensing event and the end date is the start date plus the summed days supply minus one. The start date through the end date are considered covered days. For example:

- If there are three 7-days supply dispensing events for the same medication on January 1, the start date is January 1 and the end date is January 21. Covered days include January 1–21.
- If there are two 7-days supply dispensing events for the same medication on January 1 and January 5, the start date is January 1 and the end date is January 14. Covered days include January 1–14.
- If there are three 7-days supply dispensing events for the same medication on January 1, a 7-days supply dispensing event on January 20, and a 7-days supply dispensing event on January 28, the start date is January 1 and the end date is February 4. Covered days include January 1–February 4.

Step 2	For all other dispensing events (i.e., multiple prescriptions for the same medication on different days without overlap, and multiple prescriptions for different medications on the same or different days, with or without overlap), identify the start and end dates for each dispensing event individually. The start date through the end date are considered covered days.
Step 3	Count the covered days. Consider each calendar day covered by one or more medications to be one covered day.
Identifying same or different drugs	<p>To identify “same” or “different” drugs, use Table HDO-A, which identifies the medications lists for the measure. Dispensing events from any of the Fentanyl medication lists, even if they are on different rows, are all considered the “same” drug.</p> <p>For all other types of opioids, the table includes a “Medication Lists” column that identifies the “same” high-risk medications by grouping them on the same row. For example, a dispensing event from the <u>Codeine Sulfate 15 mg Medications List</u> is considered the same drug as a dispensing event from the <u>Codeine Sulfate 30 mg Medications List</u>. Conversely, a dispensing event from the <u>Codeine Sulfate 15 mg Medications List</u> is considered a different drug than a dispensing event from the <u>Acetaminophen Codeine 15 mg Medications List</u> because they are in different table rows.</p>
Treatment period	<i>To identify the treatment period:</i> For all dispensing events, identify the start and end dates for each dispensing event individually. The treatment period start date is the start date of the earliest dispensing event during the measurement year. The treatment period end date is the last end date during the measurement year.
MME	Morphine milligram equivalent. The dose of oral morphine that is the analgesic equivalent of a given dose of another opioid analgesic (Table HDO-A).
Opioid dosage unit	For each dispensing event, use the following calculation to determine the opioid dosage unit. $\# \text{ of Opioid Dosage Units per day} = \frac{\text{opioid quantity dispensed}}{\text{opioid days supply}}$
MME daily dose	For each dispensing event, use the following calculation to determine the MME daily dose. Convert each medication into the MME using the appropriate MME conversion factor and strength associated with the opioid product of the dispensing event (refer to Table HDO-A for MME conversion factor and strength). $\text{MME Daily Dose} = (\# \text{ of opioid dosage units per day}) \times (\text{strength (e.g., mg, mcg)}) \times (\text{MME conversion factor [Table HDO-A]})$ <p><i>Example 1:</i> 10 mg oxycodone tablets X (120 tablets / 30 days) X 1.5 = 60 MME/day</p> <p><i>Example 2:</i> 25 mcg/hr fentanyl patch X (10 patches / 30 days) X 7.2 = 60 MME/day</p>
Total daily MME	The total sum of the MME daily doses for all opioid dispensing events on 1 day.
Average MME	The average MME for all opioids dispensed during the treatment period.

Eligible Population

Product lines	Commercial, Medicaid, Medicare (report each product line separately).
Age	18 years and older as of January 1 of the measurement year.
Continuous enrollment	The measurement year.
Allowable gap	None.
Anchor date	None.
Benefit	Medical and pharmacy.
Event/diagnosis	Use the steps below to determine the eligible population. <ul style="list-style-type: none"> Step 1 Identify members who met both of the following criteria during the measurement year: <ul style="list-style-type: none"> • Two or more opioid dispensing events on different dates of service. Use all the medication lists in Table HDO-A to identify opioid medication dispensing events. • ≥15 total days covered by opioids. Required exclusions Exclude members who met any of the following any time during the measurement year: <ul style="list-style-type: none"> • Cancer (<u>Malignant Neoplasms Value Set</u>). • Sickle cell disease (<u>Sickle Cell Anemia and HB S Disease Value Set</u>). • 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>; ICD-10-CM code Z51.5). • Members in hospice or using hospice services. Refer to <i>General Guideline 15: Members in Hospice</i>. • Members who died any time during the measurement year. Refer to <i>General Guideline 16: Deceased Members</i>.

