

**Connecticut Quality Council
Quality Benchmarks
Measure Specifications**

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¹ In addition to reporting statewide performance on the Obesity Equity Measure, OHS will also report the three-year rolling average obesity rate for the Black, non-Hispanic population against target values of 37% for 2024 and 35% for 2025.

² BRFSS: Behavioral Risk Factor Surveillance System

Asthma Medication Ratio (AMR)

SUMMARY OF CHANGES TO HEDIS MY 2024

- Added a laboratory claim exclusion to value sets for which laboratory claims should not be used.

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 indicate 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:*
 - American Indian or Alaska Native.
 - Asian.
 - Black or African American.
 - Native Hawaiian or Other Pacific Islander.
 - White.
 - 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

Ages 5–64 as of December 31 of the measurement year. Report the following age stratifications and a total rate:

- 5–11 years.
- 12–18 years.
- 19–50 years.
- 51–64 years.
- Total.

The total is the sum of the age stratifications for each product line.

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	Follow the steps below to identify the eligible population. Step 1 Identify members as having persistent asthma who met at least one of the following criteria during both the measurement year and the year prior to the measurement year. Criteria need not be the same across both years. <ul style="list-style-type: none">• At least one ED visit or acute inpatient encounter (<u>ED and Acute Inpatient Value Set</u>), with a principal diagnosis of asthma (<u>Asthma 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, telephone visits or e-visits or virtual check-ins (<u>Outpatient and Telehealth 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 (<u>Asthma Value Set</u>), 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: <ul style="list-style-type: none">• Members who had a diagnosis that requires a different treatment approach than members with asthma (<u>Respiratory Diseases With Different Treatment Approaches Than Asthma Value Set</u>) any time during the member's history through December 31 of the measurement year. Do not include laboratory claims (claims with POS code 81).

- Members who had no asthma controller or reliever medications ([Asthma Controller and Reliever Medications List](#)) dispensed during the measurement year.
- Members who use hospice services ([Hospice Encounter Value Set](#); [Hospice Intervention Value Set](#)) or elect to use a hospice benefit any time during the measurement year. Organizations that use the Monthly Membership Detail Data File to identify these members must use only the run date of the file to determine if the member elected to use a hospice benefit during the measurement year.
- Members who die any time during the measurement year.

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 0.5 rule) to the nearest whole number.

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

Step 5 Sum the total number of members who have a ratio of ≥ 0.50 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

Description	Prescriptions	Medication Lists	Route
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	AmericanIndianOrAlaskaNative	Direct	EligiblePopulation	For each Stratification
	Asian	Indirect	Numerator	For each Stratification
	BlackOrAfricanAmerican	Unknown**	Rate	(Percent)
	NativeHawaiianOrOtherPacificIslander	Total		
	White			
	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*	Unknown**	Rate	(Percent)
	Unknown**	Total		

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

**Race/Ethnicity = "Unknown" is only reported for Source = "Unknown" and Source = "Unknown" is only reported for Race/ Ethnicity = "Unknown."

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.

Controlling High Blood Pressure (CBP)

SUMMARY OF CHANGES TO HEDIS MY 2024

- Added a laboratory claim exclusion to value sets for which laboratory claims should not be used.
- Revised the method for identifying advanced illness.
- Moved previously listed *Exclusions* to *Required exclusions*.
- Revised the numerator to clarify settings where CPT Category II code modifiers should not be used (previously covered in a General Guideline).
- Revised the “Denominator Exclusions” criteria in the Clinical Components table under *Rules for Allowable Adjustments of HEDIS*.

Description

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

Definitions

Adequate control	Both a representative systolic BP <140 mm Hg and a representative diastolic BP of <90 mm Hg.
Representative BP	The most recent BP reading during the measurement year on or after the second diagnosis of hypertension. If multiple BP measurements occur on the same date, or are noted in the chart on the same date, use the lowest systolic and lowest diastolic BP reading. If no BP is recorded during the measurement year, assume that the member is “not controlled.”

