Health Insurance Exchange

2024 Quality Rating System Measure Technical Specifications

September 2023

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Technical Assistance and Contact Information

The following links and contact information should be used to obtain additional details and technical assistance related to the Quality Rating System (QRS) measure set for 2024 (Measurement Year 2023).

Website Links

- Centers for Medicare & Medicaid Services (CMS) Health Insurance Marketplace Quality Initiatives website: http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityInitiativesGenInfo/Health-Insurance-Marketplace-Quality-Initiatives.html

- National Committee for Quality Assurance (NCQA) Healthcare Effectiveness Data and Information Set (HEDIS®)[1] Compliance Audit™ website: http://www.ncqa.org/HEDISQualityMeasurement/CertifiedSurveyVendorsAuditorsSoftwareVendors/HEDISComplianceAuditProgram.aspx

Contact Information

- For questions regarding the QRS clinical measure specifications, please contact the appropriate measure steward:
    - NCQA for the HEDIS® measures: via the Policy Clarification Support (PCS) system available at https://my.ncqa.org/
    - Pharmacy Quality Alliance (PQA) for the PQA measures: https://www.pqaalliance.org/QRS
- For questions regarding the general guidelines for data collection, please contact NCQA via the PCS system available at https://my.ncqa.org/
- For questions regarding QRS survey measures, the QHP Enrollee Survey, or QRS requirements, please contact the Marketplace Service Desk (MSD) via email at CMS_FEPS@cms.hhs.gov or via phone at 1-855-CMS-1515 (1-855-267-1515). Reference the “Marketplace Quality Initiative (MQI)-QRS”.

[1] HEDIS® is a registered trademark of the National Committee for Quality Assurance.

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1. Introduction

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Introduction

Document Purpose

This document includes the measure specifications and guidelines for data collection for the 2024 Quality Rating System (QRS) measure set. Qualified Health Plan (QHP) issuers will need to reference this document in order to collect and submit QRS measure data to the Centers for Medicare & Medicaid Services (CMS) in accordance with the QRS 2024 requirements. The document specifically details the following:

- *QRS measure set*. This section includes a list of the QRS measures and a brief background on the QRS measure set. The QRS measure set is comprised of clinical quality measures, including the National Committee for Quality Assurance (NCQA) Healthcare Effectiveness Data and Information Set (HEDIS) measures and Pharmacy Quality Alliance (PQA) measures. The measure set also includes survey measures based on questions from the Qualified Health Plan Enrollee Experience Survey (QHP Enrollee Survey).
- *QRS clinical measure technical specifications*. This section includes measure specifications and data collection guidelines for NCQA's HEDIS measures and the PQA measures in the QRS measure set. For the PQA measures, QHP issuers should refer to NCQA's "General Guidelines for Data Collection" (see Section 3.1 for guidance related to data collection protocols, with the exception of a few guidelines specific to the PQA measures as noted in Section 3.2).
- *QRS survey measure technical specifications*. This section includes descriptions for the survey measures in the QRS measure set that will be collected as part of the QHP Enrollee Survey.

CMS anticipates updating this document on an annual basis to reflect any changes to the measure set, including changes to the measure specifications or data collection guidelines. This document includes the measure specifications for all potential measures in the 2024 QRS measure set (i.e., any measures proposed for addition and removal in the *Draft 2023 Call Letter for the QRS and QHP Enrollee Survey*).[2]

In the fall of 2023, CMS intends to publish the *Quality Rating System and Qualified Health Plan Enrollee Experience Survey: Technical Guidance for 2024* (2024 QRS and QHP Enrollee Survey Technical Guidance), reflecting applicable finalized changes announced in the *Final 2023 QRS and QHP Enrollee Survey Call Letter*. The 2024 QRS and QHP Enrollee Survey Technical Guidance will announce which measures eligible QHP issuers are required to collect and submit to CMS for the 2024 QRS ratings year.

Background

In accordance with the requirements specified in the annual Quality Rating System and Qualified Health Plan Enrollee Experience Survey: Technical Guidance*,* QHP issuers that offered coverage through a Health Insurance Exchange (Exchange) in the prior year are required to submit third-party validated QRS clinical measure data and QHP Enrollee Survey response data to CMS as a condition of certification.[3] CMS will calculate the quality performance ratings for QHPs offered through all Exchanges, regardless of the Exchange model. CMS will apply the QRS rating methodology to validated QRS clinical measure data and a subset of the QHP Enrollee Survey response data (QRS survey measures) to produce quality ratings on a 5-star rating scale.[4] CMS will collect data and calculate quality ratings for each QHP issuer's product type (e.g., health maintenance organization [HMO]) within each state and apply these ratings to each product type's QHPs in that state.

[2] The Draft 2023 Call Letter for the QRS and QHP Enrollee Survey is available at: https://www.cms.gov/files/document/draft-2023-call-letter-qrs-and-qhp-enrollee-survey-508-compliant.pdf
[3] 45 CFR § 156.200(b)(5)(h); § 156.1120; and § 156.1125.
[4] The QHP Enrollee Survey includes a core question set that will be used to assess enrollee experience with health care services. Specific questions are grouped to form survey measures that will be used in the QRS.

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2. QRS Measure Set

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QRS Measure Set

The QRS measure set consists of measures that address areas of clinical quality management; enrollee experience; and plan efficiency, affordability, and management. Exhibit 1 includes the list of all potential QRS measures for 2024 as proposed in the *Draft 2023 Call Letter for the QRS and QHP Enrollee Survey*. Measures denoted with a strikethrough (–) are under consideration for retirement or removal from the QRS measure set. If these measures are removed as proposed, they will not be collected for the 2024 ratings year. Measures denoted with an asterisk (*) are under consideration for addition to the QRS measure set. If these measures are finalized as proposed, they will be required for 2024 QRS data collection but will not be included in 2024 QRS scoring. CMS will communicate final changes to the 2024 QRS measure set in the *Final 2023 Call Letter for the QRS and QHP Enrollee Survey*, which CMS anticipates publishing in late spring of 2023.

The measure set includes a subset of NCQA's HEDIS measures and PQA measures. The survey measures in the QRS measure set will be collected as part of the QHP Enrollee Survey, which is largely based on items from the Consumer Assessment of Healthcare Providers and Systems[5] (CAHPS®) surveys. For a crosswalk that maps each QRS survey measure to the relevant QHP Enrollee Survey item(s), refer to the annual QRS and QHP Enrollee Survey: Technical Guidance.

Some measures have multiple indicators (or rates). QHP issuers are required to collect and submit validated data for every indicator associated with a measure, unless a specific indicator is shown in parentheses next to the measure, in which case only the indicator must be reported (e.g., for *Immunizations for Adolescent [Combination 2]*, only Combination 2 must be reported).

Exhibit 1. Proposed 2024 QRS Measures

Measure Title	Measure Steward	National Quality Forum (NQF) ID[6]
QRS Clinical Measures		
Adult Immunization Status (AIS-E)*	NCQA	3620
~~Annual Dental Visit~~	~~NCQA~~	~~1388~~
Annual Monitoring for Persons on Long-term Opioid Therapy	PQA	3541
Antidepressant Medication Management	NCQA	0105
~~Appropriate Testing for Pharyngitis~~	~~NCQA~~	~~0002~~
Appropriate Treatment for Upper Respiratory Infection	NCQA	0069
Asthma Medication Ratio	NCQA	1800
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis	NCQA	0058
~~Breast Cancer Screening~~	~~NCQA~~	~~2372~~
Breast Cancer Screening (BCS-E)[7]	NCQA	2372
Cervical Cancer Screening	NCQA	0032
Child and Adolescent Well-Care Visits	NCQA	N/A
Childhood Immunization Status (Combination 10)	NCQA	0038
Chlamydia Screening in Women	NCQA	0033
Colorectal Cancer Screening	NCQA	0034
Controlling High Blood Pressure	NCQA	0018

[5] CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality. The surveys are available at https://cahps.ahrq.gov.
[6] Definitions of NQF-endorsed measures can be found here: http://www.qualityforum.org/Home.aspx
[7] Please refer to the Final 2023 Call Letter for the final decision regarding whether this measure will be used in scoring for the 2024 ratings year if the measure finalized for addition to the QRS measure set.

2. QRS Measure Set

Measure Title	Measure Steward	National Quality Forum (NQF) ID[6]
Follow-Up After Hospitalization for Mental Illness (7-Day Follow-Up and 30- Day Follow-Up)	NCQA	0576
~~Hemoglobin A1c (HbA1c) Control for Patient with Diabetes: HbA1c control (<8.0%)~~	NCQA	0575
Hemoglobin A1c (HbA1c) Control for Patient with Diabetes: HbA1c poor control (>9.0%)*	NCQA	0575
Immunizations for Adolescents (Combination 2)	NCQA	1407
Initiation and Engagement of Substance Use Disorder Treatment	NCQA	0004
International Normalized Ratio Monitoring for Individuals on Warfarin	PQA	0555
Kidney Health Evaluation for Patients with Diabetes	NCQA	N/A
Oral Evaluation Dental Services*	NCQA	2517
Plan All-Cause Readmissions	NCQA	1768
Prenatal and Postpartum Care	NCQA	1517
Proportion of Days Covered	PQA	0541
Social Needs Screening and Intervention (SNS-E)*	NCQA	N/A
Use of Imaging Studies for Low Back Pain	NCQA	0052
Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents	NCQA	0024
Well-Child Visits in the First 30 Months of Life	NCQA	1392
QRS Survey Measures		
Access to Care	AHRQ, CMS	0006
Access to Information	AHRQ, CMS	0007
Care Coordination	AHRQ, CMS	0006
~~Flu Vaccinations for Adults Ages 18-64~~	~~NCQA~~	~~0039~~
Medical Assistance with Smoking and Tobacco Use Cessation	NCQA	0027
Plan Administration	AHRQ, CMS[8]	0006
Rating of All Health Care	AHRQ	0006[7]
Rating of Health Plan	AHRQ	0006[7]
Rating of Personal Doctor	AHRQ	0006[7]
Rating of Specialist	AHRQ	0006[7]

Finalized Data Submission Requirements for the 2024 Ratings Year

In June 2023, CMS published the Final 2023 Call Letter, which announced finalized changes proposed to the QRS measure set for the 2024 ratings year (2023 measurement year). CMS has updated this document, the *2024 QRS Measure Technical Specifications*, to provide guidance on the finalized data submission requirements for the 2024 ratings year. Specifically, CMS has added callout boxes summarizing the final decision regarding measure specification changes and reporting requirements, measures, and/or measure rates proposed for addition; measures proposed for transition; and those proposed for removal in the Draft 2023 Call Letter. These final decisions for the QRS measure set for 2024 include:

- CMS finalized the removal of the *Annual Dental Visit*, *Flu Vaccinations for Adults Ages 18-64,* and *Appropriate Testing for Pharyngitis* measures.
- CMS finalized the addition of the *Oral Evaluation, Dental Services* and *Adult Immunization Status* measures.
- CMS finalized the transition of the *Hemoglobin A1c (HbA1c) Control for Patients with Diabetes: HbA1c control (<8.0%)* measure to the *Hemoglobin A1c (HbA1c) Control for Patients with Diabetes: HbA1c poor control (>9.0%)* measure.
- CMS finalized the incorporation of optional Electronic Clinical Data Systems (ECDS) reporting for the *Cervical Cancer Screening* measure.
- CMS finalized the transition of the *Breast Cancer Screening* measure to ECDS-only reporting.
- CMS finalized the requirement to collect and report stratified race and ethnicity data for the *Asthma Medication Ratio, Breast Cancer Screening, Immunizations for Adolescents, Initiation and Engagement of Substance Use Disorder Treatment,* and *Well-Child Visits in the First 30 Months of Life* measures.

For more details, please refer to the specifications for each measure, the Final 2023 Call Letter, and 2024 QRS and QHP Enrollee Survey Technical Guidance.

[8] Measure consists of CAHPS survey items and a survey item developed for purposes of the QHP Enrollee Survey.

3. QRS Clinical Measure Specifications

3.1 NCQA Measure Specifications

3.2 PQA Measure Specifications

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Measurement Year 2023 (MY 2023) HEDIS® General Guidelines for the QRS Measure Technical Specifications

NCQA Customer Support: 888-275-7585
NCQA Fax: 202-955-3599
NCQA Website: www.ncqa.org

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Overview

HEDIS MY 2023

The Healthcare Effectiveness Data and Information Set (HEDIS) is one of the most widely used sets of health care performance measures in the United States. The term "HEDIS" originated in the late 1980s as the product of a group of forward-thinking employers and quality experts, and was entrusted to NCQA in the early 1990s. NCQA has expanded the size and scope of HEDIS to include measures for physicians, Accountable Care Organizations and other organizations.

How HEDIS Is Developed

NCQA's Committee on Performance Measurement (CPM), which includes representation from purchasers, consumers, health plans, clinicians and policy makers, oversees the evolution of the measurement set. Multiple Measurement Advisory Panels (MAP) provide clinical and technical knowledge required to develop the measures. Additional HEDIS Expert Panels and the Technical Measurement Advisory Panel (TMAP) provide invaluable assistance by identifying methodological issues and providing feedback on new and existing measures.

What's New in HEDIS for the Quality Rating System?

This publication contains specifications for Measurement Year 2023 (MY 2023). MY 2023 refers to the 2023 calendar year data that is reported on June 14, 2024.

Please note that this publication includes the specifications for measures and/or measure rates that are proposed for inclusion in the 2024 QRS measure set in the *Draft 2023 Call Letter for the Quality Rating System (QRS) and Qualified Health Plan (QHP) Enrollee Experience Survey* (Draft 2023 Call Letter). Refer to the *Final 2023 Call Letter for the QRS and QHP Enrollee Experience Survey* (Final 2023 Call Letter), anticipated April-May 2023, for finalized changes.

The *Quality Rating System and Qualified Health Plan Enrollee Experience Survey: Technical Guidance for 2024* (*2024 QRS and QHP Enrollee Survey Technical Guidance*) will announce which measures eligible QHP issuers are required to collect and submit to CMS for the 2024 ratings year.

New measures

- Oral Evaluation, Dental Services (OED).
- Measures Reported Using Electronic Clinical Data Systems (ECDS):
  - Adult Immunization Status (AIS-E).
  - Cervical Cancer Screening (CCS-E).
  - Depression Screening and Follow-Up for Adolescents and Adults (DSF-E).
  - Social Need Screening and Intervention (SNS-E).

Removed measures

- Annual Dental Visit (ADV).
- Appropriate Testing for Pharyngitis (CWP).
- Breast Cancer Screening (BCS)*.
- Flu Vaccinations for Adults Ages 18–64 (FVA).

**Only the BCS-E measure will be reported. Refer to Revised Measures below for more information.*

Revised measures

For specific revisions, refer to each measure's *Summary of Changes.*

- CMS proposed in the Draft 2023 Call Letter to transition HbA1c Control for Patient With Diabetes: HbA1c Control (<8.0%) to the HbA1c Control for Patient With Diabetes: HbA1c Poor Control (>9.0%) measure. If the measure

is finalized for inclusion in the QRS measure set, CMS will begin collecting it for the 2024 ratings year, with scoring for the measure beginning with the 2025 ratings year. Refer to the Final 2023 Call Letter and the 2024 *QRS and QHP Enrollee Survey Technical Guidance* for guidance on reporting this measure.

- CMS proposed in the Draft 2023 Call Letter to transition Breast Cancer Screening (BCS) to the Breast Cancer Screening (BCS-E) measure. Refer to the Final 2023 Call Letter and the 2024 *QRS and QHP Enrollee Survey Technical Guidance* for guidance on reporting this measure.

Overall changes

- Moved all optional exclusions to required exclusions.
- Removed the definition of "primary care physician" from Appendix 1: Practitioner Types.

Additional Resources

QRS and QHP Enrollee Survey Technical Guidance

Technical specification updates. The Centers for Medicare & Medicaid Services (CMS) publishes guidance for Qualified Health Plans (QHP) in the Exchanges to specify requirements for participating in the Quality Rating System (QRS), including the clinical and survey measures that must be reported. The *2024 QRS and QHP Enrollee Survey Technical Guidance* will be posted to the CMS Marketplace Quality Initiatives (MQI) website in the fall of 2023 (https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityInitiativesGenInfo/ACA-MQI/ACA-MQI-Landing-Page).

HEDIS® for QRS Technical Update for Measurement Year 2023

In April 2023, the National Committee for Quality Assurance (NCQA) released a critical update to the *Colorectal Cancer Screening (COL and COL-E)* measure specifications for MY 2023. The HEDIS® for QRS Technical Update Memo contains corrections, policy changes, and clarifications to the *MY 2023 HEDIS® for QRS: Measure Technical Specifications*. With this release, NCQA freezes the HEDIS® for QRS measure technical specifications for MY 2023.

Additionally, CMS publishes an updated version of the QRS Measure Technical Specifications, which includes guidance on the finalized data submission requirements for the QRS measure set. Specifically, CMS includes callout boxes summarizing the final decision regarding measures and/or measure rates proposed for addition and those proposed for removal in the Draft Call Letter and finalized via the Final Call Letter. CMS anticipates releasing an updated version of the QRS Measure Technical Specifications for years when refinements to the QRS measures and/or measure rates are addressed via the QRS and QHP Enrollee Survey Call Letter process and finalized via the Final Call Letter. The updated 2024 QRS Measure Technical Specifications will be posted to the CMS Marketplace Quality Initiatives (MQI) website in the fall of 2023 (https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityInitiativesGenInfo/ACA-MQI/ACA-MQI-Landing-Page).

NCQA will freeze the specifications on March 31, 2023, with the release of the *MY 2023 HEDIS for QRS Technical Update*:

- **The HEDIS for QRS Technical Update Memo** will be posted to the NCQA website (https://www.ncqa.org).
- The following are available for free order in the NCQA Store. Once ordered, they will be made available in the My Downloads section of My NCQA on March 31, 2023.
  - **MY 2023 Quality Rating System (QRS) HEDIS Value Set Directory:** https://store.ncqa.org/my-2023-quality-rating-system-qrs-hedis-value-set-directory.html
  - **HEDIS MY 2023 Medication List Directory:** https://store.ncqa.org/hedis-my-2023-medication-list-directory.html
  - **HEDIS MY 2023 Risk Adjustment Tables:** https://store.ncqa.org/hedis-my-2023-risk-adjustment-tables.html

Referring to HEDIS Measures and Rates

HEDIS measures and resulting rates must always retain the HEDIS name. Specifically, for *unadjusted* measures:

- Refer to all *unadjusted* HEDIS measures as **"HEDIS Health Plan measures."**
- Calculated measure rates that are based on *unadjusted* HEDIS specifications that *have not* been certified through NCQA's Measure Certification Program™ may not be called "Health Plan HEDIS Rates" until they are audited and designated reportable by an NCQA-Certified HEDIS Compliance Auditor. Refer to these rates as **"Uncertified, Unaudited Health Plan HEDIS Rates."** Such uncertified rates may only be used for internal, quality improvement purposes (e.g., trend analysis) and no incentive payments may be made on such rates.
- Calculated measure rates that are based on *unadjusted* HEDIS specifications and have been certified through NCQA's Measure Certification Program may not be called "Health Plan HEDIS Rates" until they are audited and designated reportable by an NCQA-Certified Auditor. Refer to these rates as **"Unaudited Health Plan HEDIS rates."**

Organizations that need assistance in determining the correct naming convention for HEDIS measures/ rates should contact NCQA through My NCQA at https://my.ncqa.org.

If You Have Questions About the Specifications or General Guidelines for Data Collection

Policy Clarification Support

NCQA provides different types of policy support to customers, including a function that allows customers to submit specific policy interpretation questions to NCQA staff through My NCQA at https://my.ncqa.org.

FAQs and Policy Updates

The FAQs and Policy Updates clarify HEDIS for QRS uses and specifications; and are posted to the NCQA website (https://my.ncqa.org) on the 15th of each month.

Reporting Hotline for Fraud and Misconduct

NCQA does not tolerate submission of fraudulent, misleading, or improper information by organizations as part of their survey process or for any NCQA program.

NCQA has created a confidential and anonymous Reporting Hotline to provide a secure method for reporting perceived fraud or misconduct, including submission of falsified documents or fraudulent information to NCQA that could affect NCQA-related operations (including, but not limited to, the survey process, the HEDIS measures and determination of NCQA status and level).

How to Report

- Toll-Free Telephone:
  - English-speaking USA and Canada: **844-440-0077** (not available from Mexico).
  - Spanish-speaking North America: **800-216-1288** (from Mexico, user must dial 001-800-216-1288).
- **Website:** https://www.lighthouse-services.com/ncqa.
- **Email:** reports@lighthouse-services.com (must include NCQA's name with the report).
- **Fax:** 215-689-3885 (must include NCQA's name with the report).

Reporting Data Errors to NCQA

Because audited HEDIS data are used to establish plans' Accreditation status in many state and federal programs, NCQA must be made aware of data problems in any previously reported rate.

Organizations must immediately report any error in a measure rate or in its component (in any previous submission, regardless of timing) that is >5% higher or lower than what was reported originally. These

should be reported to NCQA through PCS system via My NCQA (https://my.ncqa.org) by selecting Product/Program Type as "HEDIS Audit" and General Content Area as "Data Errors." The report to NCQA must include:

- A description of the issue that includes:
  - The correct rate.
  - The error's cause.
  - How the error was discovered.
  - How the error was corrected.
- The HEDIS measure year and the measures affected.
- The submissions affected.
- The impact on reported rates.

Auditors must document all findings for the year in question and the current year's corrections. Findings must be included in the work papers and must be noted in detail in the organization's Final Audit Report.

General Guidelines for Data Collection

General Guidelines for Data Collection

These MY 2023 HEDIS for QRS General Guidelines for the *MY 2023 Quality Rating System Measure Technical Specifications* are unique to the issuers offering plans on the Exchanges and participating in the CMS Quality Rating System (QRS).[1,2]

SUMMARY OF CHANGES TO MY 2023 HEDIS FOR QRS

- Updated *General Guideline 9*: *Deceased Members*.
- Updated *General Guideline 23*: *Race and Ethnicity Stratification*.
- Revised *General Guideline 35*: *Visits that Result in an Inpatient Stay* to clarify that visits resulting in an inpatient stay are now identified based on visit date of service and inpatient stay dates of service
- Removed references to optional exclusions.

MY 2023 HEDIS for QRS Data Collection

1. Exchange Product Line

QHP issuers ("organizations") must collect HEDIS for QRS measure data separately for the Health Insurance Exchange (often called the Health Insurance Marketplace®) population. The HEDIS for QRS specifications are for reporting the Exchange product line only.

2. Reporting Units (Product)

Organizations must collect HEDIS for QRS measure data for each product (EPO, HMO, POS, PPO) offered through an Exchange in 2024 that had more than 500 enrollees as of July 1 in the prior year (July 1, 2023) and continues to have more than 500 enrollees as of January 1 of the ratings year (January 1, 2024). Reporting units that are decertified or discontinued before June 15 of the ratings year (June 15, 2024) are exempt from QRS reporting requirements.

All enrollees in QHPs offered on an Exchange that provide family and/or adult-only medical coverage should be included (unless noted otherwise in the *MY 2023 Quality Rating System Measure Technical Specifications*). At this time, organizations should not include indemnity plans (i.e., fee-for-service plans), child-only plans or stand-alone dental plans in the reporting unit. Organizations should not include any enrollees from health plans offered outside the Exchange or non-QHPs. Non-QHPs are health plans that are offered outside of the Exchange and designated with a HIOS variant ID-00. Organizations should not include any enrollees from basic health plans.

Additionally, sampling for QRS measures that specify a hybrid method for data collection will occur at the product level.

Combining products into one reporting unit is not allowed.

[1] The Patient Protection and Affordable Care Act of 2010 (Pub. L. 111–148) as amended by the Health Care and Education Reconciliation Act of 2010 (Pub. L. 111–309) (collectively referred to as the Affordable Care Act) established an Affordable Insurance Exchange (or Exchange) within each state Exchange.

[2] A QHP issuer has a certification issued by or recognized by an Exchange to demonstrate that each health plan offered in the Exchange is a QHP and meets the requirements described in 45 CFR 155.2. Each QHP issuer is defined by a separate federal Health Insurance Oversight (HIOS) Issuer ID. Each QHP issuer is defined by a State geographic unit. A QHP issuer must operate on an Exchange for at least one year before it is required to collect QRS measure data. Final rule—https://www.federalregister.gov/documents/2014/05/27/2014-11657/patient-protection-and-affordable-care-act-exchange-and-insurance-market-standards-for-2015-and

Definitions

EPO Exclusive provider organization. A type of health insurance product that usually limits coverage to care from providers, or groups of providers, who have contracts with the health insurance issuer to be part of a network of participating providers. EPO members will generally not be reimbursed or receive benefits for out-of-network services; however, some EPOs will provide partial reimbursement for emergency situations.

HMO Health maintenance organization. An organized health care system that is accountable for both the financing and delivery of a broad range of comprehensive health services to an enrolled population. An HMO is accountable for assessing access and ensuring quality and appropriate care. Practitioners affiliated with the health care system render health care services. In this type of organization, members must obtain all services from affiliated practitioners and must usually comply with a predefined authorization system to receive reimbursement.

A **practitioner** is a professional who provides health care services and is usually required to be licensed as defined by law.

POS Point of Service. An HMO with an opt-out option. In this type of organization, members may choose to receive services either with the organization's health care system (e.g., an in-network practitioner) or outside the organization's health care delivery system (e.g., an out-of-network practitioner).

The level of benefits or reimbursement is generally determined by whether the member uses the in-network or out-of-network services. Common uses of "POS" include references to products that enroll each member in an HMO (or HMO-like) system in an indemnity product. A POS product is also referred to as an "HMO swing-out organization," an "out-of-organization benefits rider to an HMO" or an "open-ended HMO."

PPO Preferred provider organization. PPOs are responsible for providing health benefits-related services to covered individuals and for managing a practitioner network. They may administer health benefits programs for employers by assuming insurance risk or by providing only administrative services.

3. Minimum Enrollment Threshold

Organizations are required to submit data for each product offered through an Exchange in 2024 that had more than 500 enrollees as of July 1, 2023, and continues to have more than 500 enrollees as of January 1 of the ratings year (2024).

4. Individual and Small Business Health Options Program (SHOP) Members

Include SHOP and individual Exchange members in the same Exchange reporting unit (do not separate).

The NCQA HEDIS Compliance Audit™

The HEDIS Compliance Audit is required for all HEDIS for QRS measures in MY 2023.

The HEDIS Compliance Audit runs concurrent with the data collection process. The audit allows comparability across organizations and ensures validity and integrity of reported HEDIS data.

5. Audit Preparation

Contract with an audit firm. The organization requests an application for a HEDIS for QRS Audit from an NCQA Licensed Organization (https://www.ncqa.org/programs/data-and-information-technology/hit-and-data-certification/hedis-compliance-audit-certification/) and is responsible for determining fees and entering

into contracts. The first activity in audit preparation is contract execution. An organization contacts NCQA Licensed Organizations (LO) for bids and selects a firm to conduct the HEDIS audit.

The contracting phase includes assessing measures to report, executing the contract with all the necessary ancillary agreements (e.g., confidentiality and conflict of interest) and negotiating a timeline.

All LOs employ or contract with Certified HEDIS Compliance Auditors (CHCA) and select an audit team for the organization.

HEDIS Roadmap. Each organization must complete the HEDIS Record of Administration, Data Management and Processes (Roadmap). The Roadmap contains detailed questions about all audit standards and describes the operational and organizational structure of the organization. Auditors use the HEDIS Roadmap to review information about an organization's systems for collecting and processing data used to produce HEDIS reports and to organize the site visit.

Medical record review validation (MRRV). The medical record review validation (MRRV) process uses like-measure groupings for measure validation; includes hybrid measure exclusions; applies a different statistical test to the process; and defines MRR milestones clearly to ensure consistency across organizations. Refer to *Volume 5, HEDIS Compliance Audit: Standards, Policies and Procedures.*

HEDIS Audit Timeline. Organizations must follow the HEDIS Audit Timeline, which will be posted on the NCQA website (https://www.ncqa.org/hedis/measures/) on March 31, 2023, and is published in *Volume 5: HEDIS Compliance Audit: Standards, Policies and Procedures.*

6. Reporting

Audit results. HEDIS Compliance Audits result in audited rates or calculations at the measure and indicator level, and indicate if the measures can be publicly reported. All measures must have a final, audited result. The auditor approves the rate or report status of each measure and survey included in the audit, as shown below.