Administrative Specification

Denominator	The eligible population.
Numerator	The number of members whose average MME was ≥90 during the treatment period. Follow the steps below to identify numerator compliance. <ul style="list-style-type: none"> Step 1 Use all the medication lists in Table HDO-A to identify all opioid medication dispensing events during the measurement year. Step 2 For each member, calculate the MME daily dose for each medication dispensing event. Step 3 For a single dispensing event, multiply the MME daily dose by the dispensing event's days supply. For example, a dispensing event with a MME daily dose of 90 and a days supply of 5 would have a total MME of 450 for that dispensing event. As multiple dispensing events can overlap on one calendar day, for each

day, sum the MME daily doses for all dispensing events to determine the total daily MME for that day.

Step 4 Determine the treatment period.

Step 5 Determine the average MME. Sum the total daily MME for the treatment period and divide by the number of days in the treatment period. Members whose average MME was ≥ 90 meet the numerator criteria.

Table HDO-A: Opioid Medications¹

Type of Opioid	Medication Lists	Strength	MME Conversion Factor
Benzhydrocodone	Acetaminophen Benzhydrocodone 4.08 mg Medications List	4.08 mg	1.2
	Acetaminophen Benzhydrocodone 6.12 mg Medications List	6.12 mg	
	Acetaminophen Benzhydrocodone 8.16 mg Medications List	8.16 mg	
Butorphanol	Butorphanol 10 MGPML Medications List	10 mg	7
Codeine	Codeine Sulfate 15 mg Medications List	15 mg	0.15
	Codeine Sulfate 30 mg Medications List	30 mg	
	Codeine Sulfate 60 mg Medications List	60 mg	
Codeine	Acetaminophen Codeine 2.4 MGPML Medications List	2.4 mg	0.15
	Acetaminophen Codeine 15 mg Medications List	15 mg	
	Acetaminophen Codeine 30 mg Medications List	30 mg	
	Acetaminophen Codeine 60 mg Medications List	60 mg	
Codeine	Acetaminophen Butalbital Caffeine Codeine 30 mg Medications List	30 mg	0.15
Codeine	Aspirin Butalbital Caffeine Codeine 30 mg Medications List	30 mg	0.15
Codeine	Aspirin Carisoprodol Codeine 16 mg Medications List	16 mg	0.15
Dihydrocodeine	Acetaminophen Caffeine Dihydrocodeine 16 mg Medications List	16 mg	0.25
Dihydrocodeine	Aspirin Caffeine Dihydrocodeine 16 mg Medications List	16 mg	0.25
Fentanyl buccal or sublingual tablet, transmucosal lozenge (mcg) ²	Fentanyl 100 mcg Medications List	100 mcg	0.13
	Fentanyl 200 mcg Medications List	200 mcg	
	Fentanyl 300 mcg Medications List	300 mcg	
	Fentanyl 400 mcg Medications List	400 mcg	
	Fentanyl 600 mcg Medications List	600 mcg	
	Fentanyl 800 mcg Medications List	800 mcg	
	Fentanyl 1200 mcg Medications List	1200 mcg	
	Fentanyl 1600 mcg Medications List	1600 mcg	
Fentanyl oral spray (mcg) ³	Fentanyl 100 MCGPS Oral Medications List	100 mcg	0.18
	Fentanyl 200 MCGPS Oral Medications List	200 mcg	
	Fentanyl 400 MCGPS Oral Medications List	400 mcg	
	Fentanyl 600 MCGPS Oral Medications List	600 mcg	
	Fentanyl 800 MCGPS Oral Medications List	800 mcg	