Eligible Population

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

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

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

Ages	18–85 years as of December 31 of the measurement year.
Continuous enrollment	The measurement year.
Allowable gap	No more than one gap in continuous enrollment of up to 45 days during the measurement year. To determine continuous enrollment for a Medicaid beneficiary for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage (e.g., a member whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).
Anchor date	December 31 of the measurement year.
Benefit	Medical.
Event/diagnosis	Follow the steps below to identify the eligible population. <ul style="list-style-type: none"> Step 1 Identify members who had at least two outpatient visits, telephone visits, e-visits or virtual check-ins (<u>Outpatient and Telehealth Without UBREV Value Set</u>) on different dates of service with a diagnosis of hypertension (<u>Essential Hypertension Value Set</u>) on or between January 1 of the year prior to the measurement year and June 30 of the measurement year. Step 2 Remove members who had a nonacute inpatient admission during the measurement year. To identify nonacute inpatient admissions: <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>) on the claim. 3. Identify the admission date for the stay.
Required exclusions	Exclude members who meet any of the following criteria: <ul style="list-style-type: none"> • Members who use hospice services (<u>Hospice Encounter Value Set</u>; <u>Hospice Intervention Value Set</u>) or elect to use a hospice benefit any time during the measurement year. Organizations that use the Monthly Membership Detail Data File to identify these members must use only the run date of the file to determine if the member elected to use a hospice benefit during the measurement year. • Members who die any time during the measurement year. • 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>) any time during the measurement year.

- Members who had an encounter for palliative care (ICD-10-CM code Z51.5) anytime during the measurement year. Do not include laboratory claims (claims with POS code 81).
- Members with a diagnosis that indicates end-stage renal disease (ESRD) (ESRD Diagnosis Value Set; History of Kidney Transplant Value Set), any time during the member's history on or prior to December 31 of the measurement year. Do not include laboratory claims (claims with POS code 81).
- Members with a procedure that indicates ESRD: dialysis (Dialysis Procedure Value Set), nephrectomy (Total Nephrectomy Value Set; Partial Nephrectomy Value Set) or kidney transplant (Kidney Transplant Value Set) any time during the member's history on or prior to December 31 of the measurement year.
- Members with a diagnosis of pregnancy (Pregnancy Value Set) any time during the measurement year. Do not include laboratory claims (claims with POS code 81).
- 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** frailty and advanced illness criteria to be excluded:
 1. **Frailty.** 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. Do not include laboratory claims (claims with POS code 81).
 2. **Advanced Illness.** Either of the following during the measurement year or the year prior to the measurement year:
 - Advanced illness (Advanced Illness Value Set) on at least two different dates of service. Do not include laboratory claims (claims with POS code 81).
 - 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. Do not include laboratory claims (claims with POS code 81).

Dementia Medications

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

Administrative Specification

Denominator The eligible population.

Numerator Identify the most recent BP reading (Systolic Blood Pressure Value Set; Diastolic Blood Pressure Value Set) taken during the measurement year. Do not include CPT Category II codes (Systolic and Diastolic Result Value Set) with a modifier (CPT CAT II Modifier Value Set). Do not include BPs taken in an acute inpatient setting (Acute Inpatient Value Set; Acute Inpatient POS Value Set) or during an ED visit (ED Value Set; POS code 23).

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

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

If the most recent blood pressure was identified based on a CPT Category II code (Systolic and Diastolic Result Value Set) use the following to determine compliance:

- Systolic Compliant: Systolic Less Than 140 Value Set.
- Systolic Not Compliant: CPT-CAT-II code 3077F.
- Diastolic Compliant: Diastolic Less Than 90 Value Set.
- Diastolic Not Compliant: CPT-CAT-II code 3080F.

Hybrid Specification

Denominator A systematic sample drawn from the eligible population.

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

Identifying the medical record

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

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

- Identify the member's PCP.

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

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

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

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

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

Do not include BP readings:

- Taken during an acute inpatient stay or an ED visit.
- Taken on the same day as a diagnostic test or diagnostic or therapeutic procedure that requires a change in diet or change in medication on or one day before the day of the test or procedure, with the exception of fasting blood tests.
- Taken by the member using a non-digital device such as with a manual blood pressure cuff and a stethoscope.

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

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

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

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

Note

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

Data Elements for Reporting

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

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

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

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

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

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

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

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

**Race/Ethnicity = "Unknown" is only reported for Source = "Unknown" and Source = "Unknown" is only reported for Race/ Ethnicity = "Unknown."

Rules for Allowable Adjustments of HEDIS

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

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

Rules for Allowable Adjustments of Controlling High Blood Pressure

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

Glycemic Status Assessment for Patients With Diabetes (GSD)

SUMMARY OF CHANGES TO HEDIS MY 2024

- Updated the measure title.
- Added glucose management indicator as an option to meet numerator criteria.
- Updated the event/diagnosis criteria.
- Updated the Diabetes Medications table.
- Removed the required exclusion for members who did not have a diagnosis of diabetes.
- Added a laboratory claim exclusion to value sets for which laboratory claims should not be used.
- Moved previously listed *Exclusions* to *Required exclusions*.
- Revised the method for identifying advanced illness.
- Revised the numerator to clarify settings where CPT Category II code modifiers should not be used (previously covered in a General Guideline).
- Clarified that “Unknown” is not considered a result/finding.
- Revised the “Denominator Exclusions” criteria in the Clinical Components table under *Rules for Allowable Adjustments of HEDIS*.