For Performance Measures

Rate/Result	Comment
R	*Reportable*. A reportable rate was submitted for the measure.
NA	*Small Denominator.* The organization followed the specifications, but the denominator was too small (e.g., less than 30) to report a valid rate. a. For Effectiveness of Care (EOC) measures and EOC-like measures, when the denominator is less than 30. b. For all Risk Adjusted Utilization measures, when the denominator is less than 150. c. For measures reported using ECDS, when the denominator is less than 30. *NA (Not Applicable)* is a status, not an audit designation. Measure rates that result in NA are considered Reportable (R), but the denominator is too small to report.
NB	*No Benefit*. The organization did not offer the health benefit required by the measure (e.g., mental health, chemical dependency). Benefits are assessed at the global level, not the service level (refer to *General Guideline 16: Required Benefits*).
NR	*Not Reported.* The organization chose not to report the measure.
BR	*Biased Rate.* The calculated rate was materially biased.

Material bias. Bias differs by measure and domain and is determined by the degree of data completeness for the data collection method used. Organizations may not report a rate for a measure that the auditor determines is biased. Auditors use a standardized set of bias assessments found in the Bias Determination appendix in *Volume 5: HEDIS Compliance Audit: Standards, Policies and Procedures*.

In Which Reports Do Exchange Members Remain?

7. Eligible Population

The **eligible population** for any measure is all members who satisfy all specified criteria, including age, continuous enrollment, benefit, event and the anchor date enrollment requirement. Organizations must include all members (regardless of benefit type) in the appropriate Exchange report.

- *For the Administrative Method,* calculate the rate using the eligible population after exclusions are removed.
- *For the Hybrid Method,* calculate the rate using the denominator (the systematic sample drawn from the eligible population) after exclusions are removed.
- *For the ECDS method*, calculate the rate using the denominator (the initial population minus exclusions).

Note: *Refer to the measurement specifications for eligible population criteria.*

8. Members in Hospice

Exclude members who use hospice services or elect to use a hospice benefit any time during the measurement year regardless of when the services began. These members may be identified using various methods, which may include, but are not limited to, enrollment data, medical record, claims/ encounter data (Hospice Encounter Value Set; Hospice Intervention Value Set) or supplemental data for this required exclusion. If organizations use the Monthly Membership Detail Data File to identify these members, use only the run date of the file to determine if the member elected to use a hospice benefit during the measurement year.

Organizations should attempt to remove these members prior to determining a measure's eligible population and drawing the sample for hybrid measures. If a member is found to be in hospice or using hospice services during medical record review, the member is removed as a valid data error from the sample and replaced by a member from the oversample. Documentation that a member is near the end of life (e.g., comfort care, DNR, DNI) or is in palliative care does not meet criteria for the hospice exclusion.

Exclusion of members in hospice is subject to auditor review.

Note

- *Supplemental data can be used for the hospice exclusion for all applicable measures, including measures that say, "supplemental data may not be used for the measure" (e.g., PCR).*
- *For ECDS reporting, hospice data from Monthly Membership Detail Data Files must be flagged for the administrative Source System of Record.*

9. Deceased Members

For this required exclusion, exclude members who die any time during the measurement year. These members may be identified using various methods that may include, but are not limited to, enrollment data, medical record, claims/encounter data or supplemental data.

Organizations should attempt to remove these members prior to determining a measure's eligible population and drawing the sample for hybrid measures. A deceased member found during medical record review is removed as a valid data error from the sample and replaced by a member from the oversample.

Exclusion of deceased members is subject to auditor review.

Note

- *NCQA does not require organizations to develop databases or other methods to identify deceased members.*
- *Supplemental data can be used for excluding deceased members for all applicable measures, including measures that say, "supplemental data may not be used for the measure" (e.g., URI).*
- *This is a member-level exclusion. For episode-based measures, if one event does not meet numerator criteria, remove all member events/episodes from the measure.*
- *General Guideline 9: Deceased Members does not apply to the Proportion of Days Covered (PDC) measure.*

Membership Changes

10. Members Who Switch Organizations

Members who switch to different organizations or to a sister organization may be counted as continuously enrolled if they joined an organization that assumes ownership of or responsibility for members' administrative data and medical records for the entire period of continuous enrollment specified in the measure.

If an organization reports these members as continuously enrolled, it follows the definition of "continuous enrollment" in *General Guideline 13: Continuous Enrollment*, and all other guidelines affecting continuous enrollment (allow switching between products [HMO, POS, PPO, EPO] or product lines [Medicaid, Commercial, Medicare, Exchange]) consistently, across all measures.

11. Members Who Switch Organizations as a Result of a Merger or Acquisition

Measures with a continuous enrollment period. Members who switch organizations because of a merger that occurred during the measurement year may be counted as continuously enrolled.

Measures without a continuous enrollment period. The surviving organization may include members from the non-surviving entity in the eligible population, starting on the official date of the merger or acquisition. For example, if the merger or acquisition occurred on March 1 of the measurement year, the surviving organization excludes members acquired from the non-surviving entity from the eligible population for January and February.

This guideline must be used consistently across all measures.

12. Members Who Switch Products/Product Lines

Measures with a continuous enrollment requirement. Members who enrolled in different **products** or **product lines** in the time specified for continuous enrollment for a measure are continuously enrolled and are included in the product and product-line specific HEDIS report in which they were enrolled as of the end of the continuous enrollment period. For example, a member enrolled in the Medicaid product line who switches to the Exchange product line during the continuous enrollment period is reported in the Exchange HEDIS for QRS report. If a measure allows a gap at the end of the continuous enrollment period, report members in the product and product line-specific HEDIS report in which they were enrolled as of the last enrollment segment.

The organization must use claims data from all products/product lines, even when there is a gap in enrollment.

Measures without a continuous enrollment requirement. Members who enrolled in different products or product lines are reported in the product and product line-specific HEDIS report in which they were enrolled on the date of service (outpatient, ED or observation visits) or date of discharge requirement (inpatient stays).

Required Enrollment Periods and Benefits

13. Continuous Enrollment

Continuous enrollment specifies the minimum amount of time that a member must be enrolled in an organization before becoming eligible for a measure. It ensures that the organization has enough time to render services. The continuous enrollment period and allowable gaps are specified in each measure. To be considered continuously enrolled, a member must also be continuously enrolled with the benefit specified for each measure (e.g., pharmacy or mental health), accounting for any allowable gap.

A **gap** is the time when a member is not covered by the organization (i.e., the time between disenrollment and re-enrollment). For example, if a member disenrolls on June 30 and re-enrolls on July 1, there is no gap because the member is covered by the organization on both June 30 and July 1. If the member disenrolls on June 30 and re-enrolls on July 2, there is a 1-day gap because the member is without coverage on July 1.

An **allowable gap** can occur any time during continuous enrollment. For example, the Child and Adolescent Well-Care Visits measure requires continuous enrollment throughout the measurement year (January 1–December 31) and allows one gap in enrollment of up to 45 days. A member who enrolls for the first time on February 8 of the measurement year is considered continuously enrolled as long as there are no other gaps in enrollment throughout the remainder of the measurement year. The member has one 38-day gap (January 1–February 7).

14. Continuous Enrollment Over Multiple Years

Unless otherwise specified, for measures that span more than 1 year, members are allowed one gap in enrollment of up to 45 days during each year of continuous enrollment. A gap in enrollment that extends over multiple years of a continuous enrollment period may exceed 45 days. For example, in the Colorectal Cancer Screening measure (which requires 2 years of continuous enrollment), a member who disenrolls on November 30 of the year prior to the measurement year and re-enrolls on February 1 of the measurement year is considered continuously enrolled as long as there are no other gaps in enrollment during either year. The member has one gap of 31 days (December 1–31) in the year prior to the measurement year and one gap of 31 days (January 1–31) in the measurement year.

15. Anchor Dates

If a measure requires a member to be enrolled and to have a benefit on a specific date, the allowable gap must not include that date; the member must also have the benefit on that date. For example, a 30-year-old member who has only one gap in enrollment from November 30 of the measurement year throughout the remainder of the year is not eligible for the Cervical Cancer Screening measure. Although they meet the continuous enrollment criteria, they do not meet the anchor date criteria, which requires enrollment as of December 31 of the measurement year.

16. Required Benefits

HEDIS for QRS measures evaluate performance and hold organizations accountable for services provided in their members' benefits package. Measure specifications include benefits (medical, pharmacy, mental health, chemical dependency) required during the continuous enrollment period. HEDIS for QRS measures do not define benefits at the service or metal level (e.g., if the organization offers a pharmacy benefit but

does not cover a specific medication class, the member has a pharmacy benefit and is included in the applicable measures requiring this benefit; similarly if the member has partial coverage of mental health services (either by service or diagnosis), they are included as having a mental health benefit). Organizations must assess benefits first at the organization level and then at the individual member level using continuous enrollment data.

At the organization level: Organizations report HEDIS for QRS measures requiring a specific benefit provided to members directly or through a contractor. Organizations are not required to report HEDIS for QRS measures specifying a benefit that it does not offer. Before reporting a measure specifying a benefit, the organization must be able to determine if a member has the required benefit.

If the organization does not offer the benefit, the plan does not report the measure and receives an NB (No Benefit) audit designation. No member assessment is necessary.

At the member level: Members who do not have a specified benefit are not counted in the measure; for example, exclude members without a pharmacy benefit from the Asthma Medication Ratio measure.

Exhausted benefits *(optional).* *For measures without a continuous enrollment criterion,* include only services or procedures that occurred while the member had a benefit. For a member whose benefit is lost or exhausted during the time specified in the measure, include services or procedures that occurred while the member had the benefit.

For measures with a continuous enrollment criterion, the required benefits must be active for the period of continuous enrollment, accounting for any allowable gap. Exclude a member if the period when the benefit is exhausted exceeds any allowable gap or anchor date. For example, the Asthma Medication Ratio measure requires a pharmacy benefit during the measurement year. Exclude a member whose pharmacy benefit is exhausted in September of the measurement year, because this exceeds the 45-day allowable gap period.

Carved-out benefits *(optional).* Some organizations can obtain the necessary information from a carved-out entity and may include these members in their measures. For example, an employer contracts directly with a pharmacy benefit manager (PBM), which shares pharmacy information with the organization. The employer's members may be included in the measure.

This guideline must be used consistently across all measures.

17. Accessing Medical Records Prior to Enrollment

Data that can be accessed from a complete medical record are used to calculate a measure. If data from a medical record cannot be accessed because data were updated before the member was enrolled, the organization calculates the measure with the data that are available.

HEDIS for QRS Data Submission and Reporting to NCQA

18. Reporting Date

For MY 2023 HEDIS for QRS, all organizations reporting audited data to NCQA through the IDSS must submit data to NCQA on or before June 14, 2024.

Note: *Organizations must submit and "plan-lock" audited HEDIS for QRS data to allow auditors sufficient time to review, approve and audit lock all submissions by the June 14 deadline. For MY 2023 HEDIS for QRS reporting, organizations are required to "plan-lock" audited HEDIS for QRS data no later than* ***June 1, 2024.***

19. Required Data Elements

Organizations that submit audited HEDIS for QRS data to NCQA must report the data elements identified in each measure specification. Data elements are standard for hybrid and administrative measures. Refer to *General Guideline 42: Reporting Tables* and *Appendix 2: Data Element Definitions.*

Data Collection Methods and Data Sources

20. Data Collection Methods

HEDIS for QRS measures are specified for one or more data collection methods:

- Administrative Method.
- Hybrid Method.
- Survey Method.
- ECDS Method.

Each measure specifies the data collection methods that must be used. If a measure includes both the Administrative and Hybrid Methods, either method may be used.

Administrative Method: Transaction data or other administrative data are used to identify the eligible population and numerator. The reported rate is based on all members who meet the eligible population criteria and who are found through administrative data to have received the service required for the numerator.

Hybrid Method: Organizations look for numerator compliance in both administrative and medical record data. The denominator consists of a systematic sample of members drawn from the measure's eligible population. Organizations review administrative data to determine if members in the systematic sample received the service and review medical record data for members who do not meet the numerator criteria through administrative data. The reported rate is based on members in the sample who received the service required for the numerator.

Survey Method: HEDIS for QRS includes the specifications for NCQA clinical survey measures collected through the Qualified Health Plan Enrollee Experience Survey (QHP Enrollee Survey). For additional details on the QHP Enrollee Survey data collection protocols, refer to the *Qualified Health Plan Enrollee Experience Survey: Technical Specifications,* which are available on the CMS QHP Enrollee Survey page of the MQI website (https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityInitiativesGenInfo/ACA-MQI/Consumer-Experience-Surveys/Surveys-page).

ECDS Method: *Refer to the Guidelines for Measures Reported Using Electronic Clinical Data Systems for additional information for this data collection method.* ***Note:*** *Supplemental data are considered an administrative data source; however, for all non-survey measures, numerator events identified using supplemental data are reported separately from numerator events identified by administrative (claims/encounter) and medical record data, as indicated in the applicable Data Elements for Reporting tables.*

Any data found in a supplemental data source are considered a supplemental data hit if the member would not be compliant for the measure/indicator without the data source. If supplemental data are not used, report zero in the "Numerator events by supplemental data" element. For all other measures, numerator events identified using supplemental data are reported in the "Numerator events by administrative data" element. Refer to General Guideline 21: Supplemental Data.

21. Supplemental Data

Supplemental data uses. Organizations may find information about services for their members in administrative data, medical records and other data sources. When evidence to support the measure is found in multiple data sources, a hierarchy is applied. Supplemental data are considered last as long as the specifications are followed as written (e.g., if the organization uses a combination of data sources to identify the HbA1c control indicators in the *Hemoglobin A1c Control for Patients With Diabetes* measure, the most recent test must be used, regardless of data source).

For administrative-only measures, medical record data are considered supplemental data.

Supplemental data may help determine:

- Numerators that are labeled as *numerators* in the specification.
- Members in hospice and members who have died.
- Eligible population-required exclusions that are labeled as required exclusions in the specification.

Supplemental data may not be used for:

- Denominator events. Organizations *may not* create and use records to identify denominator events, other than for required exclusions.
- Clinical conditions that change. Organizations *may not* create and use records, on an ongoing basis, for exclusions for clinical conditions that change.
- Correcting bills or identifying valid data errors. Organizations *may not* use supplemental data to adjust incorrect billing practices or to identify valid data errors. This practice results in a change in claims data and is not allowed.
- Measures where the specification specifically indicates supplemental data cannot be used, except for applying the hospice exclusion and for excluding deceased members.

Supplemental Data Definitions

The auditor determines the classification of all supplemental data, not the organization.

Standard supplemental data. Electronically generated files that come from service providers (providers who rendered the service). Production of these files follows clear policies and procedures; standard file layouts remain stable from year to year.

> **Audit requirements.** Standard supplemental files are not required to be accompanied by proof-of-service documents and the audit does not require primary source verification, unless requested by the auditor.
>
> ***Note:*** *The prior year's validated historic hybrid medical record result files are reviewed as part of the Data Preproduction Processing section of the HEDIS Roadmap. These data are loaded as administrative data.*

Nonstandard supplemental data. Data used to capture missing service data not received through administrative sources (claims or encounters) or in the standard electronically generated files described above, whether collected by a plan, an organization, a provider or a contracted vendor. These types of data might be collected from sources on an irregular basis and could be in files or formats that are not stable over time.

Organizations must have clear policies and procedures that describe how the data are collected and by whom, how they are validated and used for HEDIS for QRS reporting.

Organizations *may not* conduct phone calls to members or providers to collect information about services already rendered.

Audit requirements. All nonstandard supplemental data must be substantiated by proof-of-service documentation from the legal health record. Proof-of-service documentation is required for only a sample, selected by the auditor, as part of the audit's annual primary source verification.

Proof-of-service documentation that *is allowed* for primary source verification:

- A copy of the information from the member's chart from the service provider or the PCP.
- A copy of the clinical report or clinical summary from the visit for service, such as lab or radiology reports (i.e., forms from the rendering provider proving the service occurred).
- A screen shot of:
  - Online electronic health record (EHR) records.
  - State- or county-sponsored immunization registry records.

Proof-of-service documentation that *is not allowed* for primary source verification*:*

- *Member surveys.* Organizations and providers may not use information obtained from surveys or other documents completed by the member.
- *Phone calls.* Recorded phone calls to collect information about services rendered are not proof of service.

Continuity of Care Documents. CCDs are used for the electronic exchange of clinical data without loss of meaning. The files provide a summary of a patient's care as a snapshot in time, but they are not a replacement for an EHR. These files are typically XML-based and are considered nonstandard supplemental data for at least the first year of use. The organization must demonstrate the accuracy of these (through primary source verification (PSV)) to ensure that the data in the file match the EHR. This data source must meet both criteria:

- There is a completed, current year's Roadmap section.
- The Roadmap must include a description of how the CCD is created and by whom (e.g., produced by the provider in the office and sent to the plan or created by a vendor), the validation process and how the data are transmitted.

Audit requirements. The auditor confirms that the data meet all requirements. Primary source verification is required (e.g., go back to each unique EHR) to validate the CCDs' accuracy. This level of validation is required for at least the first year, or the first submission by the EHR, but may continue in subsequent years until the auditor is certain the data are accurate, reliable and have not changed.

NCQA DAV Data

For data from an NCQA-Validated Data Aggregator Validation (DAV) entity, the auditor must:

- Receive a completed current year's Roadmap Section 5 from the reporting entity using the data. The Roadmap must explain how data from the validated DAV entity are transferred to the reporting entity, and what the entity does to the data. This is completed by the health plan; no documentation is required from the DAV entity, which has already been validated.
  - If the reporting entity processes the validated CCD in any way after receipt, the auditor must validate the file back to the original validated CCD to ensure that no data were changed.
- Receive the final validation report that indicates the validated data cases and clusters and the date when they were validated.

If an NCQA-validated DAV entity includes data from an unvalidated data stream, the auditor must validate the data, following the nonstandard supplemental data guidelines, before the data can be used for HEDIS reporting.

The auditor may not perform PSV on any validated data stream.

Required Data Elements

Standard supplemental data. Organizations must have policies and procedures for using data files as standard supplemental data. Data files must have standard file layouts, standard data fields and industry standard codes, and must include all elements required by measure specifications, including payment status when applicable, and evidence that tests or services were performed and not merely ordered.

Nonstandard supplemental data. Nonstandard supplemental data must have all data elements required to meet criteria specified by the measure specifications, including:

- Payment status, when applicable.
- Evidence that tests or services were performed, not just ordered.
  - When data are abstracted from medical record sources to be used as supplemental data, codes alone (without additional documentation of the service provided) do not meet criteria for proof of service. If a provider performs a service, it is expected that there is additional documentation in the medical record or in the primary source document. Auditors must validate, through primary source verification, all elements required by the measure specification.
- Evidence of provider accountability from the practitioner or practitioner group (signed contracts with accountability tied to passwords, signatures or TIN/NPI data). For home visits, if clinical services are rendered, there must be evidence of accountability by the practitioner, and at a minimum include the date, name and signature on each in-home form. Documentation of the practitioner's TIN/NPI is not required; however, documentation of TIN/NPI with date, name and signature is preferred.
- More than a simple yes or no attestation on provider forms. Forms must have all necessary data elements and be signed by the rendering practitioner.
- All data elements for a measure must be captured for member-reported services (date and place of service, procedure, prescription, test result or finding, practitioner type). When using supplemental data derived from medical records to meet administrative specifications, documentation must be clinically synonymous with the codes included in the measure's value sets. Refer to *General Guideline 30: Member-Reported Services and Biometric Values*.

All supplemental data. All proof-of-service documents must show that services were rendered by the deadline established for the measure (refer to *General Guideline 25: Date Specificity* for date specificity requirements).

When pharmacy data are classified as supplemental data, the following data elements must be present: the generic name (or brand name), strength/dose, route and date when the medication was dispensed or shipped to the member. For mail order prescriptions "shipped date" meets criteria for dispense date. "Start date" documented in the medical record does not meet criteria. Data elements must map to a medication listed in the Medication List Directory to be eligible for use. Generic documentation in the medical record (e.g., that a patient "was prescribed" or "is taking" a medication) that does not include drug name, strength/dose and dispense date does not meet criteria.

All supplemental data used to show eligibility for exclusions must follow the requirements for exclusions in each measure.

Supplemental Data Timeline

Supplemental data may be collected during the measurement year and into the beginning of the reporting year. Supplemental data collection and use must adhere to all applicable deadlines in the Audit Timeline posted on NCQA's website.

Identifying and Validating Supplemental Data

All supplemental data (standard and nonstandard) must be identifiable. Because supplemental data can affect reporting and incentives, plans or vendors that use supplemental data for HEDIS for QRS reporting must mark the data files, regardless of the source. Auditors must be able to assess the contribution of each supplemental data source to the applicable components of the measure (numerator events or appropriate exclusions).

Auditors must review all supplemental data annually—there are no exceptions. At a minimum, the annual review includes the following for each supplemental data source:

- A completed current year's *Supplemental Data* section of the HEDIS Roadmap, including all attachments.
- Impact of supplemental data source by measure (e.g., lists of numerator-positive hits from the supplemental data, by measure; year-to-year comparisons of percentage increases associated with supplemental data; proportion of numerator compliance from supplemental data).
- Primary source verification, where required or requested by the auditor.

Supplemental data that do not pass all audit validation steps by the deadline may not be used to calculate HEDIS for QRS rates. Organizations may wait to load supplemental data until primary source verification is complete and the source is approved.

For additional information about audit requirements for supplemental data, refer to *Volume 5, HEDIS Compliance Audit: Standards, Policies and Procedures*.

22. Obtaining Information for the Systematic Sample

Organizations (and their contractors) that use the Hybrid Method are responsible for determining compliance with HEDIS for QRS measurement specifications. Information may be abstracted from the member's legal health record by designated medical record review (MRR) staff. Abstraction of data for members in the systematic sample is performed by entities or vendors who adhere to training, policies and procedures, use of appropriate tools, oversight and all other audit components.

MRR abstractors count a service if the legal health record contains the date of the service and evidence that the service occurred. All services must be rendered and documented in the medical record by the deadline established in the measure (e.g., by the child's second birthday, for the *Childhood Immunization Status* measure).

Organizations must be able to determine that a test or service was *performed* within the time frame specified, not merely ordered. Only completed events count toward HEDIS for QRS compliance. Documentation in a medical record of a diagnosis or procedure code alone does not comply with the numerator criteria.

Processes used to determine the validity and integrity of abstracted data, including interrater reliability, quality control and rater-to-standard results, are reviewed by the certified HEDIS Compliance Auditor.

Data refresh for the systematic sample. Because the NCQA HEDIS Compliance Audit requires that the systematic sample be stable and reproducible, organizations may not change the sample after it is created. If an organization refreshes the HEDIS repository after the sample is drawn and chart review is in progress, it should follow the guidelines below to use the newer administrative data for all hybrid measures.

Exclusions found through a data refresh must be reported in the "ExclusionValidDataErrors" data element.

Note: *Organizations may elect to refresh data for administrative-only measures but must apply the refresh to all applicable measures.*

Manually updating the sample. Organizations may compare only the numerator-negative members in the sample to screen shots of the refreshed data; they are not required to update every measure manually or to reassess denominator compliance for every member in the sample.

Records used for numerator compliance are subject to medical record review validation.

Automated updates to the sample. Organizations may use an automated process that loads the entire sample for each measure and compares it to the refreshed data. All data must be used consistently in the samples.

- If recent data contradict numerator compliance, those data must be used.
- If recent data exclude a member, those data must be used and the oversample must provide a substitute member.
- If the oversample is exhausted, the organization must use the Sampling Guidelines to ensure meeting the minimum required sample size (MRSS) is possible.
- The auditor must review and approve the timing, processes and results of the refresh, but does not need to include the records used for numerator compliance in the medical record review validation.

23. Race and Ethnicity Stratification

Finalized Race and Ethnicity Data Submission Requirements for the 2024 Ratings Year

In the Final 2023 Call Letter, CMS finalized the requirement to collect and report race and ethnicity stratifications for the following additional measures in the QRS program: *Asthma Medication Ratio, Breast Cancer Screening, Immunizations for Adolescents, Initiation and Engagement of Substance Use Disorder Treatment,* and *Well-Child Visits in the First 30 Months of Life.*

The following measures instruct the organization to categorize members by the race and ethnicity stratification (RES):

- Asthma Medication Ratio.
- Breast Cancer Screening (BCS-E).
- Child and Adolescent Well-Care Visits.
- Colorectal Cancer Screening (including COL-E).
- Controlling High Blood Pressure.
- Hemoglobin A1c Control for Patients With Diabetes: HbA1c poor control (>9%).
- Immunizations for Adolescents (including IMA-E).
- Initiation and Engagement of Substance Use Disorder Treatment.
- Prenatal and Postpartum Care.
- Well-Child Visits in the First 30 Months of Life.

Reporting categories

NCQA requires reporting race and ethnicity as defined by the Office of Management and Budget (OMB) Standards for Maintaining, Collecting, and Presenting Federal Data on Race and Ethnicity.[3,4,5]

Race and ethnicity values must be rolled up into the OMB categories specified in this guideline. If more detailed race or ethnicity information is collected, these data must be aggregated and reported in the OMB categories provided. For health plans using the CMS classification scheme for race and ethnicity, refer to Table RES-A-4 for a crosswalk to HEDIS for QRS reporting.

Report member race and ethnicity separately. If a combined race/ethnicity category question is used to collect data, data must be disaggregated, and race and ethnicity categories must be reported separately. When using the combined

[3] Office of Management and Budget Revisions to the Standards for the Classification of Federal Data on Race and Ethnicity. https://www.govinfo.gov/content/pkg/FR-1997-10-30/pdf/97-28653.pdf
[4] 2020 Census Questions: Race. https://2020census.gov/en/about-questions/2020-census-questions-race.html
[5] 2020 Census Questions: Hispanic Origin. https://2020census.gov/en/about-questions/hispanic-origin.html

race/ethnicity data format for collection, refer to Table RES-B-4 for a crosswalk of reporting categories.

Tables RES-C-4 and RES-D-4 crosswalk the HEDIS reporting categories to code values specified by the Race and Ethnicity extensions of the HL7 US Core Implementation Guide. Organizations must use or map to the documented Direct reference codes and Value sets described here. Code values originate from two code systems:

- "Race & Ethnicity – CDC" (CDCREC) is used to report distinct OMB race and ethnicity categories.
- "Some Other Race," "Asked but No answer" and "Unknown" use the HL7 version 3 NullFlavor code system.

Determining race reporting category

Report members in only one of the nine race stratifications listed below and the total.

- *White*: Identification with one or more nationalities or ethnic groups originating in Europe, the Middle East or North Africa. Examples of these groups include, but are not limited to, German, Irish, English, Italian, Lebanese, Egyptian, Polish, French, Iranian, Slavic, Cajun and Chaldean.
- *Black or African American*: Identification with one or more nationalities or ethnic groups originating in any of the Black racial groups of Africa. Examples of these groups include, but are not limited to, African American, Jamaican, Haitian, Nigerian, Ethiopian and Somali. The category also includes groups such as Ghanaian, South African, Barbadian, Kenyan, Liberian and Bahamian.
- *American Indian or Alaska Native*: Identification with any of the original peoples of North and South America (including Central America) and who maintain tribal affiliation or community attachment. It includes people who identify as "American Indian" or "Alaska Native" and includes groups such as Navajo Nation, Blackfeet Tribe, Mayan, Aztec, Native Village of Barrow Inupiat Traditional Government and Nome Eskimo Community.
- *Asian*: Identification with one or more nationalities or ethnic groups originating in the Far East, Southeast Asia or the Indian subcontinent. Examples of these groups include, but are not limited to, Chinese, Filipino, Asian Indian, Vietnamese, Korean and Japanese. The category also includes groups such as Pakistani, Cambodian, Hmong, Thai, Bengali or Mien.
- *Native Hawaiian or Other Pacific Islander*: Identification with one or more nationalities or ethnic groups originating in Hawaii, Guam, Samoa, or other Pacific Islands. Examples of these groups include, but are not limited to, Native Hawaiian, Samoan, Chamorro, Tongan, Fijian and Marshallese. The category also includes groups such as Palauan, Tahitian, Chuukese, Pohnpeian, Saipanese or Yapese.
- *Some Other Race*: People whose race information has been collected but does not fit into any of the other seven race categories. This category includes people who may be Mulatto, Creole and Mestizo or another race not specified in the Census "Race" categories.
- *Two or More Races*: People with any combination of races, including "Some Other Race."
- *Asked but No Answer:* People who the organization asked to identify race but who declined to provide a response.