Type of Opioid	Medication Lists	Strength	MME Conversion Factor
Fentanyl nasal spray (mcg) ⁴	Fentanyl 100 MCGPS Nasal Medications List Fentanyl 300 MCGPS Nasal Medications List Fentanyl 400 MCGPS Nasal Medications List	100 mcg 300 mcg 400 mcg	0.16
Fentanyl transdermal film/patch (mcg/hr) ⁵	Fentanyl 12 MCGPH Medications List Fentanyl 25 MCGPH Medications List Fentanyl 37.5 MCGPH Medications List Fentanyl 50 MCGPH Medications List Fentanyl 62.5 MCGPH Medications List Fentanyl 75 MCGPH Medications List Fentanyl 87.5 MCGPH Medications List Fentanyl 100 MCGPH Medications List	12 mcg 25 mcg 37.5 mcg 50 mcg 62.5 mcg 75 mcg 87.5 mcg 100 mcg	7.2
Hydrocodone	Hydrocodone 10 mg Medications List Hydrocodone 15 mg Medications List Hydrocodone 20 mg Medications List Hydrocodone 30 mg Medications List Hydrocodone 40 mg Medications List Hydrocodone 50 mg Medications List Hydrocodone 60 mg Medications List Hydrocodone 80 mg Medications List Hydrocodone 100 mg Medications List Hydrocodone 120 mg Medications List	10 mg 15 mg 20 mg 30 mg 40 mg 50 mg 60 mg 80 mg 100 mg 120 mg	1
Hydrocodone	Acetaminophen Hydrocodone .5 MGPML Medications List Acetaminophen Hydrocodone .67 MGPML Medications List Acetaminophen Hydrocodone 2.5 mg Medications List Acetaminophen Hydrocodone 5 mg Medications List Acetaminophen Hydrocodone 7.5 mg Medications List Acetaminophen Hydrocodone 10 mg Medications List	.5 mg .67 mg 2.5 mg 5 mg 7.5 mg 10 mg	1
Hydrocodone	Hydrocodone Ibuprofen 2.5 mg Medications List Hydrocodone Ibuprofen 5 mg Medications List Hydrocodone Ibuprofen 7.5 mg Medications List Hydrocodone Ibuprofen 10 mg Medications List	2.5 mg 5 mg 7.5 mg 10 mg	1
Hydromorphone	Hydromorphone 1 MGPML Medications List Hydromorphone 2 mg Medications List Hydromorphone 3 mg Medications List Hydromorphone 4 mg Medications List Hydromorphone 8 mg Medications List Hydromorphone 12 mg Medications List Hydromorphone 16 mg Medications List Hydromorphone 32 mg Medications List	1 mg 2 mg 3 mg 4 mg 8 mg 12 mg 16 mg 32 mg	4

Type of Opioid	Medication Lists	Strength	MME Conversion Factor
Levorphanol	Levorphanol 2 mg Medications List Levorphanol 3 mg Medications List	2 mg 3 mg	11
Meperidine	Meperidine 10 MGPML Medications List Meperidine 50 mg Medications List Meperidine 75 mg Medications List Meperidine 100 mg Medications List Meperidine 150 mg Medications List	10 mg 50 mg 75 mg 100 mg 150 mg	0.1
Methadone ⁶	Methadone 1 MGPML Medications List Methadone 2 MGPML Medications List Methadone 5 mg Medications List Methadone 10 mg Medications List Methadone 10 MGPML Medications List Methadone 40 mg Medications List	1 mg 2 mg 5 mg 10 mg 10 mg 40 mg	3
Morphine	Morphine 2 MGPML Medications List Morphine 4 MGPML Medications List Morphine 5 mg Medications List Morphine 10 mg Medications List Morphine 15 mg Medications List Morphine 20 MGPML Medications List Morphine 20 mg Medications List Morphine 30 mg Medications List Morphine 40 mg Medications List Morphine 45 mg Medications List Morphine 50 mg Medications List Morphine 60 mg Medications List Morphine 75 mg Medications List Morphine 80 mg Medications List Morphine 90 mg Medications List Morphine 100 mg Medications List Morphine 120 mg Medications List Morphine 200 mg Medications List	2 mg 4 mg 5 mg 10 mg 15 mg 20 mg 20 mg 30 mg 40 mg 45 mg 50 mg 60 mg 75 mg 80 mg 90 mg 100 mg 120 mg 200 mg	1
Morphine	Morphine Naltrexone 20 mg Medications List Morphine Naltrexone 30 mg Medications List Morphine Naltrexone 50 mg Medications List Morphine Naltrexone 60 mg Medications List Morphine Naltrexone 80 mg Medications List Morphine Naltrexone 100 mg Medications List	20 mg 30 mg 50 mg 60 mg 80 mg 100 mg	1
Opium	Belladonna Opium 30 mg Medications List Belladonna Opium 60 mg Medications List	30 mg 60 mg	1
Oxycodone	Oxycodone 1 MGPML Medications List Oxycodone 5 mg Medications List Oxycodone 7.5 mg Medications List Oxycodone 9 mg Medications List	1 mg 5 mg 7.5 mg 9 mg	1.5