Description

The percentage of members 18–75 years of age with diabetes (types 1 and 2) whose most recent glycemic status (hemoglobin A1c [HbA1c] or glucose management indicator [GMI]) was at the following levels during the measurement year:

- Glycemic Status <8.0%.
- Glycemic Status >9.0%.

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

Eligible Population

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

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

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

Ages	18–75 years as of December 31 of the measurement year.
Continuous enrollment	The measurement year.
Allowable gap	No more than one gap in enrollment of up to 45 days during the measurement year. To determine continuous enrollment for a Medicaid beneficiary for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage (e.g., a member whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).
Anchor date	December 31 of the measurement year.
Benefit	Medical.
Event/diagnosis	<p>There are two ways to identify members with diabetes: by claim/encounter data and by pharmacy data. The organization must use both methods to identify the eligible population, but a member only needs to be identified by one method to be included in the measure. Members may be identified as having diabetes during the measurement year or the year prior to the measurement year.</p> <p><i>Claim/encounter data.</i> Members who had at least two diagnoses of diabetes (<u>Diabetes Value Set</u>) on different dates of service during the measurement year or the year prior to the measurement year. Do not include laboratory claims (claims with POS code 81).</p> <p><i>Pharmacy data.</i> Members who were dispensed insulin or hypoglycemics/ antihyperglycemics during the measurement year or the year prior to the measurement year (<u>Diabetes Medications List</u>) and have at least one diagnosis of diabetes (<u>Diabetes Value Set</u>) during the measurement year or the year prior to the measurement year. Do not include laboratory claims (claims with POS code 81).</p>

Diabetes Medications

Description	Prescription		
Alpha-glucosidase inhibitors	• Acarbose	• Miglitol	
Amylin analogs	• Pramlintide		
Antidiabetic combinations	• Alogliptin-metformin • Alogliptin-pioglitazone	• Empagliflozin-metformin • Ertugliflozin-metformin	• Linagliptin-metformin • Metformin-pioglitazone

Description	Prescription		
	<ul style="list-style-type: none"> • Canagliflozin-metformin • Dapagliflozin-metformin • Dapagliflozin-saxagliptin • Empagliflozin-linagliptin • Empagliflozin-linagliptin-metformin 	<ul style="list-style-type: none"> • Ertugliflozin-sitagliptin • Glimepiride-pioglitazone • Glipizide-metformin • Glyburide-metformin 	<ul style="list-style-type: none"> • Metformin-repaglinide • Metformin-rosiglitazone • Metformin-saxagliptin • Metformin-sitagliptin
Insulin	<ul style="list-style-type: none"> • Insulin aspart • Insulin aspart-insulin aspart protamine • Insulin degludec • Insulin degludec-liraglutide • Insulin detemir • Insulin glargine • Insulin glargine-lixisenatide 	<ul style="list-style-type: none"> • 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 	<ul style="list-style-type: none"> • Repaglinide 	
Biguanides	<ul style="list-style-type: none"> • Metformin 		
Glucagon-like peptide-1 (GLP1) agonists	<ul style="list-style-type: none"> • Albiglutide • Dulaglutide • Exenatide 	<ul style="list-style-type: none"> • Liraglutide • Lixisenatide • Semaglutide 	
Sodium glucose cotransporter 2 (SGLT2) inhibitor	<ul style="list-style-type: none"> • Canagliflozin • Dapagliflozin 	<ul style="list-style-type: none"> • Ertugliflozin • Empagliflozin 	
Sulfonylureas	<ul style="list-style-type: none"> • Chlorpropamide • Glimepiride 	<ul style="list-style-type: none"> • Glipizide • Glyburide 	<ul style="list-style-type: none"> • Tolazamide • Tolbutamide
Thiazolidinediones	<ul style="list-style-type: none"> • Pioglitazone 	<ul style="list-style-type: none"> • Rosiglitazone 	
Dipeptidyl peptidase-4 (DDP-4) inhibitors	<ul style="list-style-type: none"> • Alogliptin • Linagliptin 	<ul style="list-style-type: none"> • Saxagliptin • Sitagliptin 	

Required exclusions

Exclude members who meet any of the following criteria:

- Members who use hospice services (Hospice Encounter Value Set; Hospice Intervention Value Set) or elect to use a hospice benefit any time during the measurement year. Organizations that use the Monthly Membership Detail Data File to identify these members must use only the run date of the file to determine if the member elected to use a hospice benefit during the measurement year.
- Members who die any time during the measurement year.
- Members receiving palliative care (Palliative Care Assessment Value Set; Palliative Care Encounter Value Set; Palliative Care Intervention Value Set) any time during the measurement year.
- Members who had an encounter for palliative care (ICD-10-CM code Z51.5) any time during the measurement year. Do not include laboratory claims (claims with POS code 81).