- *Unknown:* People for whom the organization did not obtain race information and for whom the organization did not receive a declined response ("Asked but No Answer").
- *Total:* Total of all categories above.

Notes:

- *The "Asked but No Answer" category is only reported using direct data.*
- *The "Unknown" category is only reported using indirect data.*

Determining ethnicity reporting category

Report members in only one of the four ethnicity stratifications listed below and the total.

- *Hispanic or Latino*: Identification with one or more nationalities or ethnic groups originating in Mexico, Puerto Rico, Cuba, Central and South America and other Spanish cultures. Examples of these groups include, but are not limited to, Mexican or Mexican American, Puerto Rican, Cuban, Salvadoran, Dominican and Colombian. "Hispanic, Latino or Spanish origin" also includes groups such as Guatemalan, Honduran, Spaniard, Ecuadorian, Peruvian or Venezuelan.
- *Not Hispanic or Latino*: People not of Hispanic, Latino or Spanish culture or origin.
- *Asked but No Answer:* People who the organization asked to identify ethnicity but who declined to provide a response.
- *Unknown:* People for whom the organization did not obtain ethnicity information and for whom the organization did not receive a declined response ("Asked but No Answer").
- *Total:* Total of all categories above.

Notes:

- *The "Asked but No Answer" category is only reported using direct data.*
- *The "Unknown" category is only reported using indirect data.*

Data source

Approved data sources include data collected directly from members or data obtained through indirect methods. NCQA strongly encourages plans to report directly collected data when available and emphasizes the importance of improving completeness of directly collected member race and ethnicity data.

For each measure with the race and ethnicity stratification, plans will report each race and ethnicity value by data source. Plans will report the number of members in the eligible population from direct and indirect data sources, and the number of members in the numerator from direct and indirect data sources. IDSS will calculate the total number of members in the eligible population and numerator (combining both direct and indirect data sources).

Supplemental data may be used as a data source for RES.

Direct data

Data collected directly from members method reflects members' self-identification and is the preferred data source.

Directly collected data includes any source for which the member self-identified race or ethnicity. This includes data collected directly from members by the health plan, as well as third-party data collected directly from a member by another entity (e.g., the state or CMS). Direct sources may include, but are not limited to:

- Surveys.
- Health risk assessments.
- Disease management registries.
- Case management systems.
- Electronic health records.
- CMS/state databases.
- Enrollment information furnished by enrolling entities (e.g., state Medicaid agencies, employers).
- CCDs.

Indirect data

Plans may choose to report race and ethnicity data supplemented by indirect methods. Indirect assignment of race and ethnicity values include using an alternate data source, such as nationally representative data obtained from databases like the American Community survey, to assign a race or ethnicity value to a member based on their primary location of residence. Some commonly used indirect methods combine geographic data with additional imputation methods such as surname analysis.

NCQA reiterates that directly collected race and ethnicity is considered the gold standard and is highly preferred to indirectly assigned race and ethnicity. For plans choosing to use indirect methods to report the HEDIS for QRS race and ethnicity stratification, NCQA emphasizes the following:

- When applying indirect methods that involve assignment of race or ethnicity based on geographic data and member's location of residence, the smallest geographic unit possible is preferred. For example, geographic assignment at the census block level is likely to be more accurate than assignment using census tract or zip code level data.
- Indirect data sources and methods should be evaluated for reliability and validity and selection of a source and method should be prioritized based on demonstrated validity and reliability for the population in which it will be applied (e.g., age group, geography, product line).
- Indirect methods of race and ethnicity assignment are to be used for population-level reporting and analysis but are not appropriate for member-level intervention.

Sampling

For measures collected using the Hybrid Method with the race and ethnicity stratification, follow the guidelines for sampling outlined in Guidelines for Calculation and Sampling *Guidelines for the Hybrid Method.* The race and ethnicity stratifications are applied to the eligible population and denominator after hybrid sampling.

Reporting

Reporting of the race and ethnicity stratification follows the parameters for denominator size outlined in *General Guideline 6: Reporting*.

Table RES-A-4: CMS Categories Crosswalked to HEDIS/OMB Race and Ethnicity

CMS Category	HEDIS/OMB Race	HEDIS/OMB Ethnicity
White	White	Unknown
Black	Black	Unknown
American Indian/Alaska Native	American Indian or Alaska Native	Unknown
Asian/Pacific Islander	Asian	Unknown
Hispanic	Unknown	Hispanic or Latino
Other	Some Other Race	Unknown
Unknown	Unknown	Unknown
(No equivalent category)	Native Hawaiian or Other Pacific Islander	Unknown
(No equivalent category)	Two or more races	Unknown

Table RES-B-4: Combined Categories Crosswalked to HEDIS/OMB Race and Ethnicity

Race/Ethnicity Combined Category	HEDIS/OMB Race	HEDIS/OMB Ethnicity
White	White	Not Hispanic or Latino
Black	Black	Not Hispanic or Latino
American Indian/Alaska Native	American Indian or Alaska Native	Not Hispanic or Latino
Asian	Asian	Not Hispanic or Latino
Native Hawaiian and Other Pacific Islander	Native Hawaiian or Other Pacific Islander	Not Hispanic or Latino
Hispanic/Latino/White	White	Hispanic or Latino
Hispanic/Latino/Black	Black	Hispanic or Latino
Other	Some Other Race	Unknown
Multiple races marked	Two or more races	Unknown
Unknown	Unknown	Unknown

Table RES-C-4: HEDIS/OMB Race Crosswalked for Use With HEDIS Reporting Categories

HEDIS/OMB Race	CDCREC OMB Category Direct Reference Code	CDCREC Detailed Category Value Set
White	2106-3	White Detailed Race Value Set
Black	2054-5	Black or African American Detailed Race Value Set
American Indian or Alaska Native	1002-5	American Indian or Alaska Native Detailed Race Value Set
Asian	2028-9	Asian Detailed Race Value Set
Native Hawaiian or Other Pacific Islander	2076-8	Native Hawaiian or Other Pacific Islander Detailed Race Value Set
Some Other Race	OTH*	NA
Two or More Races	NA**	NA

HEDIS/OMB Race	CDCREC OMB Category Direct Reference Code	CDCREC Detailed Category Value Set
Asked but No Answer	ASKU*	NA
Unknown	UNK*	NA

*HL7 v3 Code System NullFlavor.

**This value is defined by the measure calculation logic as the presence of two or more distinct CDCREC category codes and does not map to a specific direct reference code or value set.

Table RES-D-4: HEDIS/OMB Ethnicity Crosswalked for Use With HEDIS Reporting Categories

HEDIS/OMB Race	CDCREC OMB Category Direct Reference Code	CDCREC Detailed Category: Value Set
Hispanic or Latino	2135-2	Hispanic or Latino Detailed Ethnicity
Not Hispanic or Latino	2186-5	NA
Asked but No Answer	ASKU*	NA
Unknown	UNK*	NA

*The NullFlavor concepts 'Asked but no answer' and 'Unknown' are not included in the terminology binding for the US Core Ethnicity FHIR extension on which this digital logic is structured. NCQA allows these concepts to express ethnicity data to align with bound values for the US Core Race extension.

Note

- *Race is a social construct, not biological; stratifying HEDIS for QRS measures by race and ethnicity is intended to be used to further understanding of racial and ethnic disparities in care and to hold health plans accountable to address such disparities, with the goal of achieving equitable health care and outcomes. Data are not to be used to further bias in health care or suggest that race and ethnicity are biological determinants of health.*
- *When multiple sources of data are used for race and ethnicity, there may be disagreements in the data collected. When this happens, data sources should be prioritized based on evaluation of anticipated accuracy. This includes use of specific categories over nonspecific categories, most frequent or consistently reported category and selection of data with clear provenance (source, method of collection) over data without clear provenance.*
- *Race and ethnicity data may come from different categories of data source (direct, indirect). In such cases, use the data source that applies to the data element (race, ethnicity). If the same data element is received from two different data sources, prioritize data sources based on the note above.*

24. Date of Service for Laboratory Tests

Laboratory tests can have multiple dates of service; an order date (the date the provider ordered the test), a collection date (the date when the specimen was drawn), a result/reported date (the date when results were calculated and reported), a claim date (the date of service on the claim) and a documented date (the date the provider documented the result in the medical record).

Order date and documented date are not eligible for use in HEDIS for QRS reporting.

For laboratory tests identified using claims data (numerator events by administrative data), use the claim date of service.

When abstracting laboratory tests from the medical record for use in hybrid reporting or for nonstandard supplemental data, the documentation must include the test date and the result (or evidence that the test was performed). The result/reported date may be used as the test date.

Organizations may consider all events with dates no more than 7 days apart to be the same test and may use the collected date for reporting. For example:

- If a member had an HbA1c sample collected on December 28 of the measurement year and an HbA1c result on January 2 of the year after the measurement year, the dates are within 7 days and may be considered the same test. The result is present and the collection date is eligible for use in reporting.
- If a member had an HbA1c sample collected on December 28 of the measurement year and an HbA1c result on January 15 of the year after the measurement year, the dates are not within 7 days and may not be considered the same test. The December 28 test is used for reporting and the result is missing.
- If a test had a collection date of December 1 and a reported date of December 8, these dates are not more than 7 days apart and may be considered the same test.
- If a test had a collection date of December 1 and a reported date of December 9, these dates are more than 7 days apart and may not be considered the same test.

25. Date Specificity

HEDIS for QRS requires that a date be specific enough to determine that an event occurred during the time established in the measure. For example, in the Childhood Immunization Status measure, members must receive three hepatitis B vaccines. For HEDIS MY 2023, assume a member was born on February 5, 2021. Documentation in the medical record that the first hepatitis B vaccine was given “at birth” is specific enough to determine that it was given prior to the deadline for this measure (the child’s second birthday), but if the medical record states that the third hepatitis B vaccine was given in February 2023, the organization cannot count the immunization because the date is not specific enough to confirm that it occurred prior to the member’s second birthday.

There are instances when documentation of the year alone is adequate; for example, measures that look for events in the “measurement year or the year prior to the measurement year.” Terms such as “recent,” “most recent” or “at a prior visit” are not acceptable.

For documented history of an event (e.g., documented history of a disease), undated documentation may be used if it is specific enough to determine that the event occurred during the time frame specified in the measure. For example, for the Childhood Immunization Status measure, undated documentation on an immunization chart stating “chicken pox at age 1” is specific enough to determine that it occurred prior to the child’s second birthday. Similarly, for the Breast Cancer Screening measure, undated documentation on a problem list stating “bilateral mastectomy in 1999” is specific enough to determine that this exclusion occurred on or before December 31 of the measurement year.

26. Collecting Data for Measures With Multiple Numerator Events

The following measures require more than one event to satisfy the numerator:

- Childhood Immunization Status.
- Immunizations for Adolescents.
- Well-Child Visits in the First 30 Months of Life.

For only the measures listed above, the organization may use a single data source or a combination of administrative data, which may include audited supplemental data, and medical record data to determine numerator compliance for members in the denominator. To avoid double counting events, when only assessing administrative data or when combining administrative and medical record data, all events must be at least 14 days apart.

For example, the organization may count two influenza vaccines identified through administrative data if the dates of service are at least 14 days apart; if the service date for the first vaccine was February 1, then the service date for the second vaccine must be on or after February 15. When combining administrative and medical record data, the dates of service must also be at least 14 days apart in order to count toward numerator compliance.

If the organization has one event from the medical record and one from administrative data and dates are less than 14 days apart (or the organization cannot determine if the dates are at least 14 days apart), it must use only the medical record event. The 14-day threshold does not apply when using only medical record data. For example, the organization may count two influenza vaccines identified through medical record data that are not 14 days apart.

27. Measures That Use Medication Lists

Some measures require the use of clinical pharmacy data or pharmacy claims data to identify dispensed medications. The specifications reference medication lists that must be used for HEDIS for QRS reporting for each pharmacy-dependent measure in the specifications, medication list references are underlined (e.g., Antidepressant Medications List). Medication lists used for HEDIS for QRS reporting are included in the Medication List Directory. A medication list includes the National Drug Codes (NDC) and RxNorm codes that may be used for reporting along with the generic name, the brand name (if applicable), the strength/dose and the route for each code.

If an organization uses both pharmacy data (NDC codes) and clinical data (RxNorm codes) for reporting, to avoid double counting, if there are both NDC codes and RxNorm codes on the same date of service, use only one data source for that date of service (use only NDC codes *or* only RxNorm codes) for reporting.

Note: *RxNorm codes may not be used to assess the numerator in the Asthma Medication Ratio measure.*

28. Identifying Events/Diagnoses Using Laboratory or Pharmacy Data

Many organizations find a high rate of false positives when they use laboratory data to identify members with a disease or condition. Diagnosis codes are frequently reported on laboratory tests in cases where the condition is being ruled out. Use laboratory claims and data only for the Drug Test Value Set, INR Test Value Set, Pregnancy Tests Value Set, Sexual Activity Value Set (which do not contain LOINC codes) and value sets that contain LOINC codes.

Claims data indicating a member had a laboratory test during a visit with a provider are not considered laboratory data. Laboratory data are claims or lab result data for the sole purpose of a laboratory test performed outside of a visit with a provider. Claims with a code from the Independent Laboratory Value Set are considered laboratory claims. Organizations may need to use other methods to differentiate between laboratory claims data and clinical/provider claims that may include a laboratory test.

Diagnosis codes on pharmacy claims may not be used.

29. Member-Collected Samples

Test results from member-collected samples may be used for FOBT, urinalysis testing, blood spots for HbA1c or LDL-C. Member-collected samples must be sent to the laboratory or provider's office for analysis.30. Member-Reported Services and Biometric Values

Member-reported services and biometric values (height, weight, BMI percentile) are acceptable only if the information is collected by a primary care practitioner (refer to Appendix 1 for the definition of "PCP") or specialist, if the specialist is providing a primary care service related to the condition being assessed, while taking a patient's history. The information must be recorded, dated and maintained in the member's legal health record.

HEDIS Coding Conventions

31. Coding Systems Included in HEDIS Reporting

HEDIS measures include codes from the following coding systems:

- CMS Place of Service (POS).
- Current Procedural Terminology (CPT).
- CVX—Vaccines Administered.
- Healthcare Common Procedure Coding System (HCPCS) Level II.
- International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM).
- International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM).
- International Classification of Diseases, 10th Revision, Procedure Coding System (ICD-10-PCS).
- Logical Observation Identifiers Names and Codes (LOINC).
- Systematized Nomenclature of Medicine—Clinical Terms (SNOMED CT).
- Uniform Bill (UB) revenue and Type of Bill (TOB).

32. Presentation of Codes in HEDIS for QRS

HEDIS for QRS measure specifications reference value sets and single codes (referred to as "direct reference" codes) that must be used for HEDIS for QRS reporting.

Value sets	A value set contains one or more codes that meet criteria for a service or condition. In the specifications, value set references are capitalized and underlined (e.g., Essential Hypertension Value Set). Organizations refer to the Value Set Directory (VSD) for codes in the value sets.
Direct reference codes	A direct reference code is a single code that meets criteria for a service or condition. Direct reference codes are listed in the measure specification and are also included in the Direct Reference Codes spreadsheet of the VSD (as are direct reference codes used for measures reported using ECDS). ***Note:*** *Value sets that contain only one code will be phased out (and turned into direct reference codes) as measures are digitalized.*

Refer to *ECDS Guideline 7* in the *Guidelines for Measures Reported Using Electronic Clinical Data Systems* for information on how codes are presented for measures reported using ECDS.

33. Telehealth

Synchronous telehealth visits, telephone visits and asynchronous telehealth (e-visits, virtual check-ins) are considered separate modalities for HEDIS reporting.

Synchronous telehealth requires real-time interactive audio and video telecommunications. A measure specification that is silent about telehealth includes synchronous telehealth. This is because telehealth is billed using standard CPT and HCPCS codes for professional services in conjunction with a telehealth modifier and/or a telehealth POS code. Therefore, the CPT or HCPCS code in the value set will meet criteria (regardless of whether a telehealth modifier or POS code is present). A measure specification will indicate when synchronous telehealth is not eligible for use and should be excluded.

A measure will indicate when telephone visits are eligible for use by referencing the Telephone Visits Value Set.

Asynchronous telehealth, sometimes referred to as an e-visit or virtual check-in, is not "real-time" but still requires two-way interaction between the member and provider. For example, asynchronous telehealth can occur using a patient portal, secure text messaging or email. A measure will indicate when asynchronous telehealth visits are eligible for use by referencing the Online Assessments Value Set.

34. Using Claims to Identify Events in Conjunction With Diagnoses or other Events

Many measures' administrative specifications require that a visit code or procedure code be used in conjunction with a diagnosis code.

Except for inpatient stays (as described below) and unless noted otherwise in a measure specification, when a measure requires a code be in conjunction with another code the codes must be from the same visit. The organization develops a method for identifying claims from the same visit (e.g., the same outpatient visit, the same inpatient stay). The method is subject to review by the HEDIS auditor.

Identifying acute or nonacute inpatient stays is a two-step process. The first step uses the Inpatient Stay Value Set to identify all acute and nonacute inpatient stays. The second step uses the Nonacute Inpatient Stay Value Set to identify stays that were nonacute. When identifying nonacute codes in step 2, the nonacute code must be on the same claim that was identified in step 1. In addition, any required diagnosis or procedure must be on the same claim.

35. Visits that Result in an Inpatient Stay

Some measures require exclusion of visits that result in an inpatient stay or observation stay.

A visit results in a stay when the visit date of service occurs on the day prior to the admission date or any time during the admission (admission date through discharge date).

36. Principal vs. Secondary Diagnosis

Principal and secondary diagnoses are mentioned throughout HEDIS for QRS. Generally, a **principal diagnosis** (or **primary diagnosis**) is the diagnosis given at discharge and the one listed first on a claim form. A diagnosis listed on a claim or encounter form that is not classified as the principal diagnosis is a **secondary diagnosis**. A claim form can contain several secondary diagnoses. Organizations follow the measure specifications to determine whether a diagnosis must be principal or can be secondary. If the specification does not specify that the principal diagnosis must be used, any applicable diagnosis is used.

Some measures require a specific principal diagnosis for eligibility; other measures allow any diagnosis (principal or secondary). For example, the *Comprehensive Diabetes Care* measure specifies that any diagnosis of diabetes is eligible. If a member's claim lists the principal diagnosis as "severe cough," but diabetes is listed as a secondary diagnosis on the same claim form, the member is included in the *Comprehensive Diabetes Care* measure.

The concept of "principal" and "secondary" diagnoses is unique to claims data. Supplemental data (such as EHR data) may not include this concept. Therefore, when using supplemental data to identify a "principal" or "primary" diagnosis, use any diagnosis.

37. Code Modifiers

Modifiers are two-digit extensions that, when added to CPT or HCPCS codes, provide additional information about a service or procedure.

Exclude any CPT Category II code in conjunction with a 1P, 2P, 3P or 8P modifier code (CPT CAT II Modifier Value Set) from HEDIS for QRS reporting. These modifiers indicate the service *did not occur.* In the HEDIS for QRS Value Set Directory, CPT Category II codes are identified in the Code System column as "CPT-CAT-II."

Unless otherwise specified, if a CPT or HCPCS code specified in HEDIS for QRS appears in the organization's database with any modifier other than those specified above, the code may be counted in the HEDIS for QRS measure.

38. SNOMED Codes

When using SNOMED codes to identify "history of" procedures, the date of the procedure must be available (do not use *the date when the provider documented the procedure* as the date of the procedure).

39. Uniform Bill Code Specificity

Uniform Bill (UB) codes, primarily type of bill and revenue codes, are used to identify services.

The HEDIS for QRS Value Set Directory specifies UB type of bill codes using four digits. The organization may also use the equivalent three-digit version of the code (which consists of the four-digit code without the leading zero); for example, to identify skilled nursing facility (SNF) encounters, use either 21x or 021x.

Note: *The three-digit versions of the codes are not included in the HEDIS for QRS Value Set Directory.*

40. Mapping Proprietary or Other Codes

Organizations may only map the following codes for use in HEDIS reporting:

- *State-specific codes.* The organization must provide the auditor with evidence that the codes are required by the state.
- *NDC codes.* An NDC code that is not in the HEDIS MLD can only be mapped if its generic name (or brand name), strength/dose and route match those of a code in the MLD. NDC codes that identify immunizations can be mapped to codes in value sets that identify immunizations.
- *RxNorm codes*. An RxNorm code that is not in the HEDIS MLD can only be mapped if its generic name (or brand name), strength/dose and route match those of a code in the MLD.

For audit purposes, the organization documents the method used to map codes. At a minimum, documentation includes a crosswalk containing the relevant codes, descriptions and clinical information.

The organization documents the process for implementing codes. Auditors may request additional information.

41. Retiring Codes

NCQA annually tracks codes that are designated obsolete. NCQA does not remove codes in the year in which they receive the designation of obsolete because of the look-back period in many HEDIS for QRS measures. Obsolete codes are deleted from the HEDIS for QRS specifications one year after the look-back period is exhausted.

For example, since the Asthma Medication Ratio measure counts a principal diagnosis of asthma in the measurement year or the year prior to the measurement year, asthma codes, for this measure, have a 2-year look-back period. A code that is designated obsolete effective January 1, 2021, is deleted from the specifications in HEDIS MY 2023 after the 2-year look-back period (2022, 2023) plus one additional year (2021) is exhausted.

HEDIS Specification Tables

42. Table Names

Measure specifications contain two types of tables: one to present medication lists and one used by organizations to submit data. Tables use a standardized naming system.

Medication tables Medication tables are labeled with the corresponding medication list name found in the Medication List Directory.

Reporting tables Data element tables begin with the measure's three-character abbreviation. Each product line is assigned a number; for example:

- SPC-4 (Exchange).

If more than one table will be reported for a product line, the table is assigned an uppercase letter. For example, the tables for the Colorectal Cancer Screening measure are COL-A-4, COL-B-4 and COL-C-4.

43. Reporting Tables

The reporting tables in the measure specifications outline the data elements required for reporting. Refer to *Appendix 2: Data Element Definitions* for additional information.

Format The reporting tables in the measure specifications follow a standard format corresponding to the structure of the IDSS submission XML file:

- *Metric*: For single-metric measures, the metric describes the subject of the measure. For multi-metric measures, the metrics describe the various concepts evaluated in the measure (e.g., Screening, Follow-up, Influenza, Tdap). For wide tables, the metric column may be shown above the table.
- *Stratification*: Only applies to measures that include one or more stratifications (e.g., age, gender). For measures with multiple stratifications, the reporting instructions apply for all stratification combinations.
- *Data Element*: The data elements required for reporting (depending on data collection method).
- *Reporting Instructions*: These instructions specify how the data elements must be reported (e.g., for each metric, repeat per metric), or the units or formula for IDSS calculated data elements.
- *A*: This column is used in hybrid measures to indicate which data elements are required for reporting for the Administrative Method. For the Hybrid Method, all data elements must be reported, unless otherwise specified in the measure specifications.

  For administrative-only measures, all data elements must be reported.

Example Data Elements for Reporting Table

Metric	Stratification1	Stratification2	Data Element	Reporting Instructions	A
Metric1	Level1	Level1	DataElement1	Instruction1	✓
Metric2	Level2	Level2	DataElement2	Instruction2	✓
	Total	Level3	DataElement3	Instruction3	
		Total	DataElement4	Instruction4	
			DataElement5	Instruction5	✓
			DataElement6	Instruction6	
			Rate	Calculation / (Units)	✓

HEDIS for QRS measures consist of one-to-many indicators for reporting. Each indicator corresponds to a unique combination of a metric and any stratifications (if applicable). For example, a measure with 2 metrics; 3 age stratifications and a total; and 2 gender stratifications and a total consists of 24 indicators.

Example:

# of indicators = # of metrics X (# of stratifications 1 + total) X
(# of stratifications 2 + total)

Shading

Cells in the data element tables are shaded according to how data are reported:

- *No shading*: Data are reported by the organization.
- *Light gray shading*: Data are calculated by IDSS.
- *Solid black shading*: Data are not used or reported.

Reported by the organization
Calculated by IDSS
Data not used

Guidelines for Calculations and Sampling

Guidelines for Calculations and Sampling

This section contains guidelines for calculating rates based on the Administrative and Hybrid Methods, as well as specifications for sampling when using the Hybrid Method. Organizations that use the Hybrid Method must follow the systematic sampling methodology described in this section or receive written authorization from NCQA for an alternative sort or sampling method; written authorization from NCQA is required annually. Proper use and implementation of these methods is assessed as part of NCQA's HEDIS Compliance Audit.

SUMMARY OF CHANGES TO MY 2023 HEDIS FOR QRS

- Updated Table 1: Sample Size Information for Hybrid Measures and guidance for reducing sample sizes for measures with multiple stratifications.
- Updated the HEDIS MY 2023 RAND Table for Measures Using the Hybrid Method.
- Removed references to "optional exclusions," including the three approaches to using optional exclusions in data collection.

How to Use the Administrative Method

Step 1 Identify the eligible population and remove all required exclusions. All required exclusions must be removed from the final eligible population.

Step 2 Search administrative systems to identify numerator events for all members in the eligible population.

Step 3 Calculate the rate.

Guidelines for the Hybrid Method

A subset of the HEDIS for QRS measures specify Hybrid Method data collection. Organizations must apply the hybrid methodology and sample at the product level.

Measures that can be collected using the Hybrid Method are listed in Table 1. Each hybrid measure can be classified into one of the following categories:

- *Membership-dependent denominator*—Defined by membership data only (e.g., women between 24 and 64 years of age, for Cervical Cancer Screening), ***or***
- *Claim-dependent denominator*—Defined by membership and claims data (e.g., members diagnosed with hypertension, for Controlling High Blood Pressure).

Drawing the sample prior to the reporting year

Organizations are strongly encouraged to draw samples no earlier than January 2024 for the 2023 measurement year. This increases the accuracy and completeness of the eligible population from which the sample is drawn.

Organizations must adhere to the following guidelines if samples are drawn prior to these dates.

Membership-dependent denominators

The eligible population for the following measures is determined through membership data. Do not draw the sample prior to December 1 of the measurement year.

- Childhood Immunization Status.
- Immunizations for Adolescents.

- Cervical Cancer Screening.
- Colorectal Cancer Screening.

An organization that draws its sample on or between December 1 and 31 of the measurement year must perform the following tasks:

- Oversample to account for individuals included in the sample who were found to be noncompliant with the denominator criteria, subsequent to December 31 of the measurement year.
- On or after December 31 of the measurement year, verify that members included in the sample remain eligible for the particular measure. Another record must be substituted for a member who does not meet all the denominator criteria.
  - For example, for the Childhood Immunization Status measure, on December 5 of the measurement year, an organization draws a sample of children who turn 2 years of age during the measurement year. On or after December 31 of the measurement year, the organization must ensure that all members included in the sample remain eligible for the measure (i.e., meet the continuous enrollment criteria, are members of the organization as of their second birthday).
  - Any ineligible member (i.e., does not meet one or more denominator criterion) must be excluded and replaced by an eligible member from the oversample group.

Claim-dependent denominators

The eligible population for the following measures is determined through membership data and claims data. Organizations may draw the sample for these measures as early as December 1 of the measurement year. If an organization draws the sample on or between December 1 and December 31 of the measurement year, it must perform the tasks included in the *Membership-dependent denominators* section above (i.e., oversample as necessary and verify that members remain eligible on or after December 31 of the measurement year).

- Weight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents.
- Controlling High Blood Pressure.
- Hemoglobin A1c Control for Patients With Diabetes.
- Eye Exam for Patients With Diabetes.
- Prenatal and Postpartum Care.