Type of Opioid	Medication Lists	Strength	MME Conversion Factor
	Oxycodone 10 mg Medications List	10 mg	
	Oxycodone 13.5 mg Medications List	13.5 mg	
	Oxycodone 15 mg Medications List	15 mg	
	Oxycodone 18 mg Medications List	18 mg	
	Oxycodone 20 mg Medications List	20 mg	
	Oxycodone 20 MGPML Medications List	20 mg	
	Oxycodone 27 mg Medications List	27 mg	
	Oxycodone 30 mg Medications List	30 mg	
	Oxycodone 36 mg Medications List	36 mg	
	Oxycodone 40 mg Medications List	40 mg	
	Oxycodone 60 mg Medications List	60 mg	
	Oxycodone 80 mg Medications List	80 mg	
Oxycodone	Acetaminophen Oxycodone 1 MGPML Medications List	1 mg	1.5
	Acetaminophen Oxycodone 2 MGPML Medications List	2 mg	
	Acetaminophen Oxycodone 2.5 mg Medications List	2.5 mg	
	Acetaminophen Oxycodone 5 mg Medications List	5 mg	
	Acetaminophen Oxycodone 7.5 mg Medications List	7.5 mg	
	Acetaminophen Oxycodone 10 mg Medications List	10 mg	
Oxycodone	Aspirin Oxycodone 4.84 mg Medications List	4.84 mg	1.5
Oxycodone	Ibuprofen Oxycodone 5 mg Medications List	5 mg	1.5
Oxymorphone	Oxymorphone 5 mg Medications List	5 mg	3
	Oxymorphone 7.5 mg Medications List	7.5 mg	
	Oxymorphone 10 mg Medications List	10 mg	
	Oxymorphone 15 mg Medications List	15 mg	
	Oxymorphone 20 mg Medications List	20 mg	
	Oxymorphone 30 mg Medications List	30 mg	
	Oxymorphone 40 mg Medications List	40 mg	
Pentazocine	Naloxone Pentazocine 50 mg Medications List	50 mg	0.37
Tapentadol	Tapentadol 50 mg Medications List	50 mg	0.4
	Tapentadol 75 mg Medications List	75 mg	
	Tapentadol 100 mg Medications List	100 mg	
	Tapentadol 150 mg Medications List	150 mg	
	Tapentadol 200 mg Medications List	200 mg	
	Tapentadol 250 mg Medications List	250 mg	
Tramadol	Tramadol 5 MGPML Medications List	5 mg	0.1
	Tramadol 50 mg Medications List	50 mg	
	Tramadol 100 mg Medications List	100 mg	
	Tramadol 150 mg Medications List	150 mg	
	Tramadol 200 mg Medications List	200 mg	
	Tramadol 300 mg Medications List	300 mg	
Tramadol	Acetaminophen Tramadol 37.5 mg Medications List	37.5 mg	0.1

¹ National Center for Injury Prevention and Control. CDC compilation of benzodiazepines, muscle relaxants, stimulants, zolpidem, and opioid analgesics with oral morphine milligram equivalent conversion factors, 2017 version. Atlanta, GA: Centers for Disease Control and Prevention; 2017. Available at <https://www.cdc.gov/drugoverdose/resources/data.html>.