- Medicare members 66 years of age and older as of December 31 of the measurement year who meet either of the following:
 - Enrolled in an Institutional SNP (I-SNP) any time during the measurement year.
 - Living long-term in an institution any time during the measurement year as identified by the LTI flag in the Monthly Membership Detail Data File. Use the run date of the file to determine if a member had an LTI flag during the measurement year.
- Members 66 years of age and older as of December 31 of the measurement year (all product lines) with frailty **and** advanced illness. Members must meet **both** frailty and advanced illness criteria to be excluded:
 1. **Frailty.** 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. Do not include laboratory claims (claims with POS code 81).
 2. **Advanced Illness.** Either of the following during the measurement year or the year prior to the measurement year:
 - Advanced illness (Advanced Illness Value Set) on at least two different dates of service. Do not include laboratory claims (claims with POS code 81).
 - Dispensed dementia medication (Dementia Medications List).

Dementia Medications

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

Administrative Specification

Denominator The eligible population.

Numerators

Glycemic Status <8% Identify the most recent glycemic status assessment (HbA1c or GMI) (HbA1c Lab Test Value Set; HbA1c Test Result or Finding Value Set; LOINC code 97506-0) during the measurement year. Do not include CPT Category II codes (HbA1c Test Result or Finding Value Set) with a modifier (CPT CAT II Modifier Value Set). The member is numerator compliant if the most recent glycemic status assessment has a result of <8.0%. The member is not numerator compliant if the result of the most recent glycemic status assessment is ≥8.0% or is missing a result, or if a glycemic status assessment was not done during the measurement year. If there are multiple glycemic status assessments on the same date of service, use the lowest result.

If the most recent glycemic status assessment was an HbA1c test identified based on a CPT Category II code (HbA1c Test Result or Finding Value Set), use the following to determine compliance:

- Compliant: HbA1c Level Less Than 8.0 Value Set.
- Not compliant: HbA1c Level Greater Than or Equal To 8.0 Value Set.

Glycemic Status >9% Identify the most recent glycemic status assessment (HbA1c or GMI) (HbA1c Lab Test Value Set; HbA1c Test Result or Finding Value Set; LOINC code 97506-0) during the measurement year. Do not include CPT Category II codes (HbA1c Test Result or Finding Value Set) with a modifier (CPT CAT II Modifier Value Set). The member is numerator compliant if the most recent glycemic status assessment has a result of >9.0% or is missing a result, or if a glycemic status assessment was not done during the measurement year. The member is not numerator compliant if the result of the most recent glycemic status assessment during the measurement year is ≤9.0%. If there are multiple glycemic status assessments on the same date, use the lowest result.

If the most recent glycemic status assessment was an HbA1c test identified based on a CPT Category II code (HbA1c Test Result or Finding Value Set), use the following to determine compliance:

- Compliant: CPT Category II code 3046F.
- Not compliant: HbA1c Level Less Than or Equal To 9.0 Value Set.

Note: A lower rate indicates better performance for this indicator (i.e., low rates of Glycemic Status >9% indicate better care).

Hybrid Specification

Denominator A systematic sample drawn from the eligible population.

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

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

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

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

Numerators

Glycemic Status <8% The result of the *most recent* glycemic status assessment (HbA1c or GMI) (performed during the measurement year) is <8.0% as documented through laboratory data or medical record review.

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

Medical record At a minimum, documentation in the medical record must include a note indicating the date when the glycemic status assessment (HbA1c or GMI) was performed, and the result. The member is numerator compliant if the result of the most recent glycemic status assessment during the measurement year is <8.0%.

When identifying the most recent glycemic status assessment (HbA1c or GMI), GMI values must include documentation of the continuous glucose monitoring data date range used to derive the value. The terminal date in the range should be used to assign assessment date.

If multiple glycemic status assessments were recorded for a single date, use the lowest result.