Determining the required sample size

Using the Hybrid Method to collect and report a measure requires a sample to be drawn from the eligible population. Use Table 1 to determine the appropriate sample size for measures. For hybrid measures reported in the prior year, use the last column of Table 1 to determine whether the prior year's audited result can be used to reduce the current year's sample size.

Use Table 2 if the prior year's rate is used to determine the current year's sample. The organization may also use the product line-specific rate derived from administrative data for the current measurement year and Table 2 to reduce the required sample size. The required sample size decreases as the organization's rate improves; for example, the organization calculates a 77% administrative rate for the commercial product line for a new measure and decides to implement the Hybrid Method.

Instead of using a sample size of 411, the organization reduces the sample size for this measure for its Exchange product line by using the 77% administrative rate and

Table 2. According to Table 2, the minimum required sample size is 296. The sample size can be reduced even when the original eligible member (EM) population is less than 411.

Organization responsibility for chart review

An organization that uses the Hybrid Method for a measure should attempt to pursue charts for all noncompliant members in the systematic sample, to preserve the integrity of the sample and its representative rate. Chart pursuit is recommended but is determined by the organization.

After the systematic sample is generated and chart pursuit has started, the sample may be reduced on rare occasions, such as after a natural disaster. Removing uninvestigated members from the sample in this situation is an alternative sampling method, and the organization must submit a request for approval to PCS via My NCQA (https://my.ncqa.org) that includes the reason for not completing chart review, and the auditor's approval showing that the members to be removed are distributed systematically across the larger sample and the hybrid results from the reduced sample are reportable.

Statistical assumptions for sample size

Sample size is calculated assuming a two-tailed test of significance between two proportions (α = .05, 80% power, two-tailed test of significance). A normal approximation to the binomial with a continuity correction was employed in the sample size calculation. The worst-case assumption of a 50% expected value was assumed.

The detectable difference for most measures is 10 percentage points. This was chosen because it is a big enough difference to be actionable, it is not a burden for data collection and it is not so small as to be "swamped" by nonsampling error.

Table 1: Sample Size Information for Hybrid Measures

HEDIS for QRS Measure	Sample Size	Prior Year's Rate May Be Used to Reduce MY 2023 Sample Size[1]
Cervical Cancer Screening	411	Y[4]
Childhood Immunization Status	411	Y[2,4]
Colorectal Cancer Screening	411	Y[4]
Controlling High Blood Pressure	411	Y
Eye Exam for Patients With Diabetes	411	Y
Hemoglobin A1c Control for Patients With Diabetes	411	Y[3,4]
Immunizations for Adolescents	411	Y[2,4]
Prenatal and Postpartum Care	411	Y[2.4]
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents	411	Y[2.4]

[1] Refer to *Table 2: Sample Sizes When Data Are Available on Being Measured* in this section to determine the minimum required sample size.

[2] If reducing the sample size based on the current year's administrative rate or the prior year's product line-specific rate for this measure, the lowest rate from all the indicators must be used.

[3] If the same sample is used for the two diabetes measures, the organization must first take the inverse of the HbA1c Poor Control >9.0% rate (100 minus the HbA1c Poor Control rate) and then reduce using the lowest rate among all the reported indicators of the two diabetes measures (the HbA1c Control [<8.0%], HbA1c Poor Control [>9.0%] indicators of the HBD and

EED measures). If separate samples are used for these measures, the organization 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.

[4] For measures with stratifications, use the total rate when reducing the sample size. For measures with multiple indicators and stratifications, use the lowest total rate across indicators when reducing the sample size.

*Organizations may only use the current year's administrative rate when reducing the sample size.

Organizations may use a rate calculated from the current year's administrative rate or the prior year's reported rate to determine the sample size. Table 1 must be used first to determine if a prior year's rate can be used to reduce the sample size for a particular measure.

Table 2: Sample Sizes When Data Are Available Being Measured

If the Current Year's Administrative Rate or the Prior Year's Reported Rate Is…	…the Minimum Sample Size Is:	If the Current Year's Administrative Rate or the Prior Year's Reported Rate Is…	…the Minimum Sample Size Is:
≤51%	411	74%	321
52%	410	75%	313
53%	410	76%	305
54%	409	77%	296
55%	407	78%	288
56%	405	79%	279
57%	403	80%	270
58%	401	81%	260
59%	398	82%	250
60%	395	83%	240
61%	392	84%	229
62%	388	85%	219
63%	384	86%	207
64%	380	87%	196
65%	376	88%	184
66%	371	89%	172
67%	366	90%	159
68%	360	91%	147
69%	354	92%	134
70%	348	93%	120
71%	342	94%	106
72%	335	≥95%	100
73%	328		

Note:

- *Table 2 reflects the MRSS. When reducing, an organization's sample size may be between the allowed minimum sample size in Table 2 and 411.*
- *Truncate the decimal portion of the rate to obtain a whole number.*

Systematic Sampling Methodology

NCQA implemented a systematic sampling methodology for the Hybrid Method. Proper use and implementation of this method ensures ongoing integrity of collected data and supports increasing requests for audited data. Complete the following steps for each hybrid measure.

Step 1 Determine the EM population. Develop a list of EMs, including full name (last, first), date of birth and event (if applicable).

Step 2 Determine the MRSS from Table 1 or Table 2. This number becomes the denominator for the measure. Use either Table 1 or Table 2, as appropriate, to determine the MRSS. (Refer to *Determining the required sample size* for instructions.) If the EM is ≤MRSS, proceed to step 4.

To use a larger MRSS, an organization must provide written rationale to NCQA through PCS via My NCQA (https://my.ncqa.org).

Step 3 Determine the oversample. The oversample should be an adequate number of additional records to make substitutions. Oversample only enough to guarantee that the MRSS is met; keep substitution criteria in mind.

Written approval from NCQA must be obtained to use an oversampling rate larger than 20%. Refer to *Oversample requests to NCQA* for details.

The oversample records should be used, and reported, only to replace cases taken out of the MRSS because of valid data errors, false positives and so on; otherwise, these records should not be reported on in the final denominator.

Step 4 If EM ≤MRSS, all eligible members are included in the sample. The MRSS must be reported as the EM or less than the EM if sample size reduction is applied.

If EM >MRSS + all oversample records, go to step 5.

If MRSS <EM ≤MRSS + all oversample records, proceed to step 8.

Step 5 Sort the list of EMs in alphabetical order (by applicable measurement year) by last name, first name, date of birth and event (if applicable).

Sort EMs from A to Z in even measurement years and from Z to A in odd measurement years.

For example, for MY 2023 HEDIS for QRS, sort the list of EMs from Z to A.

Note: *Sort order applies to all components. For HEDIS MY 2023, sort all fields by descending order (last name descending, first name descending, date of birth descending, event descending).*

Step 6 Calculate N = EM/(MRSS + all oversample records). Round *down* to a whole number.

Determine N, which is used in the formula to determine which member will start your sample. N is calculated using the equation:

$$N = EM/(MRSS + \text{all oversample records})$$

where EM = the eligible member population (step 1) and MRSS = the minimum required sample size (step 2).

Step 7 Calculate START = (RAND × N). Before choosing members, determine the member to start with (START). It is important that the sample be selected from a single pass through the member list. START can have many values and still allow only one pass.

Use the Random Number (RAND) table for the appropriate measurement year that lists a value between 0 and 1 for each measure where the Hybrid Method is applicable. Refer to this table to

determine the RAND to be used when determining START. The RAND for each measure is used to calculate the starting point from which to draw the final sample.

Calculate the number from which to start drawing the final sample as follows:

START = (RAND x N)

(round per the .5 rule to the nearest whole number greater than 0), where
RAND = the random number for each respective measure identified in the RAND table.

Step 8 Select the sample, choosing every i^{th} member using the formula:

i^{th} member = START + [(i-1) x (EM/MRSS + all oversample records)],

(rounding [(i-1) x EM/ (MRSS + all oversample records)] per the .5 rule to the nearest whole number greater than 0).

For i = 2,3,4, …, MRSS where EM = the eligible member population (step 1). MRSS = the minimum required sample size (step 2).

Starting with the member corresponding to the number START, choose every i^{th} member until the MRSS is met. This becomes the primary list of sampled members.

Continue choosing every i^{th} member until the oversample is met. This set of members becomes the oversample. The oversample records should be used and reported only to replace cases taken out of the MRSS because of valid data errors, false positives, and so on, otherwise, these records should not be reported in the final denominator.

Note: *From step 4, if MRSS < EM ≤ MRSS + all oversample records, sort the EMs in alphabetical order (by applicable measurement year) by last name, first name, date of birth and event (if applicable). Choose the first MRSS EMs as the primary sample and the remaining EMs as the oversample.*

The oversample list is only used to replace exclusions. All exclusions must be documented because they may be subject to audit.

Oversample requests to NCQA

Any oversampling rate larger than 20% must be approved by NCQA annually. Organizations submit a formal request with the rationale to NCQA through PCS via My NCQA (https://my.ncqa.org).

NCQA provides written notification of approval or disapproval within 7 business days. The organization must maintain the documentation for the HEDIS Compliance Audit.

Oversampling methodology

For hybrid measures, the starting sample size must be higher than the designated sample size because medical records must be substituted if a member is ineligible for the measure; for example, if a member was incorrectly identified as a diabetic through administrative data or meets exclusion criteria for the measure.

To adjust for this, divide the sample size by the percentage of charts expected to be inappropriate for review. Suppose 10% of charts are expected to be inappropriate for the measure.
To determine the oversample, multiply the MRSS by the oversample percentage and round up to the nearest whole number

$411 \times 0.10 = 41.1$
(rounded up to 42 = oversample).

The recommended methodology for substitution is:

- Replace the member's chart with that of the first member in the oversample list.
- Continue replacing each ineligible member with the next consecutive member of the oversample list.

If the initial oversample was underestimated and all oversample members have been exhausted without satisfying the MRSS, the organization must contact NCQA through PCS via My NCQA (https://my.ncqa.org) to determine next steps.

Organizations must only use the oversample for substitution and must report all measures using their MRSS.

Note: *Many factors must be considered when determining the initial sample size and oversampling percentage—such as previous years' data, frequency of exclusions and claims lag.*

HEDIS MY 2023 RAND Table for Measures Using the Hybrid Method

Measure	RAND
Cervical Cancer Screening	.25
Childhood Immunization Status	.27
Colorectal Cancer Screening	.35
Controlling High Blood Pressure	.39
Hemoglobin A1c Control for Patients With Diabetes *and* Eye Exam for Patients With Diabetes	.95*
Immunizations for Adolescents	.85
Prenatal and Postpartum Care	.47
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents	.68

*The RANDs for these measures are the same. Organizations may choose to use the same sample for the two measures. If organizations use different samples for these measures, a different MRSS is used in the sampling protocol.

Example 1

The eligible population for the Exchange product line for Immunizations for Adolescents is 9,000. Reduce the minimum required sample size using the Exchange rate from the prior year's HEDIS for QRS submission, which was 77%. Based on experience, estimate a 5% oversample rate. Follow the systematic sampling scheme.

Step 1 EM = 9,000.

Step 2 From Table 2, the MRSS is 296.

Step 3 Oversample = 296 × .05 = 14.8 (the next whole number *above* is 15, so the oversample = 15).

Step 4 Because 9,000 > 296 (MRSS) and 311 (296 + oversample) go to step 5.

Step 5 Sort the list alphabetically and in this order: last name, first name, date of birth.

Step 6 N = 9,000/311 (MRSS + oversample) = 28.

Step 7 For this example, assume that RAND = 0.66, so START = 0.66 x 28 = 18.48.
Rounding using the .5 rule, START = 18.
The 18th sorted member is chosen *first.*

The 2nd member chosen is the 18 + [(2-1) x (9,000/311)] = 18 + 29 = 47th sorted member, after rounding the term [(2-1) x (9,000/311)] to 29, using the .5 rule.

The 3rd member chosen is the 18 + [(3-1) x (9,000/311)] = 18 + 58 = 76th sorted member.

The 296th member (the last one in the primary list) is the 18 + [(296-1) x (9,000/311)] = 18 + 8,537 = 8,555th sorted member.

The last member in the oversample* is the 18 + [(311-1) x (9,000/311)] = 18 + 8,971 = 8,989th sorted member.

**Remember, members in the oversample are used only to replace members excluded from the sample.*

Example 2

The eligible member population for Colorectal Cancer Screening is 389. This measure was not collected last year, nor will the administrative rate from this year be used to reduce the sample size. Follow the systematic sampling methodology.

Step 1 EM = 389.

Step 2 From Table 1, the MRSS is 411. Since 389 <411, skip to step 4.

Step 3 *Skip this step.*

Step 4 Include all 389 members in your primary list.

Example 3

The eligible member population for Childhood Immunization Status is 436. The sample size will not be adjusted using this year's administrative rate. Based on experience with this population, about 10% of the members from the primary sample will have to be excluded. Follow the systematic sampling methodology.

Step 1 EM = 436.

Step 2 From Table 1, the MRSS is 411.

Step 3 Oversample = 411 × .10 = 41.1 (the next whole number *above* is 42, so oversample =42).

Step 4 Because 411 <436 ≤ (411 + 42), skip to step 8.

Step 5 *Skip this step.*

Step 6 *Skip this step.*

Step 7 *Skip this step.*

Step 8 Sort the list and choose the first 411 as the primary list. The remaining 25 members become the oversample list*.

**Remember, members in the oversample are used only to replace members excluded from the sample.*

Example 4

The EM population for Cervical Cancer Screening is 400. Reduce the minimum required sample size using the rate from the prior year's HEDIS submission, which was 62%. Based on experience, estimate a 5% oversample rate. Follow the systematic sampling methodology.

Step 1 EM = 400.

Step 2 From Table 2, the MRSS is 388.

Step 3 Oversample = 388 × .05 = 19.4 (the next whole number *above* is 20, so oversample = 20).

Step 4 Because 388 < 400 ≤ (388 + 20), skip to step 8.

Step 5 *Skip this step.*

Step 6 *Skip this step.*

Step 7 *Skip this step.*

Step 8 Sort the list and choose the first 388 as the primary list. The remaining 12 members become the oversample list*.

**Remember, members in the oversample are used only to replace members excluded from the sample.*

Complex Probability Sampling

Organization responsibility

Properly applied, other techniques (e.g., stratified sampling, cluster sampling and other complex probability approaches) can improve precision and increase sampling efficiency. To use a probability sampling approach different from the one specified, submit a written rationale and documentation of the approach to NCQA through PCS via My NCQA (https://my.ncqa.org). The organization must demonstrate that the sampling approach is auditable and does not introduce bias against specific members. A committee of statisticians and health policy experts staffed by NCQA reviews the approach. Written notification of NCQA approval or disapproval is provided within 10 business days.

If complex sampling methods are used, report the estimated rate, in addition to any information required to perform a valid test of significance between that rate and another organization's rate.

Report the sample size (if different from the HEDIS for QRS recommendation) and document the method used in the calculation (including software used, if applicable). Consult a statistician before implementing a complex sampling methodology.

Substituting Medical Records

Acceptable circumstances for substitution:

Organizations must specify the number of substituted records. Members who are noncompliant because they refused the service or because the organization cannot access their chart may not be substituted. Unless otherwise noted in the specifications for a particular measure, members or events may not be dropped from the sample or substituted, except under the three circumstances described below.

1. Errors in sampling data

Chart review reveals that a member or event does not meet the eligibility criteria for inclusion in the sample. Data errors can be caused by incorrect member or clinical information. Examples of valid data errors:

- A member selected for the Childhood Immunization Status sample is found to be 22 years old.
- A member in the Eye Exam for Patients With Diabetes sample has a diagnosis in the chart showing that a prescription for oral hypoglycemics was not related to diabetes.
- A member in the sample for any measure has a notation entered by the deadline established for the measure, explaining the reason for the erroneous inclusion and stating the member does not have the condition.

The medical record must have evidence that a member does not meet the criteria for the measure. A chart that does not contain a notation that substantiates or refutes the diagnosis is not evidence that the member does not have the condition being measured.

Members may also be identified as valid data errors if administrative data refresh finds they meet exclusion criteria. Report these members as valid data errors.

2. Employee/ dependent was selected for the sample

An employee of the organization or the vendor, or the employee's dependent, was selected for the sample, and the medical record must be reviewed to determine compliance with the measure. The organization or vendor may exclude employees and their dependents in this situation *only*. Employee and employee dependents are not excluded from administrative reporting and should not be removed before the sample is drawn.

References

Deming, W.E. On the interpretation of censuses as samples. 1941. *Journal of the American Statistical Association.* 36: 45–9.

Fleiss, L. *Statistical Methods for Rates and Proportions.* 2nd Ed. (New York: John Wiley & Sons, Inc.): 38–42.

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Guidelines for HEDIS Effectiveness of Care Measures

Guidelines for HEDIS Effectiveness of Care Measures

SUMMARY OF CHANGES TO MY 2023 HEDIS FOR QRS

- Removed references to optional exclusions.

HEDIS FOR QRS SPECIFIC GUIDANCE

These guidelines apply to the following measures:

- Antidepressant Medication Management (AMM).
- Appropriate Testing for Pharyngitis (CWP)*.
- Appropriate Treatment for Upper Respiratory Infection (URI).
- Asthma Medication Ratio (AMR).
- Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (AAB).
- Cervical Cancer Screening (CCS).
- Child and Adolescent Well-Care Visits (WCV).
- Childhood Immunization Status (CIS).
- Chlamydia Screening in Women (CHL).
- Colorectal Cancer Screening (COL).
- Controlling High Blood Pressure (CBP).
- Eye Exam for Patients With Diabetes (EED).
- Follow-Up After Hospitalization for Mental Illness (FUH).
- Hemoglobin A1c Control for Patients With Diabetes (HBD)**.
- Immunizations for Adolescents (IMA).
- Kidney Health Evaluation for Patients With Diabetes (KED).
- Medical Assistance with Smoking and Tobacco Use Cessation (MSC).
- Oral Evaluation, Dental Services (OED).
- Use of Imaging Studies for Low Back Pain (LBP).
- Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC).
- Well-Child Visits in the First 30 Months of Life (W30).

*In the Draft 2023 Call Letter, CMS proposed to remove Appropriate Testing for Pharyngitis (CWP) beginning with the 2024 ratings year to align with CMS's priorities of reducing burden and including measures most valuable to the Exchange population. The CWP measure specification is included in this version of the Technical Specifications for reference. Refer to the Final 2023 Call Letter and the 2024 *QRS and QHP Enrollee Survey Technical Guidance* for reporting this measure.

**In the Draft 2023 Call Letter, CMS proposed to transition Hemoglobin A1c (HbA1c) Control for Patients With Diabetes: HbA1c Control (<8.0%) to the HbA1c Control for Patients With Diabetes: HbA1c Poor Control (>9.0%) measure. If the measure is finalized for inclusion in the QRS measure set, CMS will begin collecting it for the 2024 ratings year, with scoring beginning with the 2025 ratings year. The HbA1c Control and HbA1c Poor Control measure specifications are included in this version of the Technical Specifications for reference. Refer to the Final 2023 Call Letter and the *2024 QRS and QHP Enrollee Survey Technical Guidance* for reporting this measure.

Guidelines

Which services count?

Unless otherwise specified in a measure, report all services for the Effectiveness of Care (EOC) measures, whether or not the organization paid for them. For example, report services paid for by a third party, such as a community center, or services for which payment was denied because they were not properly authorized.

The organization must include all paid, suspended, pending and denied claims, and is ultimately responsible for the quality of care it provides to members.

Organizations may choose to include reversed claims when reporting services. If an organization includes reversals, it must include these claims in all measures and avoid double counting services (e.g., if a subsequent claim is filed, use only the corrected or adjudicated claim).

Note:

Denied claims are not included when identifying numerator events, but must be used to determine the eligible population (if applicable) for the following measures:

- *Appropriate Treatment for Upper Respiratory Infection.*
- *Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis.*
- *Use of Imaging Studies for Low Back Pain.*

Organizations must include all claims (paid, suspended, pending and denied) for required exclusions in all the measures listed above.

Measure format

There are 9 possible sections in each measure specification in this domain:

1. Summary of Changes.
2. Description.
3. Calculation.
4. Definitions.
5. Eligible Population.
6. Administrative Specification.
7. Hybrid Specification.
8. Notes.
9. Data Elements for Reporting.

Eligible population criteria

The **eligible population** includes all members who meet the following seven criteria:

1. **Product line** (Exchange) applicable to the measure.
2. **Age** group and gender requirements.
3. **Continuous enrollment** criteria for the measure.
4. **Allowable gap** in benefits during the continuous enrollment period.
5. **Anchor date** specifies the required enrollment date for the eligible population (e.g., children must be enrolled in the organization on their second birthday for inclusion in the Childhood Immunization Status measure).
6. **Benefit** a member must have during the continuous enrollment period to be included in the eligible population (e.g., members must have both medical and pharmacy benefits for inclusion in the Antidepressant Medication Management measure).

7. **Event/diagnosis** specifies the medical event or diagnosis requirements for the eligible population.

Administrative Specification

The **Administrative Specification** outlines the collection and calculation of a measure using only administrative data and describes the eligible population, the numerator requirements allowed for the measure.

Hybrid Specification

The **Hybrid Specification** includes sampling requirements for the denominator population, medical record documentation requirements for the numerator allowed for the measure.

Guidelines for Access/Availability of Care Measures

Guidelines for Access/Availability of Care Measures

SUMMARY OF CHANGES TO MY 2023 HEDIS FOR QRS

- No changes to the guidelines.

HEDIS FOR QRS SPECIFIC GUIDANCE

These guidelines apply to the following measures:

- Initiation and Engagement of Substance Use Disorder Treatment (IET).
- Prenatal and Postpartum Care (PPC).

Continuous Enrollment

For some Access/Availability of Care measures, the eligible population includes individuals who were continuously enrolled for a specific period (e.g., during the measurement year). For these measures, follow the guidelines on continuous enrollment described in the *General Guidelines.*

Which Services Count?

Report all services for Access/Availability of Care measures, whether or not the organization paid for them (e.g., report services paid for by a third party such as a community center, or services for which payment was denied because they were not properly authorized). Include all paid, suspended, pending and denied claims.

Organizations are ultimately responsible for the quality of care they provide to members and for ensuring that certain services have been provided, even if another community practitioner provides the services.

To count services in the medical record, documentation in the medical record must indicate the date when the procedure was performed and the result or finding (when applicable).

Hybrid Methodology

Organizations that use the Hybrid Method for measures that include a hybrid specification must follow the guidelines pertaining to that method and substitution of medical records in the *Guidelines for Calculations and Sampling.*

Guidelines for Risk Adjusted Utilization Measures

Guidelines for Risk Adjusted Utilization Measures

SUMMARY OF CHANGES TO MY 2023 HEDIS FOR QRS

- No changes to these guidelines.

HEDIS FOR QRS SPECIFIC GUIDANCE

These guidelines apply to the following measure:

- Plan All-Cause Readmissions (PCR).

Guidelines

1. **Which services count?** Include all services, whether or not the organization paid for them or expects to pay for them (include denied claims) when applying risk adjustment in the Risk Adjusted Utilization measure (PCR). Do not include denied services (only include paid services and services expected to be paid) when identifying all other events (e.g., the IHS in the PCR measure).

   The organization may have:

   - Covered the full amount.
   - Paid only a portion of the amount (e.g., 80%).
   - Paid nothing because the member covered the entire amount to meet a deductible.
   - Paid nothing because the service was covered as part of a PMPM payment.
   - Denied the service.

   Count the service as paid or expected to be paid if:

   - The organization paid the full amount ***or*** a portion of the amount (e.g., 80%).
   - The member paid for the service as part of the benefit offering (e.g., to meet a deductible), ***or***
   - The service was covered under a PMPM payment.

   Count the service as denied if:

   - The organization denied the service for any reason, unless the member paid for the service as part of the benefit offering (e.g., to meet a deductible), ***or***
   - The claim for the service was rejected because it was missing information or was invalid for another reason.

2. **Risk adjustment.** Organizations may not use supplemental data sources when applying the risk adjustment methodology.

   Organizations may not use Risk Assessment Protocols to supplement diagnoses for calculation of the risk adjustment scores for this measure. The measurement model was developed and tested using only claims-based diagnoses and diagnoses from additional data sources would affect the validity of the models as they are current implemented in the specification.

3. **Counting transfers.** Unless otherwise specified in the measure, treat transfers *between* institutions as separate admissions. Base transfer reports *within* an institution on the type and level of services provided. Report separate admissions when the transfer is between acute and nonacute levels of service or between mental health/chemical dependency services and non-mental health/chemical dependency services.

Count only one admission when the transfer takes place within the same service category but to a different level of care; for example, from intensive care to a lesser level of care or from a lesser level of care to intensive care.

4. **Mental health and chemical dependency transfers.** Unless otherwise specified in the measure, count as a separate admission a transfer within the same institution but to a different level of care (e.g., a transfer between inpatient and residential care). Each level must appropriately include discharges and length of stay (count inpatient days under inpatient; count residential days under residential).

5. **Observation stays without an admission and/or discharge date.** For observation stays (Observation Stay Value Set) that do not have a recorded admission or discharge date, set the admission date to the earliest date of service on the claim and set the discharge date to the last date of service on the claim.

6. **Direct transfers.** A direct transfer is when the discharge date from the initial stay precedes the admission date to a subsequent stay by one calendar day or less. For example:
   - A discharge on June 1, followed by a subsequent admission on June 1, *is a direct transfer.*
   - A discharge on June 1, followed by a subsequent admission on June 2, *is a direct transfer.*
   - A discharge on June 1, followed by a subsequent admission on June 3, *is not a direct transfer;* these are two distinct stays.
   - A discharge on June 1, followed by a subsequent admission on June 2 (with discharge on June 3), followed by a subsequent admission on June 4, *is a direct transfer.*

   Direct transfers may occur from and between different facilities and/or different service levels. Refer to individual measure specifications for details.

Risk Adjustment Comorbidity Category Determination

Step 1 Identify all diagnoses for encounters during the classification period for each denominator unit of the measure. Include the following when identifying encounters:

- Outpatient visits (Outpatient Value Set).
- Telephone visits (Telephone Visits Value Set).
- Observation visits (Observation Value Set).
- ED visits (ED Value Set).
- Inpatient events:
  - Nonacute inpatient encounters (Nonacute Inpatient Value Set).
  - Acute inpatient encounters (Acute Inpatient Value Set).
  - Acute and nonacute inpatient discharges (Inpatient Stay Value Set).

Use the date of service for outpatient, observation and ED visits. Use the discharge date for inpatient events.

Exclude the principal discharge diagnosis on the IHS.

Step 2 Assign each diagnosis to a comorbid Clinical Condition (CC) category using Table CC—Mapping. If the code appears more than once in Table CC—Mapping, it is assigned to multiple CCs.

Exclude all diagnoses that cannot be assigned to a comorbid CC category. For members with no qualifying diagnoses from face-to-face encounters, skip to the *Risk Adjustment Weighting* section.

All digits must match exactly when mapping diagnosis codes to the comorbid CCs.

Step 3 Determine HCCs for each comorbid CC identified. Refer to Table HCC—Rank.

For each denominator unit's comorbid CC list, match the comorbid CC code to the comorbid CC code in the table, and assign:

- The ranking group.
- The rank.
- The HCC.

For comorbid CCs that do not match to Table HCC—Rank, use the comorbid CC as the HCC and assign a rank of 1.

Note: *One comorbid CC can map to multiple HCCs; each HCC can have one or more comorbid CCs.*

Step 4 Assess each ranking group separately and select only the highest ranked HCC in each ranking group using the "Rank" column (1 is the highest rank possible).

Drop all other HCCs in each ranking group, and de-duplicate the HCC list if necessary.

Example Assume a denominator unit with the following comorbid CCs: CC-85, CC-17 and CC-19 (assume no other CCs).

- CC-85 does not have a map to the ranking table and becomes HCC-85.
- HCC-17 and HCC-19 are part of Diabetes Ranking Group 1. Because CC-17 is ranked higher than CC-19 in Ranking Group Diabetes 1, the comorbidity is assigned as HCC-17 for Ranking Group 1.
- The final comorbidities for this denominator unit are HCC-17 and HCC-85.