² MME conversion factor for fentanyl buccal tablets, sublingual tablets, and lozenges/troche is 0.13. This conversion factor should be multiplied by the number of micrograms in a given tablet or lozenge/troche.

³ MME conversion factor for fentanyl films and oral sprays is 0.18. This reflects a 40% greater bioavailability for films compared to lozenges/tablets and 38% greater bioavailability for oral sprays compared to lozenges/tablets.

⁴ MME conversion factor for fentanyl nasal spray is 0.16, which reflects a 20% greater bioavailability for sprays compared to lozenges/tablets.

⁵ MME conversion factor for fentanyl patches is 7.2 based on the assumption that one milligram of parenteral fentanyl is equivalent to 100 milligrams of oral morphine and that one patch delivers the dispensed micrograms per hour over a 24 hour day and remains in place for 3 days. Using the formula, Strength per Unit * (Number of Units/ Days Supply) * MME conversion factor = MME/Day: 25 µg/hr. fentanyl patch * (10 patches/30 days) * 7.2 = 60 MME/day.

⁶ Adapted from Von Korff M, Saunders K, Ray GT, et al. Clin J Pain 2008;24:521–7 and Washington State Interagency Guideline on Prescribing Opioids for Pain (<http://www.agencymeddirectors.wa.gov/Files/2015AMDGOpioidGuideline.pdf>).

Note

- Do not include denied claims when identifying the eligible population (except for required exclusions) or assessing the numerator for this measure.
- 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.
- This measure does not include the following opioid medications:
 - Injectables.
 - Opioid cough and cold products.
 - lonsys® (fentanyl transdermal patch).
 - This is for inpatient use only and is available only through a restricted program under a Risk Evaluation and Mitigation Strategy (REMS).
 - Methadone for the treatment of opioid use disorder.

Data Elements for Reporting

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

Table HDO-1/2/3: Data Elements for Use of Opioids at High Dosage

Metric	Data Element	Reporting Instructions
OpioidUseHighDosage	Benefit	Metadata
	EligiblePopulation	Report once
	ExclusionAdminRequired	Report once
	NumeratorByAdmin	Report once
	Rate	(Percent)

Rules for Allowable Adjustments of HEDIS

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

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

Rules for Allowable Adjustments of Use of Opioids at High Dosage

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.
Continuous enrollment, allowable gap, anchor date	Yes	Organizations are not required to use enrollment criteria; adjustments are allowed.
Benefits	Yes	Organizations are not required to use a benefit; adjustments are allowed.
Other	Yes	Organizations may use additional eligible population criteria to focus on an area of interest defined by gender, race, ethnicity, socioeconomic or sociodemographic characteristics, geographic region or another characteristic.
CLINICAL COMPONENTS		
Eligible Population	Adjustments Allowed (Yes/No)	Notes
Event/diagnosis	Yes, with limits	Only medications that contain (or map to) codes in the medication lists may be used to identify opioid use. The medication lists and logic may not be changed. Organizations may include denied claims to calculate the denominator.
Denominator Exclusions	Adjustments Allowed (Yes/No)	Notes
Required exclusions	Yes, with limits	Apply required exclusions according to specified value sets. The hospice, deceased member and palliative care exclusions are not required. Refer to <i>Exclusions</i> in the <i>Guidelines for the Rules for Allowable Adjustments</i> .
Numerator Criteria	Adjustments Allowed (Yes/No)	Notes
Members Receiving High-Dosage Opioids	Yes, with limits	Medication lists and logic may not be changed. Organizations may include denied claims to calculate the numerator.