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

The member is not numerator compliant if the result of the most recent glycemic status assessment during the measurement year is $\geq 8.0\%$ or is missing, or if a glycemic status assessment was not performed during the measurement year.

Ranges and thresholds do not meet criteria for this indicator. A distinct numeric result is required for numerator compliance. "Unknown" is not considered a result/finding.

Glycemic Status >9% The result of the *most recent* glycemic status assessment (HbA1c or GMI) (performed during the measurement year) is >9.0% or is missing, or was not done during the measurement year, as documented through laboratory data or medical record review.

Note: *A lower rate indicates better performance for this indicator (i.e., low rates of Glycemic Status >9.0% indicate better care).*

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

Medical record At a minimum, documentation in the medical record must include a note indicating the date when the glycemic status assessment was performed and the result. The member is numerator compliant if the result of the most recent glycemic status assessment during the measurement year is >9.0% or is missing, or if a glycemic status assessment was not done during the measurement year.

When identifying the most recent glycemic status assessment (HbA1c or GMI), GMI values must include documentation of the continuous glucose monitoring data date range used to derive the value. The terminal date in the range should be used to assign assessment date.

If multiple glycemic status assessments were recorded for a single date, use the lowest result.

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

The member is not numerator compliant if the most recent glycemic status during the measurement year is $\leq 9.0\%$.

Ranges and thresholds do not meet criteria for this indicator. A distinct numeric result is required for numerator compliance. "Unknown" is not considered a result/finding.

Note

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

Data Elements for Reporting

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

Table GSD-A-1/2/3: Data Elements for Glycemic Status Assessment for Patients With Diabetes

Metric	Data Element	Reporting Instructions	A
LessThan8	CollectionMethod	Repeat per Metric	✓
GreaterThan9	EligiblePopulation*	For each Metric	✓
	ExclusionAdminRequired*	For each Metric	✓
	NumeratorByAdminElig	For each Metric	
	CYAR	(Percent)	
	MinReqSampleSize	Repeat per Metric	
	OversampleRate	Repeat per Metric	
	OversampleRecordsNumber	(Count)	
	ExclusionValidDataErrors	Repeat per Metric	
	ExclusionEmployeeOrDep	Repeat per Metric	
	OversampleRecsAdded	Repeat per Metric	
	Denominator	Repeat per Metric	
	NumeratorByAdmin	For each Metric	✓
	NumeratorByMedicalRecords	For each Metric	
	NumeratorBySupplemental	For each Metric	✓
	Rate	(Percent)	✓

Table GSD-B-1/2/3: Data Elements for Glycemic Status Assessment for Patients With Diabetes: Stratifications by Race

Metric
LessThan8
GreaterThan9

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

Table GSD-C-1/2/3: Data Elements for Glycemic Status Assessment for Patients With Diabetes: Stratifications by Ethnicity

Metric
LessThan8
GreaterThan9

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

***Race/Ethnicity= "Unknown" is only reported for Source= "Unknown" and Source= "Unknown" is only reported for Race/Ethnicity= "Unknown."

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 Glycemic Status Assessment for Patients With Diabetes

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

Child and Adolescent Well-Care Visits (WCV)

SUMMARY OF CHANGES TO HEDIS MY 2024

- Added a laboratory claim exclusion to value sets for which laboratory claims should not be used.

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	<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"> – American Indian or Alaska Native. – Asian. – Black or African American. – Native Hawaiian or Other Pacific Islander. – White. – 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. <p>Note: <i>Stratifications are mutually exclusive, and the sum of all categories in each stratification is the Total population.</i></p>
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 who use hospice services (Hospice Encounter Value Set; Hospice Intervention Value Set) or elect to use a hospice benefit any time during the measurement year. Organizations that use the Monthly Membership Detail Data File to identify these members must use only the run date of the file to determine if the member elected to use a hospice benefit during the measurement year. Members who die any time during the measurement year.

Administrative Specification

Denominator	The eligible population.
Numerator	<p>One or more well-care visits during the measurement year. Either of the following meet criteria:</p> <ul style="list-style-type: none"> A well-care visit (Well Care Visit Value Set). An encounter for well-care (Encounter for Well Care Value Set). Do not include laboratory claims (claims with POS code 81). <p>The well-care visit must occur with a PCP or an OB/GYN practitioner, but the practitioner does not have to be the practitioner assigned to the member.</p>

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.