Example: Table HCC—Rank

Ranking Group	CC	Description	Rank	HCC
NA	CC-85	Congestive Heart Failure	NA	HCC-85
Diabetes 1	CC-17	Diabetes With Acute Complications	1	HCC-17
	CC-18	Diabetes With Chronic Complications	2	HCC-18
	CC-19	Diabetes Without Complication	3	HCC-19

Step 5 Identify combination HCCs listed in Table HCC—Comb.

Some combinations suggest a greater amount of risk when observed together. For example, when diabetes *and* CHF are present, an increased amount of risk is evident. Additional HCCs are selected to account for these relationships.

Compare each denominator unit's list of unique HCCs to those in the *HCC* column in Table HCC—Comb and assign any additional HCC conditions.

If there are fully nested combinations, use only the more comprehensive pattern. For example, if the diabetes/CHF combination is nested in the diabetes/CHF/renal combination, count only the diabetes/CHF/renal combination.

If there are overlapping combinations, use both sets of combinations. Based on the combinations, a denominator unit can have none, one or more of these added HCCs.

Example For a denominator unit with comorbidities HCC-17 and HCC-85 (assume no other HCCs), assign HCC-901 in addition to HCC-17 and HCC-85. This *does not* replace HCC-17 and HCC-85.

Example: Table HCC—Comb

Comorbid HCC	Comorbid HCC	Comorbid HCC	Combination HCC	HCC-Comb Description
HCC-17	HCC-85	NA	HCC-901	Combination: Diabetes and CHF
HCC-18	HCC-85	NA	HCC-901	Combination: Diabetes and CHF
HCC-19	HCC-85	NA	HCC-901	Combination: Diabetes and CHF

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MY 2023 HEDIS for QRS Measure Technical Specifications

(Alphabetical Order)

Antidepressant Medication Management (AMM)

SUMMARY OF CHANGES TO MY 2023 HEDIS FOR QRS

- Revised the age criteria to require members to be 18 years of age and older as of the IPSD.
- Added a required exclusion for members who died during the measurement year.

Description

The percentage of members 18 years of age and older who were treated with antidepressant medication, had a diagnosis of major depression and who remained on an antidepressant medication treatment. Two rates are reported.

1. *Effective Acute Phase Treatment.* The percentage of members who remained on an antidepressant medication for at least 84 days (12 weeks).
2. *Effective Continuation Phase Treatment.* The percentage of members who remained on an antidepressant medication for at least 180 days (6 months).

Definitions

Intake period	The 12-month window starting on May 1 of the year prior to the measurement year and ending on April 30 of the measurement year.
IPSD	Index prescription start date. The earliest prescription dispensing date for an antidepressant medication where the date is in the intake period and there is a negative medication history.
Negative Medication History	A period of 105 days prior to the IPSD when the member had no pharmacy claims for either new or refill prescriptions for an antidepressant medication.
Treatment days	The actual number of calendar days covered with prescriptions within the specified measurement interval. For Effective Continuation Phase Treatment, a prescription of 90 days (3 months) supply dispensed on the 151st day will have 82 days counted in the 232-day interval.

Eligible Population

Product line	Exchange.
Ages	18 years and older as of the IPSD.
Continuous enrollment	105 days prior to the IPSD through 231 days after the IPSD.
Allowable gap	One gap in enrollment of up to 45 days.
Anchor date	IPSD.
Benefits	Medical and pharmacy.
Event/diagnosis	Follow the steps below to identify the eligible population, which is used for both rates.

Step 1

Determine the IPSD. Identify the date of the earliest dispensing event for an antidepressant medication (Antidepressant Medications List) during the intake period.

Step 2: Required exclusions

Members who did not have an encounter with a diagnosis of major depression during the 121-day period from 60 days prior to the IPSD, through the IPSD and the 60 days after the IPSD. Members who meet any of the following criteria remain in the eligible population:

- An acute or nonacute inpatient stay with any diagnosis of major depression (Major Depression Value Set) on the discharge claim. To identify acute and nonacute inpatient stays:
  1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
  2. Identify the admission and discharge dates for the stay. Either an admission or discharge during the required time frame meets criteria.
- An acute inpatient encounter with any diagnosis of major depression: Acute Inpatient Value Set ***with*** Major Depression Value Set.
- A nonacute inpatient encounter with any diagnosis of major depression: Nonacute Inpatient Value Set ***with*** Major Depression Value Set.
- An outpatient visit with any diagnosis of major depression: Visit Setting Unspecified Value Set ***with*** Outpatient POS Value Set ***with*** Major Depression Value Set.
- An outpatient visit with any diagnosis of major depression: BH Outpatient Value Set ***with*** Major Depression Value Set.
- An intensive outpatient encounter or partial hospitalization with any diagnosis of major depression: Visit Setting Unspecified Value Set ***with*** Partial Hospitalization POS Value Set ***with*** Major Depression Value Set.
- An intensive outpatient encounter or partial hospitalization with any diagnosis of major depression: Partial Hospitalization or Intensive Outpatient Value Set ***with*** Major Depression Value Set.
- A community mental health center visit with any diagnosis of major depression: Visit Setting Unspecified Value Set ***with*** Community Mental Health Center POS Value Set ***with*** Major Depression Value Set.
- Electroconvulsive therapy with any diagnosis of major depression: Electroconvulsive Therapy Value Set ***with*** Major Depression Value Set.
- A transcranial magnetic stimulation visit with any diagnosis of major depression: Transcranial Magnetic Stimulation Value Set ***with*** Major Depression Value Set.
- A telehealth visit with any diagnosis of major depression: Visit Setting Unspecified Value Set ***with*** Telehealth POS Value Set ***with*** Major Depression Value Set.
- An observation visit (Observation Value Set) ***with*** any diagnosis of major depression (Major Depression Value Set).
- An ED visit (ED Value Set) ***with*** any diagnosis of major depression (Major Depression Value Set).
- An ED visit with any diagnosis of major depression: Visit Setting Unspecified Value Set ***with*** ED POS Value Set ***with*** Major Depression Value Set.
- A telephone visit (Telephone Visits Value Set) ***with*** any diagnosis of major depression (Major Depression Value Set).

- An e-visit or virtual check-in (Online Assessments Value Set) ***with*** any diagnosis of major depression (Major Depression Value Set).

Members in hospice or using hospice services any time during the measurement year. Refer to *General Guideline 8: Members in Hospice*.

Members who died any time during the measurement year. Refer to *General Guideline 9: Deceased Members.*

Step 3 Test for Negative Medication History. Remove members who were dispensed a prescription for an antidepressant medication 105 days prior to the IPSD.

Step 4 Calculate continuous enrollment. Members must be continuously enrolled for 105 days prior to the IPSD to 231 days after the IPSD.

Administrative Specification

Denominator The eligible population.

Numerators

Effective Acute Phase Treatment At least 84 days (12 weeks) of treatment with antidepressant medication (Antidepressant Medications List) beginning on the IPSD through 114 days after the IPSD (115 total days). This allows gaps in medication treatment up to a total of 31 days during the 115-day period. Gaps can include either washout period gaps to change medication or treatment gaps to refill the same medication.

Antidepressant Medications

Description	Prescription		
Miscellaneous antidepressants	• Bupropion	• Vilazodone	• Vortioxetine
Monoamine oxidase inhibitors	• Isocarboxazid • Phenelzine	• Selegiline	• Tranylcypromine
Phenylpiperazine antidepressants	• Nefazodone	• Trazodone	
Psychotherapeutic combinations	• Amitriptyline-chlordiazepoxide	• Amitriptyline-perphenazine	• Fluoxetine-olanzapine
SNRI antidepressants	• Desvenlafaxine • Duloxetine	• Levomilnacipran • Venlafaxine	
SSRI antidepressants	• Citalopram • Escitalopram	• Fluoxetine • Fluvoxamine	• Paroxetine • Sertraline
Tetracyclic antidepressants	• Maprotiline	• Mirtazapine	
Tricyclic antidepressants	• Amitriptyline • Amoxapine • Clomipramine	• Desipramine • Doxepin (>6 mg) • Imipramine	• Nortriptyline • Protriptyline • Trimipramine

Effective Continuation Phase Treatment At least 180 days (6 months) of treatment with antidepressant medication (Antidepressant Medications List) beginning on the IPSD through 231 days after the IPSD (232 total days). This allows gaps in medication treatment up to a total of 52 days during the 232-day period. Gaps can include either washout period gaps to change medication or treatment gaps to refill the same medication.

Note

- *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 specified.*

Data Elements for Reporting

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

Table AMM-4: Data Elements for Antidepressant Medication Management

Metric	Data Element	Reporting Instructions
Acute	Benefit	Metadata
Continuation	EligiblePopulation	Repeat per Metric
	ExclusionAdminRequired	Repeat per Metric
	NumeratorByAdmin	For each Metric
	NumeratorBySupplemental	For each Metric
	Rate	(Percent)

Appropriate Testing for Pharyngitis (CWP)

SUMMARY OF CHANGES TO MY 2023 HEDIS FOR QRS

- Added a required exclusion for members who died during the measurement year.

HEDIS FOR QRS SPECIFIC GUIDANCE

- In the Draft 2023 Call Letter, CMS proposed to remove Appropriate Testing for Pharyngitis (CWP) beginning with the 2024 ratings year, to align with CMS's priorities of reducing burden and including measures most valuable to the Exchange population. The CWP measure specification is included in this version of the Technical Specifications for reference. Refer to the Final 2023 Call Letter and the *2024 QRS and QHP Enrollee Survey Technical Guidance* for reporting this measure.

Finalized Data Submission Requirements for the 2024 Ratings Year

In the Final 2023 Call Letter, CMS finalized the removal of the *Appropriate Testing for Pharyngitis* measure from the QRS measure set. CMS will not collect the *Appropriate Testing for Pharyngitis* measure for the 2024 ratings year.

Description

The percentage of episodes for members 3 years and older where the member was diagnosed with pharyngitis, dispensed an antibiotic and received a group A streptococcus (strep) test for the episode.

Definitions

Intake period	A 12-month window that begins on July 1 of the year prior to the measurement year and ends on June 30 of the measurement year. The intake period captures eligible episodes of treatment.
Episode date	The date of service for any outpatient, telephone, observation or ED visit, e-visit or virtual check-in during the intake period with a diagnosis of pharyngitis.
Negative medication history	To qualify for negative medication history, the following criteria must be met: • A period of 30 days prior to the episode date when the member had no pharmacy claims for either new or refill prescriptions for a listed antibiotic drug. • No prescriptions dispensed more than 30 days prior to the episode date that are active on the episode date. A prescription is considered active if the "days supply" indicated on the date when the member was dispensed the prescription is the number of days or more between that date and the relevant service date. The 30-day look-back period for pharmacy data includes the 30 days prior to the intake period.
Negative comorbid condition history	A period of 12 months prior to and including the episode date when the member had no claims/encounters with any diagnosis for a comorbid condition.
Negative competing diagnosis	The episode date and 3 days following the episode date when the member had no claims/encounters with a competing diagnosis.

Eligible Population

Product lines Exchange.

Ages Members who were 3 years or older as of the episode date.

Report three age stratifications and a total rate:

- 3–17 years.
- 18–64 years.
- 65 years and older.
- Total.

The total is the sum of the age stratifications.

Continuous enrollment 30 days prior to the episode date through 3 days after the episode date (34 total days).

Allowable gap None.

Anchor date None.

Benefits Medical and pharmacy.

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

Step 1 Identify all members who had an outpatient visit (Outpatient Value Set), a telephone visit (Telephone Visits Value Set), an e-visit or virtual check-in (Online Assessments Value Set), an observation visit (Observation Value Set) or an ED visit (ED Value Set) during the intake period, with a diagnosis of pharyngitis (Pharyngitis Value Set).

Step 2 Determine all pharyngitis episode dates. For each member identified in step 1, determine all outpatient, telephone, observation or ED visits, e-visits and virtual check-ins with a diagnosis of pharyngitis.

Exclude visits that result in an inpatient stay (Inpatient Stay Value Set).

Step 3 Determine if antibiotics (CWP Antibiotic Medications List) were dispensed for any of the episode dates. For each episode date with a qualifying diagnosis, determine if antibiotics were dispensed on or up to 3 days after.

Remove episode dates if the member did not receive antibiotics on or up to 3 days after the episode date.

CWP Antibiotic Medications

Description	Prescription		
Aminopenicillins	• Amoxicillin	• Ampicillin	
Beta-lactamase inhibitors	• Amoxicillin-clavulanate		
First generation cephalosporins	• Cefadroxil	• Cefazolin	• Cephalexin
Folate antagonist	• Trimethoprim		
Lincomycin derivatives	• Clindamycin		
Macrolides	• Azithromycin	• Clarithromycin	• Erythromycin
Natural penicillins	• Penicillin G benzathine	• Penicillin G sodium	• Penicillin V potassium

Description	Prescription		
	• Penicillin G potassium		
Quinolones	• Ciprofloxacin • Levofloxacin	• Moxifloxacin	• Ofloxacin
Second generation cephalosporins	• Cefaclor • Cefprozil	• Cefuroxime	
Sulfonamides	• Sulfamethoxazole-trimethoprim		
Tetracyclines	• Doxycycline • Minocycline	• Tetracycline	
Third generation cephalosporins	• Cefdinir • Cefixime	• Cefpodoxime	• Ceftriaxone

Step 4 Test for negative comorbid condition history. Remove episode dates where the member had a claim/encounter with any diagnosis for a comorbid condition during the 12 months prior to or on the episode date. A code from any of the following meets criteria for a comorbid condition:

- HIV Value Set.
- HIV Type 2 Value Set.
- Malignant Neoplasms Value Set.
- Other Malignant Neoplasm of Skin Value Set.
- Emphysema Value Set.
- COPD Value Set.
- Comorbid Conditions Value Set.
- Disorders of the Immune System Value Set.

Step 5 Test for negative medication history. Remove episode dates where a new or refill prescription for an antibiotic medication (CWP Antibiotic Medications List) was dispensed 30 days prior to the episode date or was active on the episode date.

Step 6 Test for negative competing diagnosis. Remove episode dates where the member had a claim/encounter with a competing diagnosis (Competing Diagnosis Value Set) on or 3 days after the episode date.

Step 7 Calculate continuous enrollment. The member must be continuously enrolled without a gap in coverage from 30 days prior to the episode date through 3 days after the episode date (34 total days).

Step 8 Deduplicate eligible episodes. If a member has more than one eligible episode in a 31-day period, include only the first eligible episode. For example, if a member has an eligible episode on January 1, include the January 1 visit and do not include eligible episodes that occur on or between January 2 and January 31; then, if applicable, include the next eligible episode that occurs on or after February 1. Identify visits chronologically including only one per 31-day period.

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 8: Members in Hospice*.
- Members who died any time during the measurement year. Refer to *General Guideline 9: Deceased Members.*

Administrative Specification

Denominator

The eligible population.

Numerator

A group A streptococcus test (Group A Strep Tests Value Set) in the 7-day period from 3 days prior to the episode date through 3 days after the episode date.

Data Elements for Reporting

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

Table CWP-4: Data Elements for Appropriate Testing for Pharyngitis

Metric	Age	Data Element	Reporting Instructions
AppropriatePharyngitisTesting	3-17	Benefit	Metadata
	18-64	EligiblePopulation	For each Stratification
	65+	ExclusionAdminRequired	For each Stratification
	Total	NumeratorByAdmin	For each Stratification
		NumeratorBySupplemental	For each Stratification
		Rate	(Percent)

Appropriate Treatment for Upper Respiratory Infection (URI)

SUMMARY OF CHANGES TO MY 2023 HEDIS FOR QRS

- Added a required exclusion for members who died during the measurement year.

Description

The percentage of episodes for members 3 months of age and older with a diagnosis of upper respiratory infection (URI) that did not result in an antibiotic dispensing event.

Calculation

The measure is reported as an inverted rate [1 – (numerator/eligible population)]. A higher rate indicates appropriate URI treatment (i.e., the proportion of episodes that did not result in an antibiotic dispensing event).

Definitions

Intake Period	A 12-month window that begins on July 1 of the year prior to the measurement year and ends on June 30 of the measurement year. The intake period captures eligible episodes of treatment.
Episode Date	The date of service for any outpatient, telephone, observation or ED visit, e-visit or virtual check-in during the intake period with a diagnosis of URI.
Negative Medication History	To qualify for negative medication history, the following criteria must be met: • A period of 30 days prior to the episode date when the member had no pharmacy claims for either new or refill prescriptions for a listed antibiotic drug. • No prescriptions dispensed more than 30 days prior to the Episode Date that are active on the Episode Date. A prescription is considered active if the “days supply” indicated on the date when the member was dispensed the prescription is the number of days or more between that date and the relevant service date. The 30-day look-back period for pharmacy data includes the 30 days prior to the intake period.
Negative Comorbid Condition History	A period of 12 months prior to and including the episode date, when the member had no claims/encounters with any diagnosis for a comorbid condition.
Negative Competing Diagnosis	The episode date and 3 days following the episode date when the member had no claims/encounters with a competing diagnosis.

Eligible Population

Product line	Exchange.
Ages	Members who were 3 months of age or older as of the Episode Date. Report three age stratifications and a total rate:

- 3 months–17 years.
- 18–64 years.
- 65 years and older.
- Total.

The total is the sum of the age stratifications.

Continuous enrollment 30 days prior to the episode date through 3 days after the episode date (34 total days).

Allowable gap None.

Anchor date None.

Benefits Medical and pharmacy.

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

Step 1 Identify all members who had an outpatient visit (Outpatient Value Set), a telephone visit (Telephone Visits Value Set), an e-visit or virtual check-in (Online Assessments Value Set) an observation visit (Observation Value Set) or an ED visit (ED Value Set) during the Intake Period, with a diagnosis of URI (URI Value Set).

Step 2 Determine all URI Episode Dates. For each member identified in step 1, determine all outpatient, telephone, observation or ED visits, e-visits and virtual check-ins with a URI diagnosis.

Exclude visits that result in an inpatient stay (Inpatient Stay Value Set).

Step 3 Test for negative comorbid condition history. Remove episode dates where the member had a claim/encounter with any diagnosis for a comorbid condition during the 12 months prior to or on the episode date. A code from any of the following meets criteria for a comorbid condition:

- HIV Value Set.
- HIV Type 2 Value Set.
- Malignant Neoplasms Value Set.
- Other Malignant Neoplasm of Skin Value Set.
- Emphysema Value Set.
- COPD Value Set.
- Comorbid Conditions Value Set.
- Disorders of the Immune System Value Set.

Step 4 Test for negative medication history. Remove episode dates where a new or refill prescription for an antibiotic medication (AAB Antibiotic Medications List) was dispensed 30 days prior to the episode date or was active on the episode date.

Step 5 Test for negative competing diagnosis. Remove episode dates where the member had a claim/encounter with a competing diagnosis on or three days after the episode date. A code from either of the following meets criteria for a competing diagnosis:

- Pharyngitis Value Set.
- Competing Diagnosis Value Set.

Step 6 Calculate continuous enrollment. The member must be continuously enrolled without a gap in coverage from 30 days prior to the Episode Date through 3 days after the Episode Date (34 days total).

Step 7 Deduplicate eligible episodes. If a member has more than one eligible episode in a 31-day period, include only the first eligible episode. For example, if a member has an eligible episode on January 1, include the January 1 visit and do not include eligible episodes that occur on or between January 2 and January 31; then, if applicable, include the next eligible episode that occurs on or after February 1. Identify visits chronologically, including only one per 31-day period.

Note: *The denominator for this measure is based on episodes, not on members. All eligible episodes that were not removed or deduplicated remain in the denominator.*

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 8: Members in Hospice*.
- Members who died any time during the measurement year. Refer to *General Guideline 9: Deceased Members*.

Administrative Specification

Denominator The eligible population.

Numerator Dispensed prescription for an antibiotic medication from the AAB Antibiotic Medications List on or 3 days after the Episode Date.

AAB Antibiotic Medications

Description	Prescription		
Aminoglycosides	• Amikacin • Gentamicin	• Streptomycin • Tobramycin	
Aminopenicillins	• Amoxicillin	• Ampicillin	
Beta-lactamase inhibitors	• Amoxicillin-clavulanate • Ampicillin-sulbactam	• Piperacillin-tazobactam	
First-generation cephalosporins	• Cefadroxil • Cefazolin	• Cephalexin	
Fourth-generation cephalosporins	• Cefepime		
Lincomycin derivatives	• Clindamycin	• Lincomycin	
Macrolides	• Azithromycin • Clarithromycin	• Erythromycin	
Miscellaneous antibiotics	• Aztreonam • Chloramphenicol • Dalfopristin-quinupristin	• Daptomycin • Linezolid • Metronidazole	• Vancomycin
Natural penicillins	• Penicillin G benzathine-procaine • Penicillin G potassium	• Penicillin G procaine • Penicillin G sodium	• Penicillin V potassium • Penicillin G benzathine
Penicillinase resistant penicillins	• Dicloxacillin • Nafcillin	• Oxacillin	

Description	Prescription		
Quinolones	• Ciprofloxacin • Gemifloxacin	• Levofloxacin • Moxifloxacin	• Ofloxacin
Rifamycin derivatives	• Rifampin		
Second-generation cephalosporins	• Cefaclor • Cefotetan	• Cefoxitin • Cefprozil	• Cefuroxime
Sulfonamides	• Sulfadiazine	• Sulfamethoxazole-trimethoprim	
Tetracyclines	• Doxycycline • Minocycline	• Tetracycline	
Third-generation cephalosporins	• Cefdinir • Cefixime • Cefotaxime	• Cefpodoxime • Ceftazidime • Ceftriaxone	
Urinary anti-infectives	• Fosfomycin • Nitrofurantoin	• Nitrofurantoin macrocrystals-monohydrate	• Trimethoprim

Note

- *Although denied claims are not included when assessing the numerator, all claims (paid, suspended, pending and denied) must be included when identifying the eligible population.*
- *Supplemental data may not be used for this measure.*

Data Elements for Reporting

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

Table URI-4: Data Elements for Appropriate Treatment for Upper Respiratory Infection

Metric	Age	Data Element	Reporting Instructions
AppropriateURITreatment	3m-17	Benefit	Metadata
	18-64	EligiblePopulation	For each Stratification
	65+	ExclusionAdminRequired	For each Stratification
	Total	NumeratorByAdmin	For each Stratification
		Rate	(Percent)

Asthma Medication Ratio (AMR)

SUMMARY OF CHANGES TO MY 2023 HEDIS FOR QRS

- Added instructions to report rates stratified by race and ethnicity.
- 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.

HEDIS FOR QRS SPECIFIC GUIDANCE

- In the Draft 2023 Call Letter, CMS proposed to expand required collection and reporting of stratified race and ethnicity data for this measure beginning with MY 2023 (2024 ratings year). Refer to the Final 2023 Call Letter and the *2024 QRS and QHP Enrollee Survey Technical Guidance for reporting this measure.*

Finalized Data Submission Requirements for the 2024 Ratings Year

In the Final 2023 Call Letter, CMS finalized the requirement to collect and report race and ethnicity stratifications for the *Asthma Medication Ratio* measure.

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

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

Exchange.

Stratifications

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

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.

Continuous enrollment

The total is the sum of the age stratifications.

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.

Anchor date

December 31 of the measurement year.

Benefits

Medical. Pharmacy during the measurement year.

Event/diagnosis

Follow the steps below to identify the eligible population.

Step 1

Identify members as having persistent asthma who met at least one of the following criteria during both the measurement year and the year prior to the measurement year. Criteria need not be the same across both years.

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

Step 2

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

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 8: Members in Hospice*.
- Members who died any time during the measurement year. Refer to *General Guideline 9: 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.

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

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
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 "injection" (route) medications.*
- *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 for QRS data to NCQA must provide the following data elements.

Table AMR-A-4: 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-4: 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
	Asian	Total	Rate	(Percent)
	NativeHawaiianOrOtherPacificIslander			
	SomeOtherRace			
	TwoOrMoreRaces			
	AskedButNoAnswer*			
	Unknown**			

Table AMR-C-4: 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.'

Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (AAB)

SUMMARY OF CHANGES TO MY 2023 HEDIS FOR QRS

- Added a required exclusion for members who died during the measurement year.

Description

The percentage of episodes for members 3 months of age and older with a diagnosis of acute bronchitis/ bronchiolitis that did not result in an antibiotic dispensing event.

Calculation

The measure is reported as an inverted rate [1 – (numerator/eligible population)]. A higher rate indicates appropriate acute bronchitis/bronchiolitis treatment (i.e., the proportion for episodes that did *not* result in an antibiotic dispensing event).

Definitions

Intake Period	A 12-month window that begins on July 1 of the year prior to the measurement year and ends on June 30 of the measurement year. The intake period captures eligible episodes of treatment.
Episode Date	The date of service for any outpatient, telephone, observation or ED visit, e-visit or virtual check-in during the intake period with a diagnosis of acute bronchitis/ bronchiolitis.
Negative Medication History	To qualify for negative medication history, the following criteria must be met: • A period of 30 days prior to the episode date, when the member had no pharmacy claims for either new or refill prescriptions for a listed antibiotic drug. • No prescriptions that were dispensed more than 30 days prior to the episode date and are active on the episode date. A prescription is considered active if the “days supply” indicated on the date when the member was dispensed the prescription is the number of days or more between that date and the relevant service date. The 30-day look-back period for pharmacy data includes the 30 days prior to the intake period.
Negative Comorbid Condition History	A period of 12 months prior to and including the episode date, when the member had no claims/encounters with any diagnosis for a comorbid condition.
Negative Competing Diagnosis	The episode date and 3 days following the episode date when the member had no claims/encounters with any competing diagnosis.

Eligible Population

Product line	Exchange.
Ages	Members who were 3 months or older as of the episode date. Report three age stratifications and a total rate:

- 3 months–17 years.
- 18–64 years.
- 65 years and older.
- Total.

The total is the sum of the age stratifications.

Continuous enrollment 30 days prior to the episode date through 3 days after the episode date (34 total days).

Allowable gap None.

Anchor date None.

Benefits Medical and pharmacy.

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

Step 1 Identify all members who had an outpatient visit (Outpatient Value Set), a telephone visit (Telephone Visits Value Set), an e-visit or virtual check-in (Online Assessments Value Set), an observation visit (Observation Value Set) or an ED visit (ED Value Set) during the intake period, with a diagnosis of acute bronchitis/bronchiolitis (Acute Bronchitis Value Set).

Step 2 Determine all acute bronchitis/bronchiolitis episode dates. For each member identified in step 1, determine all outpatient, telephone, observation or ED visits, e-visits and virtual check-ins with a diagnosis of acute bronchitis/bronchiolitis.

Exclude visits that result in an inpatient stay (Inpatient Stay Value Set).

Step 3 Test for negative comorbid condition history. Remove episode dates where the member had a claim/encounter with any diagnosis for a comorbid condition during the 12 months prior to or on the episode date. A code from any of the following meets criteria for a comorbid condition:

- HIV Value Set.
- HIV Type 2 Value Set.
- Malignant Neoplasms Value Set.
- Other Malignant Neoplasm of Skin Value Set.
- Emphysema Value Set.
- COPD Value Set.
- Comorbid Conditions Value Set.
- Disorders of the Immune System Value Set.

Step 4 Test for Negative Medication History. Exclude Episode Dates where a new or refill prescription for an antibiotic medication (AAB Antibiotic Medications List) was dispensed 30 days prior to the Episode Date or was active on the Episode Date.

Step 5 Test for Negative Competing Diagnosis. Remove episode dates where the member had a claim/encounter with a competing diagnosis on or 3 days after the episode date. A code from either of the following meets criteria for a competing diagnosis:

- Pharyngitis Value Set.
- Competing Diagnosis Value Set.

Step 6 Calculate continuous enrollment. The member must be continuously enrolled without a gap in coverage from 30 days prior to the episode date through 3 days after the episode date (34 total days).

Step 7 Deduplicate eligible episodes. If a member has more than one eligible episode in a 31-day period, include only the first eligible episode. For example, if a member has an eligible episode on January 1, include the January 1 visit and do not include eligible episodes that occur on or between January 2 and January 31; then, if applicable, include the next eligible episode that occurs on or after February 1. Identify visits chronologically, including only one per 31-day period.

Note: *The denominator for this measure is based on episodes, not on members. All eligible episodes that were not excluded or deduplicated remain in the denominator.*

Required exclusion 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 8: Members in Hospice*.
- Members who died any time during the measurement year. Refer to *General Guideline 9: Deceased Members*.

Administrative Specification

Denominator The eligible population.

Numerator Dispensed prescription for an antibiotic medication (AAB Antibiotic Medications List) on or 3 days after the episode date.

AAB Antibiotic Medications

Description	Prescription		
Aminoglycosides	• Amikacin • Gentamicin	• Streptomycin • Tobramycin	
Aminopenicillins	• Amoxicillin	• Ampicillin	
Beta-lactamase inhibitors	• Amoxicillin-clavulanate • Ampicillin-sulbactam	• Piperacillin-tazobactam	
First-generation cephalosporins	• Cefadroxil	• Cefazolin	• Cephalexin
Fourth-generation cephalosporins	• Cefepime		
Lincomycin derivatives	• Clindamycin	• Lincomycin	
Macrolides	• Azithromycin • Clarithromycin	• Erythromycin	
Miscellaneous antibiotics	• Aztreonam • Chloramphenicol • Dalfopristin-quinupristin	• Daptomycin • Linezolid • Metronidazole	• Vancomycin
Natural penicillins	• Penicillin G benzathine-procaine • Penicillin G potassium	• Penicillin G procaine • Penicillin G sodium	• Penicillin V potassium • Penicillin G benzathine
Penicillinase resistant penicillins	• Dicloxacillin	• Nafcillin	• Oxacillin

Description	Prescription		
Quinolones	• Ciprofloxacin • Gemifloxacin	• Levofloxacin • Moxifloxacin	• Ofloxacin
Rifamycin derivatives	• Rifampin		
Second generation cephalosporin	• Cefaclor • Cefotetan	• Cefoxitin • Cefprozil	• Cefuroxime
Sulfonamides	• Sulfadiazine	• Sulfamethoxazole-trimethoprim	
Tetracyclines	• Doxycycline	• Minocycline	• Tetracycline
Third generation cephalosporins	• Cefdinir • Cefixime	• Cefotaxime • Cefpodoxime • Ceftazidime	• Ceftriaxone
Urinary anti-infectives	• Fosfomycin • Nitrofurantoin	• Nitrofurantoin macrocrystals-monohydrate	• Trimethoprim

Note

- *Although denied claims are not included when assessing the numerator, all claims (paid, suspended, pending and denied) must be included when identifying the eligible population.*
- *Supplemental data may not be used for this measure.*

Data Elements for Reporting

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

Table AAB-4: Data Elements for Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis

Metric	Age	Data Element	Reporting Instructions
AvoidanceAntibioticTreatment	3m-17	Benefit	Metadata
	18-64	EligiblePopulation	For each Stratification
	65+	ExclusionAdminRequired	For each Stratification
	Total	NumeratorByAdmin	For each Stratification
		Rate	(Percent)

Cervical Cancer Screening (CCS)

SUMMARY OF CHANGES TO MY 2023 HEDIS FOR QRS

- Revised the optional exclusions for hysterectomy with no residual cervix, cervical agenesis or acquired absence of cervix to be required exclusions.
- Added a required exclusion for members who died during the measurement year.
- Added a direct reference code for palliative care.

HEDIS FOR QRS SPECIFIC GUIDANCE

- In the Draft 2023 Call Letter, CMS proposed to expand this measure to include optional ECDS reporting beginning with MY 2023 (2024 ratings year). Refer to *Measures Reported Using Electronic Clinical Data Systems* for the specifications. Refer to the Final 2023 Call Letter and the *2024 QRS and QHP Enrollee Survey Technical Guidance* for reporting this measure.

Finalized Data Submission Requirements for the 2024 Ratings Year

In the Final 2023 Call Letter, CMS finalized the incorporation of optional ECDS reporting alongside non-ECDS reporting for the *Cervical Cancer Screening* measure for the 2024 ratings year. QHP issuers that submit optional ECDS reporting are required to do so alongside data reported via either the administrative or hybrid methods.

Description

The percentage of women 21–64 years of age who were screened for cervical cancer using any of the following criteria:

- Women 21–64 years of age who had cervical cytology performed within the last 3 years.
- Women 30–64 years of age who had cervical high-risk human papillomavirus (hrHPV) testing performed within the last 5 years.
- Women 30–64 years of age who had cervical cytology/high-risk human papillomavirus (hrHPV) cotesting within the last 5 years.

Eligible Population

Product line	Exchange.
Ages	Women 24–64 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.
Anchor date	December 31 of the measurement year.
Benefit	Medical.
Event/diagnosis	None.
Required exclusions	Exclude members who meet any of the following criteria: • Hysterectomy with no residual cervix, cervical agenesis or acquired absence of cervix (Absence of Cervix Diagnosis Value Set; Hysterectomy With No Residual Cervix Value Set) any time during the member's history through December 31 of the measurement year. • Members in hospice or using hospice services any time during the measurement year. Refer to *General Guideline 8: Members in Hospice*. • Members who died any time during the measurement year. Refer to *General Guideline 9: 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.

Administrative Specification

Denominator The eligible population.

Numerator The number of women who were screened for cervical cancer. Either of the following meets criteria:

- Women 24–64 years of age as of December 31 of the measurement year who had cervical cytology (Cervical Cytology Lab Test Value Set; Cervical Cytology Result or Finding Value Set) during the measurement year or the two years prior to the measurement year.
- Women 30–64 years of age as of December 31 of the measurement year who had cervical high-risk human papillomavirus (hrHPV) testing (High Risk HPV Lab Test Value Set; High Risk HPV Test Result or Finding Value Set) during the measurement year or the 4 years prior to the measurement year ***and*** who were 30 years or older on the date of the test.

Note: *Evidence of hrHPV testing within the last 5 years also captures patients who had cotesting; therefore, additional methods to identify cotesting are not necessary.*

Hybrid Specification

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

Numerator The number of women who were appropriately screened for cervical cancer as documented through either administrative data or medical record review.

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

Medical record Appropriate screenings are defined by any of the following:

- Women 24–64 years of age as of December 31 of the measurement year who had cervical cytology during the measurement year or the 2 years prior to the measurement year.
  - Documentation in the medical record must include both of the following:
    - A note indicating the date when the cervical cytology was performed.
    - The result or finding.
  - Count any cervical cancer screening method that includes collection and microscopic analysis of cervical cells. Do not count lab results that explicitly state the sample was inadequate or that "no cervical cells were present"; this is not considered appropriate screening.
  - Do not count biopsies because they are diagnostic and therapeutic only and are not valid for primary cervical cancer screening.

Note: *Lab results that indicate the sample contained "no endocervical cells" may be used if a valid result was reported for the test.*

- Women 30–64 years of age as of December 31 of the measurement year who had cervical high-risk human papillomavirus (hrHPV) testing during the measurement year or the 4 years prior to the measurement year ***and*** who were 30 years or older as of the date of testing.
  - Documentation in the medical record must include both of the following:
    - A note indicating the date when the hrHPV test was performed. Generic documentation of "HPV test" can be counted as evidence of hrHPV test.
    - The results or findings.
  - Do not count biopsies, because they are diagnostic and therapeutic only and are not valid for primary cervical cancer screening.

    Note: *Evidence of hrHPV testing within the last 5 years also captures patients who had cotesting.*

Data Elements for Reporting

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

Table CCS-4: Data Elements for Cervical Cancer Screening

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

Child and Adolescent Well-Care Visits (WCV)

SUMMARY OF CHANGES TO MY 2023 HEDIS FOR QRS

- Added a required exclusion for members who died during the measurement year.

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 line

Exchange.

Stratifications

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

3–21 years as of December 31 of the measurement year. Report three age stratifications and a total rate:

- 3–11 years.
- 12–17 years.
- 18–21 years.
- Total

The total is the sum of the age stratifications.

Continuous enrollment	The measurement year.
Allowable gap	No more than one gap in enrollment of up to 45 days during the continuous enrollment period.
Anchor date	December 31 of the measurement year.
Benefit	Medical.
Event/diagnosis	None.
Required exclusion	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 8: Members in Hospice*. • Members who died any time during the measurement year. Refer to *General Guideline 9: Deceased Members*.

Administrative Specification

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

Note

- *Refer to Appendix 1 for the definition of* PCP *and* OB/GYN and other prenatal care practitioners.
- *This measure is based on the American Academy of Pediatrics Bright Futures: Guidelines for Health Supervision of Infants, Children and Adolescents (published by the National Center for Education in Maternal and Child Health). Visit the Bright Futures website for more information about well-child visits (https://brightfutures.aap.org/materials-and-tools/guidelines-and-pocket-guide/).*

Data Elements for Reporting

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

Table WCV-A-4: 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-4: 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-4: 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.'

Childhood Immunization Status (CIS)

SUMMARY OF CHANGES TO MY 2023 HEDIS FOR QRS

- Added anaphylaxis to a vaccine to select numerators.
- Added a required exclusion for members who died during the measurement year.
- Removed seropositive test results from the numerator criteria in the hybrid specification.

HEDIS FOR QRS SPECIFIC GUIDANCE

- HEDIS for QRS reports only Combination 10 and related antigens.

Description

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

Eligible Population

Product line	Exchange.
Age	Children who turn 2 years of age during the measurement year.
Continuous enrollment	12 months prior to the child's second birthday.
Allowable gap	No more than one gap in enrollment of up to 45 days during the 12 months prior to the child's second birthday.
Anchor date	Enrolled on the child's second birthday.
Benefit	Medical.
Event/diagnosis	None.
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 8: Members in Hospice*. • Members who died any time during the measurement year. *Refer to General Guideline 9: Deceased Members*. • Members who had any of the following on or before their second birthday: – Severe combined immunodeficiency (Severe Combined Immunodeficiency Value Set). – Immunodeficiency (Disorders of the Immune System Value Set). – HIV (HIV Value Set; HIV Type 2 Value Set). – Lymphoreticular cancer, multiple myeloma or leukemia (Malignant Neoplasm of Lymphatic Tissue Value Set). – Intussusception (Intussusception Value Set).

Administrative Specification

Denominator The eligible population.

Numerators

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

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

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

- At least three IPV vaccinations (Inactivated Polio Vaccine (IPV) Immunization Value Set; Inactivated Polio Vaccine (IPV) Procedure Value Set), with different dates of service. Do not count a vaccination administered prior to 42 days after birth.
- Anaphylaxis due to the IPV vaccine (SNOMED CT code 471321000124106).

MMR Any of the following meet criteria:

- At least one MMR vaccination (Measles, Mumps and Rubella (MMR) Immunization Value Set; Measles, Mumps and Rubella (MMR) Vaccine Procedure Value Set) on or between the child's first and second birthdays.
- All of the following any time on or before the child's second birthday (on the same or different date of service):
  - History of measles illness (Measles Value Set).
  - History of mumps illness (Mumps Value Set).
  - History of rubella illness (Rubella Value Set).
  - Anaphylaxis due to the MMR vaccine (SNOMED CT code 471331000124109) on or before the child's second birthday.

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

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

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

- At least three hepatitis B vaccinations (Hepatitis B Immunization Value Set; Hepatitis B Vaccine Procedure Value Set), with different dates of service.
  - One of the three vaccinations can be a newborn hepatitis B vaccination (Newborn Hepatitis B Vaccine Administered Value Set) during the 8-day period that begins on the date of birth and ends 7 days after the date of birth. For example, if the member's date of birth is December 1, the newborn hepatitis B vaccination must be on or between December 1 and December 8.

- History of hepatitis illness (Hepatitis B Value Set).
- Anaphylaxis due to the Hepatitis B vaccine (SNOMED CT code 428321000124101).

VZV Any of the following meet criteria:

- At least one VZV vaccination (Varicella Zoster (VZV) Immunization Value Set; Varicella Zoster (VZV) Vaccine Procedure Value Set), with a date of service on or between the child's first and second birthdays.
- History of varicella zoster (e.g., chicken pox) illness (Varicella Zoster Value Set) on or before the child's second birthday.
- Anaphylaxis due to the VZV vaccine (SNOMED CT code 471341000124104) on or before the child's second birthday

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

- At least four pneumococcal conjugate vaccinations (Pneumococcal Conjugate Immunization Value Set; Pneumococcal Conjugate Vaccine Procedure Value Set), with different dates of service. Do not count a vaccination administered prior to 42 days after birth.
- Anaphylaxis due to the pneumococcal conjugate vaccine (SNOMED CT code 471141000124102).

Hepatitis A Any of the following meet criteria:

- At least one hepatitis A vaccination (Hepatitis A Immunization Value Set; Hepatitis A Vaccine Procedure Value Set) with a date of service on or between the child's first and second birthdays.
- History of hepatitis A illness (Hepatitis A Value Set) on or before the child's second birthday.
- Anaphylaxis due to the hepatitis A vaccine (SNOMED CT code 471311000124103) on or before the child's second birthday.

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

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

Influenza Either of the following meets criteria:

- At least two influenza vaccinations (Influenza Immunization Value Set; Influenza Vaccine Procedure Value Set) with different dates of service on or before the child's second birthday. Do not count a vaccination administered prior to 6 months (180 days) after birth.
  - An influenza vaccination recommended for children 2 years and older (Influenza Virus LAIV Immunization Value Set; Influenza Virus LAIV Vaccine Procedure Value Set) administered on the child's second birthday meets criteria for one of the two required vaccinations.
- Anaphylaxis due to the influenza vaccine (SNOMED CT code 471361000124100) on or before the child's second birthday.

Combination rate Calculate the following rate for Combination 10.

Combination Vaccinations for Childhood Immunization Status

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

Hybrid Specification

Denominator A systematic sample drawn from the eligible population. Organizations may reduce the sample size using the current year's administrative rate. The lowest rate for all reported indicators must be used when reducing the sample size. Refer to the *Guidelines for Calculations and Sampling* for information on reducing the sample size.

Numerators For DTaP, count any of the following:

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

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

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

For IPV, pneumococcal conjugate, influenza, HiB and rotavirus, count *either of the following*:

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

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

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

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

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

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

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

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

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

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

Data Elements for Reporting

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

Table CIS-4: Data Elements for Childhood Immunization Status

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

Chlamydia Screening in Women (CHL)

SUMMARY OF CHANGES TO MY 2023 HEDIS FOR QRS

- Revised the optional exclusions for pregnancy test to be step 3 of the event/diagnosis criteria.
- Added a required exclusion for members who died during the measurement year.

Description

The percentage of women 16–24 years of age who were identified as sexually active and who had at least one test for chlamydia during the measurement year.

Eligible Population

Product line	Exchange.
Ages	Women 16–24 years as of December 31 of the measurement year. Report two age stratifications and a total rate: • 16–20 years. • 21–24 years. • Total. The total is the sum of the age stratifications.
Continuous enrollment	The measurement year.
Allowable gap	No more than one gap in enrollment of up to 45 days during the measurement year.
Anchor date	December 31 of the measurement year.
Benefit	Medical.
Event/diagnosis	Follow the steps below to identify the eligible population.
Step 1	*Identify members who are sexually active*. Two methods identify sexually active: pharmacy data and claim/encounter data. The organization must use both methods to identify the eligible population; however, a member only needs to be identified in one method to be eligible for the measure. *Claim/encounter data*. Members who had a claim or encounter indicating sexual activity during the measurement year. A code from any of the following meets criteria: • Pregnancy Value Set. • Sexual Activity Value Set. • Pregnancy Tests Value Set. *Pharmacy data.* Members who were dispensed prescription contraceptives during the measurement year (Contraceptive Medications List).

Contraceptive Medications

Description	Prescription	
Contraceptives	• Desogestrel-ethinyl estradiol • Dienogest-estradiol (multiphasic) • Drospirenone-ethinyl estradiol • Drospirenone-ethinyl estradiol-levomefolate (biphasic) • Ethinyl estradiol-ethynodiol • Ethinyl estradiol-etonogestrel • Ethinyl estradiol-levonorgestrel • Ethinyl estradiol-norelgestromin	• Ethinyl estradiol-norethindrone • Ethinyl estradiol-norgestimate • Ethinyl estradiol-norgestrel • Etonogestrel • Levonorgestrel • Medroxyprogesterone • Mestranol-norethindrone • Norethindrone
Diaphragm	• Diaphragm	
Spermicide	• Nonoxynol 9	

Step 2

For the members identified in step 1 based on a pregnancy test alone, remove members who meet either of the following:

- A pregnancy test (Pregnancy Tests Value Set) during the measurement year and a prescription for isotretinoin (Retinoid Medications List) on the date of the pregnancy test or 6 days after the pregnancy test.
- A pregnancy test (Pregnancy Tests Value Set) during the measurement year and an x-ray (Diagnostic Radiology Value Set) on the date of the pregnancy test or 6 days after the pregnancy test.

Retinoid Medications

Description	Prescription
Retinoid	Isotretinoin

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 8: Members in Hospice.*
- Members who died any time during the measurement year. Refer to *General Guideline 9: Deceased Members.*

Administrative Specification

Denominator

The eligible population.

Numerator

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

Data Elements for Reporting

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

Table CHL-4: Data Elements for Chlamydia Screening in Women

Metric	Age	Data Element	Reporting Instructions
ChlamydiaScreening	16-20	EligiblePopulation	For each Stratification
	21-24	ExclusionAdminRequired	For each Stratification
	Total	NumeratorByAdmin	For each Stratification
		NumeratorBySupplemental	For each Stratification
		Rate	(Percent)

Colorectal Cancer Screening (COL)

SUMMARY OF CHANGES TO MY 2023HEDIS FOR QRS

- Revised the optional exclusions for colorectal cancer and total colectomy to be required exclusions.
- Added a required exclusion for members who died during the measurement year.
- Updated the number of occurrences required for the frailty cross-cutting exclusion.
- Added a direct reference code for palliative care.
- Updated the Hybrid Specification to indicate that sample size reduction is allowed.
- Revised the medical record criteria for a completed colonoscopy.

HEDIS FOR QRS SPECIFIC GUIDANCE

- In the Final 2022 Call Letter, CMS finalized the incorporation of the 45- 49 years age band. CMS anticipates introducing this additional age band into scoring beginning with MY 2023 (i.e., 2024 ratings year).

Description

The percentage of members 45–75 years of age who had appropriate screening for colorectal cancer.

Eligible Population

Product line

Exchange.

Stratifications

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

46–75 years as of December 31 of the measurement year.

Report two age stratifications and a total rate:

- 46–49 years.
- 50–75 years.
- Total.

The total is the sum of the age stratifications.

Continuous enrollment

The measurement year and the year prior to the measurement year.

Allowable gap

No more than one gap in continuous enrollment of up to 45 days during each year of continuous enrollment.

Anchor date

December 31 of the measurement year.

Benefit

Medical.

Event/diagnosis

None.

Required exclusions

Exclude members who meet any of the following criteria:

- Members who had colorectal cancer (Colorectal Cancer Value Set) or a total colectomy (Total Colectomy Value Set; History of Total Colectomy Value Set) any time during the member's history through December 31 of the measurement year.
- Members in hospice or using hospice services any time during the measurement year. Refer to *General Guideline 8: Members in Hospice*.
- Members who died any time during the measurement year. Refer to *General Guideline 9: 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) 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.*

- Members 66 years of age and older as of December 31 of the measurement year 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).

Dementia Medications

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

Administrative Specification

Denominator The eligible population.

Numerator One or more screenings for colorectal cancer. Any of the following meet criteria:

- Fecal occult blood test (FOBT Lab Test Value Set; FOBT Test Result or Finding Value Set) during the measurement year. For administrative data, assume the required number of samples were returned, regardless of FOBT type.
- Flexible sigmoidoscopy (Flexible Sigmoidoscopy Value Set; History of Flexible Sigmoidoscopy Value Set) during the measurement year or the 4 years prior to the measurement year.
- Colonoscopy (Colonoscopy Value Set; History of Colonoscopy Value Set) during the measurement year or the 9 years prior to the measurement year.
- CT colonography (CT Colonography Value Set) during the measurement year or the 4 years prior to the measurement year.
- Stool DNA (sDNA) with FIT test (sDNA FIT Lab Test Value Set; sDNA FIT Test Result or Finding Value Set) during the measurement year or the 2 years prior to the measurement year.

Hybrid Specification

Denominator

A systematic sample drawn from the eligible population. Organizations may reduce the sample size using the current year's administrative rate or the prior year's audited, product line-specific rate. Refer to the *Guidelines for Calculations and Sampling* for information on reducing the sample size.

Numerator

One or more screenings for colorectal cancer. Appropriate screenings are defined by one of the following:

- FOBT during the measurement year.
- Flexible sigmoidoscopy during the measurement year or the 4 years prior to the measurement year.
- Colonoscopy during the measurement year or the 9 years prior to the measurement year.
- CT colonography during the measurement year or the 4 years prior to the measurement year.
- Stool DNA (sDNA) with FIT test during the measurement year or the 2 years prior to the measurement year.

Administrative

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

Medical record

Documentation in the medical record must include a note indicating the date when the colorectal cancer screening was performed. A result is not required if the documentation is clearly part of the member's "medical history"; if this is not clear, the result or finding must also be present (this ensures that the screening was performed and not merely ordered).

A pathology report that indicates the type of screening (e.g., colonoscopy, flexible sigmoidoscopy) and the date when the screening was performed meets criteria.

For pathology reports that do not indicate the type of screening and for incomplete procedures:

- Evidence that the scope advanced to the cecum meets criteria for a completed colonoscopy.
- Evidence that the scope advanced into the sigmoid colon meets criteria for a completed flexible sigmoidoscopy.

There are two types of FOBT tests: guaiac (gFOBT) and immunochemical (FIT). Depending on the type of FOBT test, a certain number of samples are required for numerator compliance. Follow the instructions below to determine member compliance.

- If the medical record does not indicate the type of test and there is no indication of how many samples were returned, assume the required number was returned. The member meets the screening criteria for inclusion in the numerator.
- If the medical record does not indicate the type of test and the number of returned samples is specified, the member meets the screening criteria only if the number of samples specified is greater than or equal to three samples. If there are fewer than three samples, the member does not meet the screening criteria for inclusion.

- FIT tests may require fewer than three samples. If the medical record indicates that an FIT was done, the member meets the screening criteria, regardless of how many samples were returned.
- If the medical record indicates that a gFOBT was done, follow the scenarios below.
  - *If the medical record does not indicate the number of returned samples,* assume the required number was returned. The member meets the screening criteria for inclusion in the numerator.
  - *If the medical record indicates that three or more samples were returned,* the member meets the screening criteria for inclusion in the numerator.
  - *If the medical record indicates that fewer than three samples were returned,* the member does not meet the screening criteria.

Do not count digital rectal exams (DRE), FOBT tests performed in an office setting or performed on a sample collected via DRE.

Data Elements for Reporting

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

Table COL-A-4: Data Elements for Colorectal Cancer Screening

Metric	Age	Data Element	Reporting Instructions
ColorectalCancerScreening	46-49	EligiblePopulation	For each Stratification
	50-75	ExclusionAdminRequired	For each Stratification
	Total	NumeratorByAdmin	For each Stratification
		NumeratorBySupplemental	For each Stratification
		Rate	(Percent)

Table COL-B-4: Data Elements for Colorectal Cancer Screening: Stratifications by Race

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

Table COL-C-4: Data Elements for Colorectal Cancer Screening: Stratifications by Ethnicity

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

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

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

Controlling High Blood Pressure (CBP)

SUMMARY OF CHANGES TO MY 2023 HEDIS FOR QRS

- Added a required exclusion for members who died during the measurement year.
- Replaced the reference of "female members" to "members" in the required exclusions.
- Added a direct reference code for palliative care.
- Revised the optional exclusions to be required exclusions.
- Updated the number of occurrences required for the frailty cross-cutting exclusion.

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 line Exchange.

Stratifications 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 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.

Anchor date December 31 of the measurement year.

Benefit Medical.

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

Step 1 Identify members who had at least two visits on different dates of service with a diagnosis of hypertension on or between January 1 of the year prior to the measurement year and June 30 of the measurement year. Visit type need not be the same for the two visits. Any of the following code combinations meet criteria:

- Outpatient visit (Outpatient Without UBREV Value Set) with any diagnosis of hypertension (Essential Hypertension Value Set).
- A telephone visit (Telephone Visits Value Set) with any diagnosis of hypertension (Essential Hypertension Value Set).
- An e-visit or virtual check-in (Online Assessments Value Set) with any diagnosis of hypertension (Essential Hypertension Value Set).

Step 2 Remove members who had a nonacute inpatient admission during the measurement year. To identify nonacute inpatient admissions:

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

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

- Members in hospice or using hospice services any time during the measurement year. Refer to *General Guideline 8: Members in Hospice.*
- Members who died any time during the measurement year. *Refer to General Guideline 9: 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) during the measurement year.
- Members with evidence of end-stage renal disease (ESRD) (ESRD Diagnosis Value Set), dialysis (Dialysis Procedure Value Set), nephrectomy (Total Nephrectomy Value Set; Partial Nephrectomy Value Set) or kidney transplant (Kidney Transplant 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.
- Members with a diagnosis of pregnancy (Pregnancy Value Set) 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.*

- Members 66–80 years of age as of December 31 of the measurement year 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 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 Identify the most recent BP reading (Systolic Blood Pressure Value Set; Diastolic Blood Pressure Value Set) taken during the measurement year. Exclude BPs taken in an acute inpatient setting (Acute Inpatient Value Set; Acute Inpatient POS Value Set) or during an ED visit (ED Value Set; ED POS Value Set).

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

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

Organizations that use CPT Category II codes to identify numerator compliance for this indicator must search for all codes in the following value sets and use the most recent codes during the measurement year to determine numerator compliance for both systolic and diastolic levels.

Value Set	Numerator Compliance
Systolic Less Than 140 Value Set	Systolic compliant
Systolic Greater Than or Equal To 140 Value Set	Systolic not compliant
Diastolic Less Than 80 Value Set	Diastolic compliant
Diastolic 80–89 Value Set	Diastolic compliant
Diastolic Greater Than or Equal To 90 Value Set	Diastolic not compliant

Hybrid Specification

Denominator A systematic sample drawn from the eligible population.

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

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

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

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

Numerator

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

Administrative

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

Medical record

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

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

Do not include BP readings:

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

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

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

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

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

Note

- *When identifying the most recent BP reading, all eligible BP readings in the appropriate medical record should be considered, regardless of practitioner type and setting (excluding acute inpatient and ED visit settings).*
- *An EMR can be used to identify the most recent BP reading if it meets the criteria for appropriate medical record.*
- *When excluding BP readings from the numerator, the intent is to identify diagnostic or therapeutic procedures that require a medication regimen, a change in diet or a change in medication. For example (this list is just for reference 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 just 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 for QRS data to NCQA must provide the following data elements.

Table CBP-A-4: 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-4: Data Elements for Controlling High Blood Pressure: Stratifications by Race

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

Table CBP-C-4: Data Elements for Controlling High Blood Pressure: Stratifications by Ethnicity

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

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

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

Eye Exam for Patients With Diabetes (EED)

SUMMARY OF CHANGES TO MY 2023 HEDIS FOR QRS

- 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.
- Added a Note to clarify that an eye exam result documented as "unknown" does not meet criteria.

Description

The percentage of members 18–75 years of age with diabetes (types 1 and 2) who had a retinal eye exam.