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	AmericanIndianOrAlaskaNative	Direct	EligiblePopulation	For each Stratification
	Asian	Indirect	Numerator	For each Stratification
	BlackOrAfricanAmerican	Unknown**	Rate	(Percent)
	NativeHawaiianOrOtherPacificIslander	Total		
	White			
	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*	Unknown**	Rate	(Percent)
	Unknown**	Total		

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

**Race/Ethnicity = "Unknown" is only reported for Source = "Unknown" and Source = "Unknown" is only reported for Race/ Ethnicity = "Unknown."

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 Substance Use (FUA)*

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

SUMMARY OF CHANGES TO HEDIS MY 2024

- No changes to this measure.

Description

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

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

Eligible Population

Product lines	Commercial, Medicaid, Medicare (report each product line separately).
Stratifications	<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"> – American Indian or Alaska Native. – Asian. – Black or African American. – Native Hawaiian or Other Pacific Islander. – White. – 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.

- Ages** 13 years and older as of the ED visit. Report two age stratifications and a total rate:
- 13–17 years.
 - 18 years and older.
 - Total.

The total is the sum of the age stratifications.

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

Allowable gap None.

Anchor date None.

Benefit Medical, chemical dependency and pharmacy.

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

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

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

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

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

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

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

ED visits followed by residential treatment Exclude ED visits followed by residential treatment on the date of the ED visit or within the 30 days after the ED visit. Any of the following meets criteria for residential treatment:

- Residential Behavioral Health Treatment Value Set.
- Psychiatric Residential Treatment Center (POS code 56).
- Residential Substance Abuse Treatment Facility (POS code 55).
- Residential Program Detoxification Value Set.

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

Required exclusions

Exclude members who meet either of the following criteria:

- Members who use hospice services (Hospice Encounter Value Set; Hospice Intervention Value Set) or elect to use a hospice benefit any time during the measurement year. Organizations that use the Monthly Membership Detail Data File to identify these members must use only the run date of the file to determine if the member elected to use a hospice benefit during the measurement year.
- Members who die any time during the measurement year.

Administrative Specification

Denominator The eligible population.

Numerators

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

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

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

- An outpatient visit (Visit Setting Unspecified Value Set) **with** (Outpatient POS Value Set) **with** any diagnosis of SUD (AOD Abuse and Dependence Value Set), substance use (Substance Induced Disorders Value Set) or drug overdose (Unintentional Drug Overdose Value Set).
- An outpatient visit (Visit Setting Unspecified Value Set) **with** (Outpatient POS Value Set) **with** a mental health provider.
- An outpatient visit (BH Outpatient Value Set) **with** any diagnosis of SUD (AOD Abuse and Dependence Value Set), substance use (Substance Induced Disorders Value Set) or drug overdose (Unintentional Drug Overdose Value Set).
- An outpatient visit (BH Outpatient Value Set) **with** a mental health provider.

- An intensive outpatient encounter or partial hospitalization (Visit Setting Unspecified Value Set) **with** POS code 52 **with** any diagnosis of SUD (AOD Abuse and Dependence Value Set), substance use (Substance Induced Disorders Value Set) or drug overdose (Unintentional Drug Overdose Value Set).
- An intensive outpatient encounter or partial hospitalization (Visit Setting Unspecified Value Set) **with** POS code 52 **with** a mental health provider.
- An intensive outpatient encounter or partial hospitalization (Partial Hospitalization or Intensive Outpatient Value Set) **with** any diagnosis of SUD (AOD Abuse and Dependence Value Set), substance use (Substance Induced Disorders Value Set) or drug overdose (Unintentional Drug Overdose Value Set).
- An intensive outpatient encounter or partial hospitalization (Partial Hospitalization or Intensive Outpatient Value Set) **with** a mental health provider.
- A non-residential substance abuse treatment facility visit (Visit Setting Unspecified Value Set) **with** (Non-residential Substance Abuse Treatment Facility POS Value Set) **with** any diagnosis of SUD (AOD Abuse and Dependence Value Set), substance use (Substance Induced Disorders Value Set) or drug overdose (Unintentional Drug Overdose Value Set).
- A non-residential substance abuse treatment facility visit (Visit Setting Unspecified Value Set) **with** (Non-residential Substance Abuse Treatment Facility POS Value Set) **with** a mental health provider.
- A community mental health center visit (Visit Setting Unspecified Value Set) **with** POS code 53 **with** any diagnosis of SUD (AOD Abuse and Dependence Value Set), substance use (Substance Induced Disorders Value Set) or drug overdose (Unintentional Drug Overdose Value Set).
- A community mental health center visit (Visit Setting Unspecified Value Set) **with** POS code 53, **with** a mental health provider.
- A peer support service (Peer Support Services Value Set) **with** any diagnosis of SUD (AOD Abuse and Dependence Value Set), substance use (Substance Induced Disorders Value Set) or drug overdose (Unintentional Drug Overdose Value Set).
- An opioid treatment service that bills monthly or weekly (OUD Weekly Non Drug Service Value Set; OUD Monthly Office Based Treatment Value Set) **with** any diagnosis of SUD (AOD Abuse and Dependence Value Set), substance use (Substance Induced Disorders Value Set) or drug overdose (Unintentional Drug Overdose Value Set).
- A telehealth visit (Visit Setting Unspecified Value Set) **with** (Telehealth POS Value Set) **with** any diagnosis of SUD (AOD Abuse and Dependence Value Set), substance use (Substance Induced Disorders Value Set) or drug overdose (Unintentional Drug Overdose Value Set).
- A telehealth visit (Visit Setting Unspecified Value Set) **with** (Telehealth POS Value Set) **with** a mental health provider.
- A telephone visit (Telephone Visits Value Set) **with** any diagnosis of SUD (AOD Abuse and Dependence Value Set), substance use (Substance Induced Disorders Value Set) or drug overdose (Unintentional Drug Overdose Value Set).