Eligible Population

Product lines	Exchange.
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.
Anchor date	December 31 of the measurement year.
Benefit	Medical.
Event/diagnosis	There are two ways to identify members with diabetes: by claim/encounter data and by pharmacy data. The organization must use both methods to identify the eligible population, but a member only needs to be identified by one method to be included in the measure. Members may be identified as having diabetes during the measurement year or the year prior to the measurement year. *Claim/encounter data*. Members who met any of the following criteria during the measurement year or the year prior to the measurement year (count services that occur over both years): • At least one acute inpatient encounter (Acute Inpatient Value Set) with a diagnosis of diabetes (Diabetes Value Set) ***without*** telehealth (Telehealth Modifier Value Set; Telehealth POS Value Set). • At least one acute inpatient discharge with a diagnosis of diabetes (Diabetes Value Set) on the discharge claim. To identify an acute inpatient discharge: 1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set). 2. Exclude nonacute inpatient stays (Nonacute Inpatient Stay Value Set). 3. Identify the discharge date for the stay. • At least two outpatient visits (Outpatient Value Set), observation visits (Observation Value Set), telephone visits (Telephone Visits Value Set),e-visits or virtual check-ins (Online Assessments Value Set), ED visits (ED Value Set), nonacute inpatient encounters (Nonacute Inpatient Value Set) or nonacute inpatient discharges (instructions below; the diagnosis must be on the discharge claim), on different dates of service, with a diagnosis of diabetes (Diabetes Value Set). Visit type need not be the same for the two encounters. To identify a nonacute inpatient discharge:

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

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

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

Diabetes Medications

Description	Prescription		
Alpha-glucosidase inhibitors	• Acarbose	• Miglitol	
Amylin analogs	• Pramlintide		
Antidiabetic combinations	• Alogliptin-metformin • Alogliptin-pioglitazone • Canagliflozin-metformin • Dapagliflozin-metformin • Dapagliflozin-saxagliptin • Empagliflozin-linagliptin • Empagliflozin-linagliptin metformin	• Empagliflozin-metformin • Ertugliflozin-metformin • Ertugliflozin-sitagliptin • Glimepiride-pioglitazone • Glipizide-metformin • Glyburide-metformin • Linagliptin-metformin	• Metformin-pioglitazone • Metformin-repaglinide • Metformin-rosiglitazone • Metformin-saxagliptin • Metformin-sitagliptin
Insulin	• Insulin aspart • Insulin aspart-insulin aspart protamine • Insulin degludec • Insulin 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	• Nateglinide	• Repaglinide	
Glucagon-like peptide-1 (GLP1) agonists	• Albiglutide • Dulaglutide • Exenatide	• Liraglutide (excluding Saxenda®) • Lixisenatide	• Semaglutide
Sodium glucose cotransporter 2 (SGLT2) inhibitor	• Canagliflozin	• Dapagliflozin (excluding Farxiga®)	• Empagliflozin • Ertugliflozin
Sulfonylureas	• Chlorpropamide • Glimepiride	• Glipizide • Glyburide	• Tolazamide • Tolbutamide
Thiazolidinediones	• Pioglitazone	• Rosiglitazone	
Dipeptidyl peptidase-4 (DDP-4) inhibitors	• Alogliptin • Linagliptin	• Saxagliptin • Sitagliptin	

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

Required exclusions

Exclude members who meet any of the following criteria:

- Members who do not have a diagnosis of diabetes (Diabetes Value Set), in any setting, during the measurement year or the year prior to the measurement year ***and*** who had a diagnosis of polycystic ovarian syndrome, gestational diabetes or steroid-induced diabetes (Diabetes Exclusions Value Set), in any setting, during the measurement year or the year prior to the measurement year.
- Members in hospice or using hospice services any time during the measurement year. Refer to *General Guideline 8: Members in Hospice.*
- Members who died any time during the measurement year. Refer to *General Guideline 9: 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.*

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

Dementia Medications

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

Administrative Specification

Denominator The eligible population.

Numerator Screening or monitoring for diabetic retinal disease as identified by administrative data. This includes diabetics who had one of the following:

- A retinal or dilated eye exam by an eye care professional (optometrist or ophthalmologist) in the measurement year.
- A *negative* retinal or dilated eye exam (negative for retinopathy) by an eye care professional in the year prior to the measurement year.
- Bilateral eye enucleation any time during the member's history through December 31 of the measurement year.

Any of the following meet criteria:

- Any code in the Diabetic Retinal Screening Value Set billed by an eye care professional (optometrist or ophthalmologist) during the measurement year.
- Any code in the Diabetic Retinal Screening Value Set billed by an eye care professional (optometrist or ophthalmologist) during the year prior to the measurement year, with a diagnosis of diabetes without complications (Diabetes Mellitus Without Complications Value Set).
- Any code in the Eye Exam With Evidence of Retinopathy Value Set, Eye Exam Without Evidence of Retinopathy Value Set or Automated Eye Exam Value Set billed by any provider type during the measurement year.
- Any code in the Eye Exam Without Evidence of Retinopathy Value Set billed by any provider type during the year prior to the measurement year.
- Any code in the Diabetic Retinal Screening Negative In Prior Year Value Set billed by any provider type during the measurement year.
- Unilateral eye enucleation (Unilateral Eye Enucleation Value Set) ***with*** a bilateral modifier (Bilateral Modifier Value Set).
- Two unilateral eye enucleations (Unilateral Eye Enucleation Value Set) with service dates 14 days or more apart. For example, if the service date for the first unilateral eye enucleation was February 1 of the measurement year, the service date for the second unilateral eye enucleation must be on or after February 15.
- Left unilateral eye enucleation (Unilateral Eye Enucleation Left Value Set) ***and*** right unilateral eye enucleation (Unilateral Eye Enucleation Right Value Set) on the same or different dates of service.
- A unilateral eye enucleation (Unilateral Eye Enucleation Value Set) and a left unilateral eye enucleation (Unilateral Eye Enucleation Left Value Set) with service dates 14 days or more apart.

- A unilateral eye enucleation (Unilateral Eye Enucleation Value Set) and a right unilateral eye enucleation (Unilateral Eye Enucleation Right Value Set) with service dates 14 days or more apart.

Hybrid Specification

Denominator

A systematic sample drawn from the eligible population.

Organizations that use the Hybrid Method to report the Hemoglobin A1c Control for Patients With Diabetes (HBD) and Eye Exam for Patients With Diabetes (EED) measures may use the same sample for both measures. If the same sample is used for both diabetes measures, the organization must first take the inverse of the HbA1c Poor Control >9.0% rate (100 minus the HbA1c Poor Control rate) before reducing the sample.

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

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

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

Numerator

Screening or monitoring for diabetic retinal disease as identified by administrative data or medical record review. This includes diabetics who had one of the following:

- A retinal or dilated eye exam by an eye care professional (optometrist or ophthalmologist) in the measurement year.
- A negative retinal or dilated exam (negative for retinopathy) by an eye care professional (optometrist or ophthalmologist) in the year prior to the measurement year.

Bilateral eye enucleation any time during the member's history through December 31 of the measurement year.

Administrative

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

Medical record

At a minimum, documentation in the medical record must include one of the following:

- A note or letter prepared by an ophthalmologist, optometrist, PCP or other health care professional indicating that an ophthalmoscopic exam was completed by an eye care professional (optometrist or ophthalmologist), the date when the procedure was performed and the results.
- A chart or photograph indicating the date when the fundus photography was performed and one of the following:
  - Evidence that an eye care professional (optometrist or ophthalmologist) reviewed the results.
  - Evidence results were read by a qualified reading center that operates under the direction of a medical director who is a retinal specialist.

Evidence results were read by a system that provides an artificial intelligence (AI) interpretation.

- Evidence that the member had bilateral eye enucleation or acquired absence of both eyes. Look as far back as possible in the member's history through December 31 of the measurement year.
- Documentation of a negative retinal or dilated exam by an eye care professional (optometrist or ophthalmologist) in the year prior to the measurement year, where results indicate retinopathy was not present (e.g., documentation of normal findings).
  - Documentation does not have to state specifically "no diabetic retinopathy" to be considered negative for retinopathy; however, it must be clear that the patient had a dilated or retinal eye exam by an eye care professional (optometrist or ophthalmologist) and that retinopathy was not present. Notation limited to a statement that indicates "diabetes without complications" does not meet criteria.

Note

- *Blindness is not an exclusion for a diabetic eye exam because it is difficult to distinguish between individuals who are legally blind but require a retinal exam and those who are completely blind and therefore do not require an exam.*
- *Hypertensive retinopathy is not handled differently from diabetic retinopathy when reporting this measure; for example, an eye exam documented as positive for hypertensive retinopathy is counted as positive for diabetic retinopathy and an eye exam documented as negative for hypertensive retinopathy is counted as negative for diabetic retinopathy. The intent of this measure is to ensure that members with evidence of any type of retinopathy have an eye exam annually, while members who remain free of retinopathy (i.e., the retinal exam was negative for retinopathy) are screened every other year.*
- *An eye exam result documented as "unknown" does not meet criteria.*

Data Elements for Reporting

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

Table EED-4: Data Elements for Eye Exam for Patients With Diabetes

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

Follow-Up After Hospitalization for Mental Illness (FUH)

SUMMARY OF CHANGES TO MY 2023 HEDIS FOR QRS

- Added a required exclusion for members who died during the measurement year.

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 line	Exchange.
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.
Continuous enrollment	The total is the sum of the age stratifications. Date of discharge through 30 days after discharge.
Allowable gap	None.
Anchor date	None.
Benefits	Medical and mental health (inpatient and outpatient).
Event/diagnosis	An acute inpatient discharge with a principal diagnosis of mental illness or intentional self-harm (Mental Illness Value Set; Intentional Self-Harm Value Set) on the discharge claim on or between January 1 and December 1 of the measurement year. To identify acute inpatient discharges: 1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set). 2. Exclude nonacute inpatient stays (Nonacute Inpatient Stay Value Set). 3. Identify the discharge date for the stay. The denominator for this measure is based on discharges, not on members. If members have more than one discharge, include all discharges on or between January 1 and December 1 of the measurement year.
Acute readmission or direct transfer	Identify readmissions and direct transfers to an acute inpatient care setting during the 30-day follow-up period: 1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set). 2. Exclude nonacute inpatient stays (Nonacute Inpatient Stay Value Set). 3. Identify the admission date for the stay (the admission date must occur during the 30-day follow-up period).

4. Identify the discharge date for the stay.

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

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

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

Nonacute readmission or direct transfer

Exclude discharges followed by readmission or direct transfer to a nonacute inpatient care setting within the 30-day follow-up period, regardless of 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 any time during the measurement year. Refer to *General Guideline 8: Members in Hospice.*
- Members who died any time during the measurement year. Refer to *General Guideline 9: Deceased Members.*

Administrative Specification

Denominator

The eligible population.

Numerator

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 1 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 for QRS data to NCQA must provide the following data elements.

Table FUH-4: 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)

Hemoglobin A1c Control for Patients With Diabetes (HBD)

SUMMARY OF CHANGES TO MY 2023 HEDIS FOR QRS

- 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.

HEDIS FOR QRS SPECIFIC GUIDANCE

- In the Draft 2023 Call Letter, CMS proposed to transition HbA1c Control for Patient With Diabetes: HbA1c Control (<8.0%) to the HbA1c Control for Patient with Diabetes: HbA1c Poor Control (>9.0%) measure. If the measure is finalized for inclusion in the QRS measure set, CMS will begin collecting it for the 2024 ratings year, with scoring for the measure beginning with the 2025 ratings year. The HbA1c Control and HbA1c Poor Control measure specifications are included in this version of the Technical Specifications for reference. Refer to the Final 2023 Call Letter and the *2024 QRS and QHP Enrollee Survey Technical Guidance* for reporting this measure.

Description

The percentage of members 18–75 years of age with diabetes (types 1 and 2) whose hemoglobin A1c (HbA1c) was at the following level during the measurement year:

- HbA1c control (<8.0%).
- HbA1c Poor Control (>9.0%)

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

Eligible Population

Product line

Exchange.

Stratification

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.

Finalized Data Submission Requirements for the 2024 Ratings Year

In the Final 2023 Call Letter, CMS finalized the transition of *Hemoglobin A1c (HbA1c) Control for Patients with Diabetes: HbA1c control (<8.0%)* measure to the *Hemoglobin A1c (HbA1c) Control for Patients with Diabetes: HbA1c poor control (>9.0%)* measure for the 2024 ratings year. For the 2024 ratings year, CMS will collect the *Hemoglobin A1c (HbA1c) Control for Patients with Diabetes: HbA1c poor control (>9.0%)* measure. CMS will not collect the *Hemoglobin A1c (HbA1c) Control for Patients with Diabetes: HbA1c control (<8.0%)* measure.

In the Final 2023 Call Letter, CMS finalized required reporting of race and ethnicity stratifications for the *Hemoglobin A1c (HbA1c) Control for Patients with Diabetes: HbA1c poor control (>9.0%)* measure for the 2024 ratings year.

- 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.

Anchor date

December 31 of the measurement year.

Benefit

Medical.

Event/diagnosis

There are two ways to identify members with diabetes: by claim/encounter data and by pharmacy data. The organization must use both methods to identify the eligible population, but a member only needs to be identified by one method to be included in the measure. Members may be identified as having diabetes during the measurement year or the year prior to the measurement year.

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

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

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

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

Diabetes Medications

Description	Prescription		
Alpha-glucosidase inhibitors	• Acarbose	• Miglitol	
Amylin analogs	• Pramlintide		
Antidiabetic combinations	• Alogliptin-metformin • Alogliptin-pioglitazone • Canagliflozin-metformin • Dapagliflozin-metformin • Dapagliflozin-saxagliptin • Empagliflozin-linagliptin • Empagliflozin-linagliptin-metformin	• Empagliflozin-metformin • Ertugliflozin-metformin • Ertugliflozin-sitagliptin • Glimepiride-pioglitazone • Glipizide-metformin • Glyburide-metformin	• Linagliptin-metformin • Metformin-pioglitazone • Metformin-repaglinide • Metformin-rosiglitazone • Metformin-saxagliptin • Metformin-sitagliptin
Insulin	• Insulin aspart • Insulin aspart-insulin aspart protamine • Insulin degludec • Insulin 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	• Nateglinide	• Repaglinide	
Glucagon-like peptide-1 (GLP1) agonists	• Albiglutide • Dulaglutide • Exenatide	• Liraglutide (excluding Saxenda®) • Lixisenatide • Semaglutide	
Sodium glucose cotransporter 2 (SGLT2) inhibitor	• Canagliflozin • Dapagliflozin (excluding Farxiga®)	• Ertugliflozin • Empagliflozin	
Sulfonylureas	• Chlorpropamide • Glimepiride	• Glipizide • Glyburide	• Tolazamide • Tolbutamide
Thiazolidinediones	• Pioglitazone	• Rosiglitazone	
Dipeptidyl peptidase-4 (DDP-4) inhibitors	• Alogliptin • Linagliptin	• Saxagliptin • Sitagliptin	

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

Required exclusions

Exclude members who meet any of the following criteria:

- Members who 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 in hospice or using hospice services any time during the measurement year. Refer to *General Guideline 8: Members in Hospice.*

- Members who died any time during the measurement year. Refer to *General Guideline 9: 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.*

- Members 66 years of age and older as of December 31 of the measurement year (all product lines) with frailty ***and*** advanced illness. Members must meet **BOTH** of the following frailty and advanced illness criteria to be excluded:
  1. At least 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.
     - Identify the discharge date for the stay.
     - At least one acute inpatient encounter (Acute Inpatient Value Set) with an advanced illness diagnosis (Advanced Illness Value Set).
     - At least one acute inpatient discharge with an advanced illness diagnosis (Advanced Illness Value Set) on the discharge claim. To identify an acute inpatient discharge:
       1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
       2. Exclude nonacute inpatient stays (Nonacute Inpatient Stay Value Set).
       3. Identify the discharge date for the stay.
     - A dispensed dementia medication (Dementia Medications List).

Dementia Medications

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

Administrative Specification

Denominator The eligible population.

HbA1c Control <8% Use codes (HbA1c Lab Test Value Set; HbA1c Test Result or Finding Value Set) to identify the most recent HbA1c test during the measurement year. The member is numerator compliant if the most recent HbA1c level is <8.0%. The member is not numerator compliant if the result for the most recent HbA1c test is ≥8.0% or is missing a result, or if an HbA1c test was not done during the measurement year.

Organizations that use CPT Category II codes to identify numerator compliance for this indicator must search for all codes in the following value sets and use the most recent code during the measurement year to evaluate whether the member is numerator compliant.

Value Set	Numerator Compliance
HbA1c Level Less Than 7.0 Value Set	Compliant
HbA1c Level Greater Than or Equal To 7.0 and Less Than 8.0 Value Set	Compliant
HbA1c Level Greater Than or Equal To 8.0 and Less Than or Equal To 9.0 Value Set	Not compliant
HbA1c Level Greater Than 9.0 Value Set	Not compliant

HbA1c Poor Control >9% Use codes (HbA1c Lab Test Value Set; HbA1c Test Result or Finding Value Set) to identify the *most recent* HbA1c test during the measurement year. The member is numerator compliant if the most recent HbA1c level is >9.0% or is missing a result, or if an HbA1c test was not done during the measurement year. The member is not numerator compliant if the result for the most recent HbA1c test during the measurement year is ≤9.0%.

Organizations that use CPT Category II codes to identify numerator compliance for this indicator must search for all codes in the following value sets and use the most recent code during the measurement year to evaluate whether the member is numerator compliant.

Value Set	Numerator Compliance
HbA1c Level Less Than 7.0 Value Set	Not compliant
HbA1c Level Greater Than or Equal To 7.0 and Less Than 8.0 Value Set	Not compliant
HbA1c Level Greater Than or Equal To 8.0 and Less Than or Equal To 9.0 Value Set	Not compliant
HbA1c Level Greater Than 9.0 Value Set	Compliant

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

Hybrid Specification

Denominator

A systematic sample drawn from the eligible population.

Organizations that use the Hybrid Method to report the Hemoglobin A1c Control for Patients With Diabetes (HBD) and Eye Exam for Patients With Diabetes (EED) measures may use the same sample for both measures. If the same sample is used for both diabetes measures, the organization must first take the inverse of the HbA1c poor control >9.0% rate (100 minus the HbA1c poor control rate) before reducing the sample.

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

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

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

Numerator

HbA1C Control <8%

The most recent HbA1c level (performed during the measurement year) is <8.0% as identified by laboratory data or medical record review.

Administrative

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

Medical Record

At a minimum, documentation in the medical record must include a note indicating the date when the HbA1c test was performed and the result. The member is numerator compliant if the most recent HbA1c level during the measurement year is <8.0%. The member is not numerator compliant if the result for the most recent HbA1c level during the measurement year is ≥8.0% or is missing, or if an HbA1c test was not performed during the measurement year.

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

HbA1c Control >9%

The most recent HbA1c level (performed during the measurement year) is >9.0% or is missing, or was not done during the measurement year, as documented through laboratory data or medical record review.

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

Administrative

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

Medical Record

At a minimum, documentation in the medical record must include a note indicating the date when the HbA1c test was performed and the result. The member is numerator compliant if the result for the most recent HbA1c level during the measurement year is >9.0% or is missing, or if an HbA1c test was not done during the measurement year. The member is not numerator compliant if the most recent HbA1c level during the measurement year is ≤9.0%.

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

Note

- *If a combination of administrative, supplemental or hybrid data are used, the most recent HbA1c result must be used, regardless of data source.*

Data Elements for Reporting

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

Table HBD-A-4: Data Elements for Hemoglobin A1c Control for Patients With Diabetes

Metric	Data Element	Reporting Instructions	A
Adequate HbA1cControl	CollectionMethod	Repeat per Metric	✓
PoorHbA1cControl	EligiblePopulation*	For each Metric	✓
	ExclusionAdminRequired*	For each Metric	✓
	NumeratorByAdminElig	For each Metric	
	CYAR	(Percent)	
	MinReqSampleSize	Repeat per Metric	
	OversampleRate	Repeat per Metric	
	OversampleRecordsNumber	(Count)	
	ExclusionValidDataErrors	Repeat per Metric	
	ExclusionEmployeeOrDep	Repeat per Metric	
	OversampleRecsAdded	Repeat per Metric	
	Denominator	Repeat per Metric	
	NumeratorByAdmin	For each Metric	✓
	NumeratorByMedicalRecords	For each Metric	
	NumeratorBySupplemental	For each Metric	✓
	Rate	(Percent)	✓

Table HBD-B-4: Data Elements for Hemoglobin A1c Control for Patients With Diabetes: Stratifications by Race

Metric
AdequateHbA1cControl
PoorHbA1cControl

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

Table HBD-C-4: Data Elements for Hemoglobin A1c Control for Patients With Diabetes: Stratifications by Ethnicity

Metric
AdequateHbA1cControl
PoorHbA1cControl

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

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

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

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

*Immunizations for Adolescents (IMA)**

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

SUMMARY OF CHANGES TO MY 2023 HEDIS FOR QRS

- Added instructions to report rates stratified by race and ethnicity.
- Added a required exclusion for members who died during the measurement year.
- Added new data elements tables for race and ethnicity stratification reporting.

HEDIS FOR QRS SPECIFIC GUIDANCE

- HEDIS for QRS only reports Combination 2 and related antigens.
- In the Draft 2023 Call Letter, CMS proposed to expand required collection and reporting of stratified race and ethnicity data for this measure beginning with MY 2023 (2024 ratings year). Refer to the Final 2023 Call Letter and the *2024 QRS and QHP Enrollee Survey Technical Guidance* for reporting this measure.

Finalized Data Submission Requirements for the 2024 Ratings Year

In the Final 2023 Call Letter, CMS finalized the requirement to collect and report race and ethnicity stratifications for the *Immunization for Adolescents* measure.

Description

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

Eligible Population

Product line Exchange.

Stratifications 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	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.
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: • Members in hospice or using hospice services any time during the measurement year. Refer to *General Guideline 8: Members in Hospice.* • Members who died any time during the measurement year. *Refer to General Guideline 9: Deceased Members.*

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

Hybrid Specification

Denominator A systematic sample drawn from the eligible population. 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 or "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 for QRS data to NCQA must provide the following data elements.

Table IMA-A-4: 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	✓
Combo2	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 IMA-B-4: 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	
Combo2	Asian		Numerator	For each Metric and Stratification	✓
	NativeHawaiianOrOtherPacificIslander		Rate	(Percent)	✓
	SomeOtherRace				
	TwoOrMoreRaces				
	AskedButNoAnswer*				
	Unknown**				

Table IMA-C-4: 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	
Combo2	Unknown**		Numerator	For each Metric and Stratification	✓
			Rate	(Percent)	✓

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

Initiation and Engagement of Substance Use Disorder Treatment (IET)

SUMMARY OF CHANGES TO MY 2023 HEDIS FOR QRS

- Added instructions to report rates stratified by race and ethnicity.
- Replaced "detoxification" references with "withdrawal management."
- Added a required exclusion for members who died during the measurement year.
- Added new data elements tables for race and ethnicity stratification reporting.

Finalized Data Submission Requirements for the 2024 Ratings Year

In the Final 2023 Call Letter, CMS finalized the requirement to collect and report race and ethnicity stratifications for the *Initiation and Engagement of Substance Use Disorder Treatment* measure.

HEDIS FOR QRS SPECIFIC GUIDANCE

- In the Final 2022 Call Letter, CMS finalized temporary removal of the measure from scoring for MY 2022 (2023 ratings year) and anticipates reintroducing this measure for scoring beginning with MY 2023 (i.e., 2024 ratings year).
- In the Draft 2023 Call Letter, CMS proposed to expand required collection and reporting of stratified race and ethnicity data for this measure beginning with MY 2023 (i.e., 2024 ratings year). Refer to the Final 2023 Call Letter and the *2024 QRS and QHP Enrollee Survey Technical Guidance* for reporting this measure.

Description

The percentage of new substance use disorder (SUD) episodes that result in treatment initiation and engagement. Two rates are reported:

- *Initiation of SUD Treatment.* The percentage of new SUD episodes that result in treatment initiation through an inpatient SUD admission, outpatient visit, intensive outpatient encounter, partial hospitalization, telehealth visit or medication treatment within 14 days.
- *Engagement of SUD Treatment.* The percentage of new SUD episodes that have evidence of treatment engagement within 34 days of initiation.

Definitions

Intake Period	November 15 of the year prior to the measurement year–November 14 of the measurement year. The intake period is used to capture new SUD episodes.
SUD Episode	An encounter during the intake period with a diagnosis of SUD. *For visits that result in an inpatient stay*, the inpatient discharge is the SUD Episode (an SUD diagnosis is not required for the inpatient stay; use the diagnosis from the visit that resulted in the inpatient stay to determine the diagnosis cohort).
SUD Episode Date	The date of service for an encounter during the intake period with a diagnosis of SUD. For a visit (not resulting in an inpatient stay), the SUD episode date is the date of service. For an inpatient stay or for withdrawal management (i.e., detoxification) that occurred during an inpatient stay, *the SUD episode date is the date of discharge*. For withdrawal management (i.e., detoxification), other than those that occurred during an inpatient stay, *the SUD episode date is the date of service*.

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

Date of service for services billed weekly or monthly

For an opioid treatment service that bills monthly or weekly (OUD Weekly Non Drug Service Value Set; OUD Monthly Office Based Treatment Value Set; OUD Weekly Drug Treatment Service Value Set), if the service includes a range of dates, then use the earliest date as the date of service. Use this date for all relevant events (the SUD, negative diagnosis history and numerator events).

Direct transfer

A direct transfer is when the discharge date from the first inpatient setting precedes the admission date to a second inpatient setting by one calendar day or less. For example:

- An inpatient discharge on June 1, followed by an admission to another inpatient setting on June 1, *is a direct transfer*.
- An inpatient discharge on June 1, followed by an admission to an inpatient setting on June 2, *is a direct transfer*.
- An inpatient discharge on June 1, followed by an admission to another inpatient setting on June 3, *is not a direct transfer*; these are two distinct inpatient stays.

Use the following method to identify admissions to and discharges from inpatient settings.

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

Eligible Population

Product line

Exchange.

Stratifications

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

13 years and older as of the SUD Episode Date. Report three age stratifications and a total rate.

- 13–17 years.
- 18–64 years.
- 65+ years
- Total.

The total is the sum of the age stratifications.

SUD diagnosis cohort stratification

Report the following SUD diagnosis cohorts and a total:

- Alcohol use disorder.
- Opioid use disorder.
- Other substance use disorder.
- Total.

The total is the sum of the SUD diagnosis cohort stratifications.

Continuous enrollment

194 days prior to the SUD Episode Date through 47 days after the SUD Episode Date (242 total days).

Allowable gap

None.

Anchor date

None.

Benefits

Medical, pharmacy and chemical dependency (inpatient and outpatient).

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

Event/diagnosis

New episode of SUD during the intake period.

Follow the steps below to identify the denominator for both rates.

Step 1 Identify all SUD episodes. Any of the following meet criteria:

- An outpatient visit (Visit Setting Unspecified Value Set) ***with*** (Outpatient POS Value Set) and ***with*** one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- An outpatient visit (BH Outpatient Value Set) ***with*** one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- An intensive outpatient encounter or partial hospitalization (Visit Setting Unspecified Value Set) ***with*** (Partial Hospitalization POS Value Set) and ***with*** one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- An intensive outpatient encounter or partial hospitalization (Partial Hospitalization or Intensive Outpatient Value Set) ***with*** one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- A non-residential substance abuse treatment facility visit (Visit Setting Unspecified Value Set) ***with*** (Non-residential Substance Abuse Treatment Facility POS Value Set) and ***with*** one of the following: Alcohol Abuse and Dependence Value Set,

Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.

- A community mental health center visit (Visit Setting Unspecified Value Set) ***with*** (Community Mental Health Center POS Value Set) and ***with*** one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- A telehealth visit (Visit Setting Unspecified Value Set) ***with*** (Telehealth POS Value Set) and ***with*** one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- A substance use disorder service (Substance Use Disorder Services Value Set) ***with*** one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- A withdrawal management event (Detoxification Value Set) ***with*** one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- An ED visit (ED Value Set) ***with*** one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- An observation visit (Observation Value Set) ***with*** one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- An acute or nonacute inpatient discharge ***with*** one of the following on the discharge claim: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set. To identify acute and nonacute inpatient discharges:
  1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
  2. Identify the discharge date for the stay.
- A telephone visit (Telephone Visits Value Set) ***with*** one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- An e-visit or virtual check-in (Online Assessments Value Set) ***with*** one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- An opioid treatment service (OUD Weekly Non Drug Service Value Set; OUD Monthly Office Based Treatment Value Set; OUD Weekly Drug Treatment Service Value Set) ***with*** a diagnosis of opioid abuse or dependence (Opioid Abuse and Dependence Value Set).

Step 2 Test for Negative SUD diagnosis history. Remove SUD episodes if there was an encounter in any setting other than an ED visit (ED Value Set) or a withdrawal management event (Detoxification Value Set) ***with*** a diagnosis of SUD (Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set) during the 194 days prior to the SUD Episode Date.