- A telephone visit ([Telephone Visits Value Set](#)) **with** a mental health provider.
- An e-visit or virtual check-in ([Online Assessments Value Set](#)) **with** any diagnosis of SUD ([AOD Abuse and Dependence Value Set](#)), substance use ([Substance Induced Disorders Value Set](#)) or drug overdose ([Unintentional Drug Overdose Value Set](#)).
- An e-visit or virtual check-in ([Online Assessments Value Set](#)) **with** a mental health provider.
- A substance use disorder service ([Substance Use Disorder Services Value Set](#); [Substance Abuse Counseling and Surveillance Value Set](#)).
- A behavioral health screening or assessment for SUD or mental health disorders ([Behavioral Health Assessment Value Set](#)).
- A substance use service ([Substance Use Services Value Set](#)).
- A pharmacotherapy dispensing event ([Alcohol Use Disorder Treatment Medications List](#); [Opioid Use Disorder Treatment Medications List](#)) or medication treatment event ([AOD Medication Treatment Value Set](#); [OUD Weekly Drug Treatment Service Value Set](#)).

Alcohol Use Disorder Treatment Medications

Description	Prescription
Aldehyde dehydrogenase inhibitor	• Disulfiram (oral)
Antagonist	• Naltrexone (oral and injectable)
Other	• Acamprosate (oral; delayed-release tablet)

Opioid Use Disorder Treatment Medications

Description	Prescription	Medication Lists
Antagonist	• Naltrexone (oral)	• Naltrexone Oral Medications List
Antagonist	• Naltrexone (injectable)	• Naltrexone Injection Medications List
Partial agonist	• Buprenorphine (sublingual tablet)	• Buprenorphine Oral Medications List
Partial agonist	• Buprenorphine (injection)	• Buprenorphine Injection Medications List
Partial agonist	• Buprenorphine (implant)	• Buprenorphine Implant Medications List
Partial agonist	• Buprenorphine/naloxone (sublingual tablet, buccal film, sublingual film)	• Buprenorphine Naloxone Medications List

Note

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

Data Elements for Reporting

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

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

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

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

Metric	Race	Source	Data Element	Reporting Instructions
FollowUp30Day	AmericanIndianOrAlaskaNative	Direct	EligiblePopulation	For each Stratification, repeat per Metric
FollowUp7Day	Asian	Indirect	Numerator	For each Metric and Stratification
	BlackOrAfricanAmerican	Unknown**	Rate	(Percent)
	NativeHawaiianOrOtherPacificIslander	Total		
	White			
	SomeOtherRace			
	TwoOrMoreRaces			
	AskedButNoAnswer*			
	Unknown**			

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

Metric	Ethnicity	Source	Data Element	Reporting Instructions
FollowUp30Day	HispanicOrLatino	Direct	EligiblePopulation	For each Stratification, repeat per Metric
FollowUp7Day	NotHispanicOrLatino	Indirect	Numerator	For each Metric and Stratification
	AskedButNoAnswer*	Unknown**	Rate	(Percent)
	Unknown**	Total		

*AskedButNoAnswer is only reported for Source= "Direct."
 **Race/Ethnicity = "Unknown" is only reported for Source = "Unknown" and Source = "Unknown" is only reported for Race/ Ethnicity = "Unknown."

Rules for Allowable Adjustments of HEDIS

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

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

Rules for Allowable Adjustments of Follow-Up After Emergency Department Visit for Substance Use

NONCLINICAL COMPONENTS		
Eligible Population	Adjustments Allowed (Yes/No)	Notes
Product lines	Yes	Organizations are not required to use product line criteria; product lines may be combined and all (or no) product line criteria may be used.
Ages	Yes	The age determination date(s) may be changed (i.e., age 13 as of ED visit). Changing denominator age range is allowed.
Continuous enrollment, allowable gap, anchor date	Yes	Organizations are not required to use enrollment criteria; adjustments are allowed.
Benefits	Yes	Organizations are not required to use a benefit; adjustments are allowed.
Other	Yes	Organizations may use additional eligible population criteria to focus on an area of interest defined by gender, race, ethnicity, socioeconomic or sociodemographic characteristics, geographic region or another characteristic.
CLINICAL COMPONENTS		
Eligible Population	Adjustments Allowed (Yes/No)	Notes
Event/diagnosis	Yes, with limits	Only events and diagnoses that contain (or map to) codes in the value sets may be used to identify visits with a diagnosis. Value sets and logic may not be changed. Note: Organizations may assess at the member level by applying measure logic appropriately (i.e., percentage of members with documentation of an emergency department visit with a principal diagnosis of SUD or any diagnosis of unintentional drug overdose, who had a follow-up visit).
Denominator Exclusions	Adjustments Allowed (Yes/No)	Notes
Required exclusions	Yes	The hospice and deceased member exclusions are not required. Refer to <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 2024

- Added instructions to report rates stratified by race and ethnicity for each product line.

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).
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">– American Indian or Alaska Native.– Asian.– Black or African American.– Native Hawaiian or Other Pacific Islander.– White.– 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. <p>Note: <i>Stratifications are mutually exclusive, and the sum of all categories in each stratification is the total population.</i></p>
Ages	6 years and older as of the date of discharge. Report three age stratifications and a total rate:

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

The total is the sum of the age stratifications.

Continuous enrollment

Date of discharge through 30 days after discharge.

Allowable gap

None.

Anchor date

None.

Benefits

Medical and mental health (inpatient and outpatient).

Event/diagnosis

An acute inpatient discharge with a principal diagnosis of mental illness or intentional self-harm (Mental Illness and Intentional Self-Harm Value Set) on the discharge claim on or between January 1 and December 1 of the measurement year. To identify acute inpatient discharges:

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

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

Acute readmission or direct transfer

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

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

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

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

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

Nonacute readmission or direct transfer

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

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

3. Identify the admission date for the stay.

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

Required exclusions

Exclude members who meet either of the following criteria:

- Members who use hospice services (Hospice Encounter Value Set; Hospice Intervention Value Set) or elect to use a hospice benefit any time during the measurement year. Organizations that use the Monthly Membership Detail Data File to identify these members must use only the run date of the file to determine if the member elected to use a hospice benefit during the measurement year.
- Members who die any time during the measurement year.

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** POS code 52).
- 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; Transitional Care Management Services Value Set) **with** POS code 53.
- Electroconvulsive therapy (Electroconvulsive Therapy Value Set) **with** (Outpatient POS Value Set; POS code 24; POS code 52; POS code 53).
- A telehealth visit: (Visit Setting Unspecified Value Set) **with** (Telehealth POS 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-A-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)	

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

Metric	Race	Source	Data Element	Reporting Instructions
FollowUp30Day	AmericanIndianOrAlaskaNative	Direct	EligiblePopulation	For each Stratification, repeat per Metric
FollowUp7Day	Asian	Indirect	Numerator	For each Metric and Stratification
	BlackOrAfricanAmerican	Unknown**	Rate	(Percent)
	NativeHawaiianOrOtherPacificIslander	Total		
	White			
	SomeOtherRace			
	TwoOrMoreRaces			
	AskedButNoAnswer*			
	Unknown**			

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

Metric	Ethnicity	Source	Data Element	Reporting Instructions
FollowUp30Day	HispanicOrLatino	Direct	EligiblePopulation	For each Stratification, repeat per Metric
FollowUp7Day	NotHispanicOrLatino	Indirect	Numerator	For each Metric and Stratification
	AskedButNoAnswer*	Unknown**	Rate	(Percent)
	Unknown**	Total		

*AskedButNoAnswer is only reported for Source= "Direct."
 **Race/Ethnicity= "Unknown" is only reported for Source= "Unknown" and Source= "Unknown" is only reported for Race/ Ethnicity= "Unknown."

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.