If the SUD episode was an inpatient stay, use the admission date to determine negative SUD history.

For visits with an SUD diagnosis that resulted in an inpatient stay (where the inpatient stay becomes the SUD Episode)*,* use the earliest date of service to determine the negative SUD diagnosis history (so that the visit that resulted in the inpatient stay is not considered a positive diagnosis history).

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

Step 3 Test for negative SUD medication history. Remove SUD episodes if any of the following occurred during the 194 days prior to the SUD episode date:

- An SUD medication treatment dispensing event (Alcohol Use Disorder Treatment Medications List; Naltrexone Injection Medications List; Buprenorphine Oral Medications List; Buprenorphine Injection Medications List; Buprenorphine Implant Medications List; Buprenorphine Naloxone Medications List).
- An SUD medication administration event (Naltrexone Injection Value Set; Buprenorphine Oral Value Set; Buprenorphine Oral Weekly Value Set; Buprenorphine Injection Value Set; Buprenorphine Naloxone Value Set; Buprenorphine Implant Value Set; Methadone Oral Value Set; Methadone Oral Weekly Value Set).

Step 4 Remove SUD episodes that do not meet continuous enrollment criteria. Members must be continuously enrolled from 194 days before the SUD Episode Date through 47 days after the SUD Episode Date (242 total days), with no gaps.

Note: *The denominator for this measure is based on episodes, not on members. All eligible episodes that were not removed remain in the denominator.*

Step 5 Identify the SUD diagnosis cohort for each SUD episode.

- If the SUD episode has a diagnosis of alcohol use disorder (Alcohol Abuse and Dependence Value Set), include the episode in the alcohol use disorder cohort.
- If the SUD episode has a diagnosis of opioid use disorder (Opioid Abuse and Dependence Value Set), include the episode in the opioid use disorder cohort.
- If the SUD episode has a diagnosis of SUD that is neither for opioid nor alcohol (Other Drug Abuse and Dependence Value Set), place the member in the other substance use disorder cohort.

Include SUD episodes in all SUD diagnosis cohorts for which they meet criteria. For example, if the SUD episode has a diagnosis of alcohol use disorder and opioid use disorder, include the episode in the alcohol use disorder and opioid use disorder cohorts.

Required 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 8: Members in Hospice*.
- Members who died any time during the measurement year. Refer to *General Guideline 9: Deceased Members*.

Administrative Specification

Denominator The eligible population.

Numerator

Initiation of SUD Treatment Initiation of SUD treatment within 14 days of the SUD Episode Date. Follow the steps below to identify numerator compliance.

Step 1 *If the SUD episode was an inpatient discharge*, the inpatient stay is considered initiation of treatment and the SUD episode is compliant.

Step 2 *If the SUD Episode was an opioid treatment service that bills monthly* (OUD Monthly Office Based Treatment Value Set), the opioid treatment service is considered initiation of treatment and the SUD episode is compliant.

Step 3 For remaining SUD Episodes (those not compliant after steps 1–2), identify episodes with at least one of the following on the SUD Episode Date or during the 13 days after the SUD Episode Date (14 total days).

- An acute or nonacute inpatient admission ***with*** a diagnosis (on the discharge claim) of one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set. To identify acute and nonacute inpatient admissions:
  1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
  2. Identify the admission date for the stay.
- An outpatient visit (Visit Setting Unspecified Value Set) ***with*** (Outpatient POS Value Set) ***with*** one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- An outpatient visit (BH Outpatient Value Set) ***with*** one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- An intensive outpatient encounter or partial hospitalization (Visit Setting Unspecified Value Set) ***with*** (Partial Hospitalization POS Value Set) ***with*** one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- An intensive outpatient encounter or partial hospitalization (Partial Hospitalization or Intensive Outpatient Value Set) ***with*** one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- A non-residential substance abuse treatment Facility visit (Visit Setting Unspecified Value Set) ***with*** (Non-residential Substance Abuse Treatment Facility POS Value Set) ***with*** one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- A community mental health center visit (Visit Setting Unspecified Value Set) ***with*** (Community Mental Health Center POS Value Set) ***with*** one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.

- A telehealth visit: (Visit Setting Unspecified Value Set) ***with*** (Telehealth POS Value Set) ***with*** one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- A substance use disorder service (Substance Use Disorder Services Value Set) ***with*** one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- Observation Value Set ***with*** one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- A telephone visit (Telephone Visits Value Set) ***with*** one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- An e-visit or virtual check-in (Online Assessments Value Set) ***with*** one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- A weekly or monthly opioid treatment service (OUD Weekly Non Drug Service Value Set; OUD Monthly Office Based Treatment Value Set; OUD Weekly Drug Treatment Service Value Set).
- For SUD episodes in the alcohol use disorder cohort, an alcohol use disorder medication treatment dispensing event (Alcohol Use Disorder Treatment Medications List) or a medication administration event (Naltrexone Injection Value Set).
- For SUD episodes in the opioid use disorder cohort, an opioid use disorder medication treatment dispensing event (Naltrexone Oral Medications List; Naltrexone Injection Medications List; Buprenorphine Oral Medications List; Buprenorphine Injection Medications List; Buprenorphine Implant Medications List; Buprenorphine Naloxone Medications List) or a medication administration event (Naltrexone Injection Value Set, Buprenorphine Oral Value Set, Buprenorphine Oral Weekly Value Set, Buprenorphine Injection Value Set, Buprenorphine Implant Value Set, Buprenorphine Naloxone Value Set, Methadone Oral Value Set, Methadone Oral Weekly Value Set).

For all initiation events except medication treatment dispensing events and medication administration events, initiation on the same day as the SUD episode date must be with different providers in order to count.

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

Engagement of SUD Treatment

Follow the steps below to identify numerator compliance.

If Initiation of SUD Treatment was an inpatient admission, the 34-day period for engagement begins the day after discharge.

Step 1 Identify all SUD episodes compliant for the Initiation of SUD Treatment numerator. SUD episodes that are not compliant for Initiation of SUD Treatment are not compliant for Engagement of SUD Treatment.

Step 2 Identify SUD episodes that had at least one weekly or monthly opioid treatment service with medication administration (OUD Monthly Office Based Treatment Value Set; OUD Weekly Drug Treatment Service Value Set) on the day after the initiation encounter through 34 days after the initiation event. The opioid treatment service is considered engagement of treatment and the SUD episode is compliant.

Step 3 Identify SUD episodes with long-acting SUD medication administration events on the day after the initiation encounter through 34 days after the initiation event. The long-acting SUD medication administration event is considered engagement of treatment and the SUD Episode is compliant. Any of the following meet criteria:

- For SUD episodes in the alcohol use disorder cohort, an alcohol use disorder medication treatment dispensing event (Naltrexone Injection Medications List) or a medication administration event (Naltrexone Injection Value Set).
- For SUD episodes in the opioid use disorder cohort, an opioid use disorder medication treatment dispensing event (Naltrexone Injection Medications List; Buprenorphine Injection Medications List; Buprenorphine Implant Medications List) or a medication administration event (Naltrexone Injection Value Set; Buprenorphine Injection Value Set; Buprenorphine Implant Value Set).

Step 4 For remaining SUD episodes identify episodes with at least two of the following (any combination) on the day after the initiation encounter through 34 days after the initiation event:

- Engagement visit.
- Engagement medication treatment event.

Two engagement visits may be on the same date of service, but they must be with different providers to count as two events. An engagement visit on the same date of service as an engagement medication treatment event meets criteria (there is no requirement that they be with different providers).

Refer to the descriptions below to identify engagement visits and engagement medication treatment events.

Engagement visits Any of the following meet criteria for an engagement visit:

- An acute or nonacute inpatient admission ***with*** a diagnosis (on the discharge claim) of one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set. To identify acute or nonacute inpatient admissions:
  1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
  2. Identify the admission date for the stay.
- An outpatient visit (Visit Setting Unspecified Value Set) ***with*** (Outpatient POS Value Set) ***with*** one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- An outpatient visit (BH Outpatient Value Set) ***with*** one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- An intensive outpatient encounter or partial hospitalization (Visit Setting Unspecified Value Set) ***with*** (Partial Hospitalization POS Value Set) ***with*** one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.

- An intensive outpatient encounter or partial hospitalization (Partial Hospitalization or Intensive Outpatient Value Set) ***with*** one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- A non-residential substance abuse treatment Facility visit (Visit Setting Unspecified Value Set) ***with*** (Non-residential Substance Abuse Treatment Facility POS Value Set) ***with*** one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- A community mental health center visit (Visit Setting Unspecified Value Set) ***with*** (Community Mental Health Center POS Value Set) ***with*** one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- A telehealth visit: (Visit Setting Unspecified Value Set) ***with*** (Telehealth POS Value Set) ***with*** one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- A substance use disorder service (Substance Use Disorder Services Value Set) ***with*** one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- Observation Value Set ***with*** one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- A telephone visit (Telephone Visits Value Set) ***with*** one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- An e-visit or virtual check-in (Online Assessments Value Set) ***with*** one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- An opioid treatment service (OUD Weekly Non Drug Service Value Set).

Engagement medication treatment events

Either of the following meets criteria for a medication treatment event:

- For SUD Episodes in the alcohol use disorder cohort, an alcohol use disorder medication treatment dispensing event (Alcohol Use Disorder Treatment Medications List).
- For SUD Episodes in the opioid use disorder cohort, an opioid use disorder medication treatment dispensing event (Naltrexone Oral Medications List; Buprenorphine Oral Medications List; Buprenorphine Naloxone Medications List) or a medication administration event (Buprenorphine Oral Value Set; Buprenorphine Oral Weekly Value Set; Buprenorphine Naloxone Value Set; Methadone Oral Value Set; Methadone Oral Weekly Value Set).

Alcohol Use Disorder Treatment Medications

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

Opioid Use Disorder Treatment Medications

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

Note

- *Organizations may have different methods for billing intensive outpatient encounters and partial hospitalizations. Some organizations may bill comparable to outpatient billing, with separate claims for each date of service; others may bill comparable to inpatient billing, with an admission date, a discharge date and units of service. Organizations whose billing is comparable to inpatient billing may count each unit of service as an individual visit. The unit of service must have occurred during the required time frame for the rate.*
- *Methadone is not included on the medication lists for this measure. Methadone for opioid use disorder (OUD) administered or dispensed by federally certified opioid treatment programs (OTP) is billed on a medical claim. A pharmacy claim for methadone would be indicative of treatment for pain rather than OUD.*

Data Elements for Reporting

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

Table IET-A-4: Data Elements for Initiation and Engagement of Substance Use Disorder Treatment

Metric	Diagnosis	Age	Data Element	Reporting Instructions
Initiation	Alcohol	13-17	Benefit	Metadata
Engagement	Opioid	18-64	EligiblePopulation	For each Stratification, repeat per Metric
	Other	65+	ExclusionAdminRequired	For each Stratification, repeat per Metric
	Total	Total	NumeratorByAdmin	For each Metric and Stratification
			Rate	(Percent)

Table IET-B-4: Data Elements for Initiation and Engagement of Substance Use Disorder Treatment: Stratifications by Race

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

Table IET-C-4: Data Elements for Initiation and Engagement of Substance Use Disorder Treatment: Stratifications by Ethnicity

Metric	Ethnicity	Source	Data Element	Reporting Instructions
Initiation	HispanicOrLatino	Direct	EligiblePopulation	For each Stratification, repeat per Metric
Engagement	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.'

*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 MY 2023 HEDIS FOR QRS

- 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.

HEDIS FOR QRS SPECIFIC GUIDANCE

- In the Final 2022 Call Letter, CMS finalized the requirement for QHP issuers to collect data for the *Kidney Health Evaluation for Patients With Diabetes* (KED) measure beginning with MY 2022 (2023 ratings year). CMS anticipates including this measure in scoring beginning with MY 2023 (2024 ratings year).

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 line	Exchange.
Ages	18–85 years as of December 31 of the measurement year. Report three age stratifications and a total rate: • 18–64. • 75–85. • 65–74. • Total. The total is the sum of the age stratifications.
Continuous enrollment	The measurement year.
Allowable gap	No more than one gap in enrollment of up to 45 days during the measurement year.
Anchor date	December 31 of the measurement year.
Benefit	Medical.
Event/diagnosis	Follow the steps below to identify the eligible population. There are two ways to identify members with diabetes: by claim/encounter data and by pharmacy data. The organization must use both methods to identify the eligible population, but a member only needs to be identified by one method to be included in the measure. Members may be identified as having diabetes during the measurement year or the year prior to the measurement year. *Claim/encounter data.* Members who met any of the following criteria during the measurement year or the year prior to the measurement year (count services that occur over both years):

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

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

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

Diabetes Medications

Description	Prescription		
Alpha-glucosidase inhibitors	• Acarbose	• Miglitol	
Amylin analogs	• Pramlintide		
Antidiabetic combinations	• Alogliptin-metformin • Alogliptin-pioglitazone • Canagliflozin-metformin • Dapagliflozin-metformin • Empagliflozin-linagliptin • Empagliflozin-linagliptin-metformin	• Empagliflozin-metformin • Ertugliflozin-metformin • Ertugliflozin-sitagliptin • Glimepiride-pioglitazone • Glipizide-metformin • Glyburide-metformin • Linagliptin-metformin	• Metformin-pioglitazone • Metformin-repaglinide • Metformin-rosiglitazone • Metformin-saxagliptin • Metformin-sitagliptin
Insulin	• Insulin aspart • Insulin aspart-insulin aspart protamine • Insulin degludec • Insulin 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	• Nateglinide	• Repaglinide	

Description	Prescription		
Glucagon-like peptide-1 (GLP1) agonists	• Albiglutide • Dulaglutide • Exenatide	• Liraglutide (excluding Saxenda®) • Lixisenatide	• Semaglutide
Sodium glucose cotransporter 2 (SGLT2) inhibitor	• Canagliflozin • Dapagliflozin (excluding Farxiga®)	• Ertugliflozin • Empagliflozin	
Sulfonylureas	• Chlorpropamide • Glimepiride	• Glipizide • Glyburide	• Tolazamide • Tolbutamide
Thiazolidinediones	• Pioglitazone	• Rosiglitazone	
Dipeptidyl peptidase-4 (DDP-4) inhibitors	• Alogliptin • Linagliptin	• Saxagliptin • Sitagliptin	

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

Required exclusions

Exclude members who meet any of the following criteria:

- Members who 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 8: Members in Hospice.*
- Members who died any time during the measurement year. Refer to *General Guideline 9: 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) 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.*

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

Table KED-4: 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)

Medical Assistance With Smoking and Tobacco Use Cessation (MSC)

SUMMARY OF CHANGES TO MY 2023 HEDIS FOR QRS

- No changes to this measure.

HEDIS FOR QRS SPECIFIC GUIDANCE

- Measure collection is based on enrollee responses to a subset of the QHP Enrollee Survey questions. Refer to the CMS MQI website (https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityInitiativesGenInfo/ACA-MQI/ACA-MQI-Landing-Page) for more information about the QHP Enrollee Survey, including a crosswalk of survey questions associated with the QRS survey measures. The QHP Enrollee Survey response data are submitted to CMS.

Description

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

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

Eligible Population

Product line	Exchange.
Ages	18 years and older as of December 31 of the measurement year.
Continuous enrollment	The last 6 months of 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.
Current enrollment	Currently enrolled at the time the survey is completed.

Protocol and Survey Instrument

Collected annually by CMS as part of the QHP Enrollee Survey using a rolling average methodology.

Questions Included in the Measure

Table MSC: Medical Assistance With Smoking and Tobacco Use Cessation

Question		Response Choices
Q48	Do you now smoke cigarettes or use tobacco every day, some days, or not at all?	Every day Some days Not at all ➔If Not at all, Go to Question 52 Don't know ➔If Don't know, Go to Question 52
Q49	In the last 6 months, how often were you advised to quit smoking or using tobacco by a doctor or other health provider in your plan?	Never Sometimes Usually Always
Q50	In the last 6 months, how often was medication recommended or discussed by a doctor or health provider to assist you with quitting smoking or using tobacco? Examples of medication are: nicotine gum, patch, nasal spray, inhaler, or prescription medication.	Never Sometimes Usually Always
Q51	In the last 6 months, how often did your doctor or health provider discuss or provide methods and strategies other than medication to assist you with quitting smoking or using tobacco? Examples of methods and strategies are: telephone helpline, individual or group counseling, or cessation program.	Never Sometimes Usually Always

Calculation of Medical Assistance With Smoking and Tobacco Use Cessation

Rolling averages are calculated using the formula below.

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

Advising Smokers and Tobacco Users to Quit

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

Q48 = "Every day" or "Some days."

Q49 = "Never" or "Sometimes" or "Usually" or "Always."

Numerator The number of members in the denominator who indicated that they received advice to quit from a doctor or other health provider by answering "Sometimes" or "Usually" or "Always" to Q49.

Discussing Cessation Medications

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

Q48 = "Every day" or "Some days."

Q50 = "Never" or "Sometimes" or "Usually" or "Always."

Numerator The number of members in the denominator who indicated that their doctor or health provider recommended or discussed cessation medications by answering "Sometimes" or "Usually" or "Always" to Q50.

Discussing Cessation Strategies

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

Q48 = "Every day" or "Some days."

Q51 = "Never" or "Sometimes" or "Usually" or "Always."

Numerator The number of members in the denominator who indicated that their doctor or health provider discussed or provided cessation methods and strategies by answering "Sometimes" or "Usually" or "Always" to Q51.

*Oral Evaluation, Dental Services (OED)**

SUMMARY OF CHANGES TO HEDIS FOR QRS MY 2023

- This is the first year this measure is reported.

HEDIS FOR QRS SPECIFIC GUIDANCE

- In the Draft 2023 Call Letter, CMS proposed to add this measure to the 2024 QRS measure set. Refer to the Final 2023 Call Letter and *2024 QRS and QHP Enrollee Survey Technical Guidance* for reporting this measure.

Finalized Data Submission Requirements for the 2024 Ratings Year

In the Final 2023 Call Letter, CMS finalized the addition of the *Oral Evaluation, Dental Services* measure to the QRS measure set. CMS will collect the *Oral Evaluation, Dental Services* measure for the 2024 ratings year.

Description

The percentage of members under 21 years of age who received a comprehensive or periodic oral evaluation with a dental provider during the measurement year.

Eligible Population

Product line	Exchange.
Ages	Under 21 years as of December 31 of the measurement year. Report four age stratifications and a total rate: • 0–2 years. • 3–5 years. • 6–14 years. • 15–20 years. • Total. The total is the sum of the age stratifications.
Continuous enrollment	180 days during the measurement year.
Allowable gap	No gaps in enrollment during the continuous enrollment period.
Anchor date	None.
Benefit	Dental.
Event/diagnosis	None.
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 8: Members in Hospice*. • Members who died any time during the measurement year. Refer to *General Guideline 9: Deceased Members.*

Administrative Specification

Denominator The eligible population.

Numerator[1] A comprehensive or periodic oral evaluation (Oral Evaluation Value Set) with a dental provider (NUCC Provider Taxonomy Value Set) during the measurement year.

Data Elements for Reporting

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

Table OED-4: Data Elements for Oral Evaluation, Dental Services

Metric	Age Stratification	Data Element	Reporting Instructions
OralEvaluationDentalServices	0-2	Benefit	Metadata
	3-5	EligiblePopulation	For each Stratification
	6-14	ExclusionAdminRequired	For each Stratification
	15-20	NumeratorByAdmin	For each Stratification
	Total	Rate	(Percent)

[1] The NCQA Value Set Directory includes Current Dental Terminology (CDT) codes, © 2023 American Dental Association. All rights reserved.

Plan All-Cause Readmissions (PCR)

SUMMARY OF CHANGES TO MY 2023 HEDIS FOR QRS

- Replaced “female members” with “members” in the pregnancy exclusion.
- Clarified truncating and rounding rules in steps 6 and 8 of the *Risk Adjustment Weighting* section.

HEDIS FOR QRS SPECIFIC GUIDANCE

- HEDIS for QRS uses the commercial risk weights for risk adjustment.

Description

For members 18–64 years of age, the number of acute inpatient and observation stays during the measurement year that were followed by an unplanned acute readmission for any diagnosis within 30 days and the predicted probability of an acute readmission.

Definitions

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

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

Eligible Population

Product line	Exchange.
Ages	18–64 years as of the Index Discharge Date.
Continuous enrollment	365 days prior to the Index Discharge Date through 30 days after the Index Discharge Date.
Allowable gap	No more than one gap in enrollment of up to 45 days during the 365 days prior to the Index Discharge Date and no gap during the 30 days following the Index Discharge date.
Anchor date	Index Discharge Date.
Benefit	Medical.
Event/diagnosis	An acute inpatient or observation stay discharge on or between January 1 and December 1 of the measurement year. The denominator for this measure is based on discharges, not members. Include all acute inpatient or observation stay discharges for nonoutlier members who had one or more discharges on or between January 1 and December 1 of the measurement year. Follow the steps below to identify acute inpatient and observation stays.
Required exclusion	Members in hospice or using hospice services any time during the measurement year. Refer to *General Guideline 8: Members in Hospice*.

Administrative Specification

Denominator The eligible population.

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

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

Inpatient and observation stays where the discharge date from the first setting and the admission date to the second setting are 2 or more calendar days apart must be considered distinct stays.

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

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

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

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

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

Step 4 Exclude hospital stays for the following reasons:

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

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

Step 5 Calculate continuous enrollment.

Step 6 Remove hospital stays for outlier members and report these members as outliers in Table PCR-4.

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

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

Risk Adjustment Determination

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

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

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

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

Exclude diagnoses that cannot be mapped to Table CC_Mapping.

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

Risk Adjustment Weighting

For each IHS among nonoutliers, use the following steps to identify risk adjustment weights based on observation stays status at discharge, surgeries, discharge condition, comorbidity, age and gender. Use the **Commercial** Risk Weights for risk adjustment. Refer to the reporting indicator column in the risk adjustment tables to ensure that weights are linked appropriately.

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

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

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

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

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

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

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

OR

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

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

Truncate the estimated readmission risk for each IHS to 10 decimal places. Do not truncate or round in previous steps.

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

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

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

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

Truncate the variance *for each IHS* to 10 decimal places.

For example: If the Estimated Readmission Risk is 0.1518450741 for an IHS, then the variance for this IHS is 0.1518450741 x 0.8481549259 = 0.1287881475.

Note: *Organizations must sum the variances for each stratification and age when populating the Variance cells in the reporting tables. When reporting, round the variance to 4 decimal places using the .5 rule.*

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

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

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

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

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

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

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

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

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

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

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

- *Acute inpatient stay 1: May 1–10.*

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

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

Reporting: Number of Members in Plan Population

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

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

Reporting: Number of Outliers

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

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

Calculated: Outlier Rate

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

Reporting: Denominator

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

Reporting: Numerator

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

Calculated: Observed Readmission Rate

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

Reporting: Count of Expected 30-Day Readmissions

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

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

Calculated: Expected Readmission Rate

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

Reporting: Variance

Step 1 Calculate the total (sum) variance for each age group.

Step 2 Round to 4 decimal places using the .5 rule and report these values as the CountVariance.

Calculated: O/E Ratio

The Count of Observed 30-Day Readmissions (ObservedCount) divided by the Count of Expected 30-Day Readmissions (ExpectedCount) for each age group and totals. Calculated by IDSS as the OE.

Note

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

Data Elements for Reporting

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

Table PCR-4: Data Elements for Plan All-Cause Readmissions

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

Prenatal and Postpartum Care (PPC)

SUMMARY OF CHANGES TO MY 2023 HEDIS FOR QRS

- 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.

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 line Exchange.

Stratification 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	None specified.
Continuous enrollment	43 days prior to delivery through 60 days after delivery.
Allowable gap	None.
Anchor date	Date of delivery.
Benefit	Medical.
Event/diagnosis	Delivered a live birth on or between October 8 of the year prior to the measurement year and October 7 of the measurement year. Include members who delivered in any setting. 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. Follow the steps below to identify the eligible population, which is the denominator for both rates.
Step 1	Identify deliveries. Identify all members with a delivery (Deliveries Value Set) on or between October 8 of the year prior to the measurement year and October 7 of the measurement year. ***Note:*** *The intent is to identify the date of delivery (the date of the "procedure"). If the date of delivery cannot be interpreted on the claim, use the date of service or, for inpatient claims, the date of discharge.*
Step 2	Remove non-live births (Non-live Births Value Set).
Step 3	Identify continuous enrollment. Determine if enrollment was continuous 43 days prior to delivery through 60 days after delivery, with no gaps.
Required 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 8: Members in Hospice*. • Members who died any time during the measurement year. Refer to *General Guideline 9: Deceased Members.*

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 time frame (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.

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 timeframe. 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 1 for the definition of* PCP and OB/GYN and other prenatal 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 for QRS data to NCQA must provide the following data elements.

Table PPC-A-4: 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-4: 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-4: 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.’

Use of Imaging Studies for Low Back Pain (LBP)

SUMMARY OF CHANGES TO MY 2023 HEDIS FOR QRS

- Added a direct reference code for palliative care.
- Added a required exclusion for members who died during the measurement year.
- Updated the number of occurrences required for the frailty cross-cutting exclusion.

DESCRIPTION

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

Calculation

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

Definitions

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

Eligible Population

Product line	Exchange.
Ages	18 years as of January 1 of the measurement year to 75 years as of December 31 of the measurement year. Report two age stratifications and a total rate: • 18–64. • 65–75. • Total. The total is the sum of the age stratifications.
Continuous enrollment	180 days (6 months) prior to the IESD through 28 days after the IESD.
Allowable gap	None.
Anchor date	IESD.
Benefit	Medical.
Event/diagnosis	Follow the steps below to identify the eligible population.

Step 1

Identify all members in the specified age range who had any of the following during the intake period:

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

Step 2

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

Step 3

Test for negative diagnosis history. Remove members with a diagnosis of uncomplicated low back pain (Uncomplicated Low Back Pain Value Set) during the 180 days (6 months) prior to the IESD.

Step 4

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

Required exclusions

Exclude members who meet any of the following criteria:

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

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

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

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

  No gaps are allowed.

Corticosteroid Medications

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

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

Osteoporosis Medications

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

- *Fragility fracture.* Fragility fracture (Fragility Fractures Value Set) any time during the 3 months (90 days) prior to the IESD through 28 days after the IESD.
- *Lumbar surgery.* Lumbar surgery (Lumbar Surgery Value Set) any time during the member's history through 28 days after the IESD.

- *Spondylopathy.* Spondylopathy (Spondylopathy Value Set) any time during the member's history through 28 days after the IESD.
- *Palliative care*. Members receiving palliative care (Palliative Care Assessment Value Set; Palliative Care Encounter Value Set; Palliative Care Intervention Value Set; ICD-10-CM code Z51.5) during the measurement year.
- Members in hospice or using hospice services any time during the measurement year. Refer to *General Guideline 8: Members in Hospice.*
- Members who died any time during the measurement year. Refer to *General Guideline 9: Deceased Members.*

Exclusions

Exclude members who meet any of the following criteria:

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

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

Dementia Medications

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

Administrative Specification

Denominator The eligible population.

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

Note

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

Data Elements for Reporting

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

Table LBP-4: Data Elements for Use of Imaging Studies for Low Back Pain

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

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

SUMMARY OF CHANGES TO MY 2023 HEDIS FOR QRS

- Revised the optional exclusion for pregnant members to be a required exclusion.
- Replaced the reference to "female members" with "members" in the required exclusions.
- Added a required exclusion for members who died during the measurement year.

Description

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

- BMI Percentile documentation*.
- Counseling for Nutrition.
- Counseling for Physical Activity.

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

Definitions

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

Eligible Population

Product line	Exchange.
Ages	3–17 years as of December 31 of the measurement year. Report two age stratifications and a total for each of the three indicators: • 3–11 years. • 12–17 years. • Total. The total is the sum of the age stratifications.
Continuous enrollment	The measurement year.
Allowable gap	No more than one gap in continuous enrollment of up to 45 days during each year of continuous enrollment.
Anchor date	December 31 of the measurement year.
Benefit	Medical.
Event/diagnosis	An outpatient visit (Outpatient Value Set) with a PCP or an OB/GYN during the measurement year.

Required exclusions	Exclude members who meet any of the following criteria: • Members who have a diagnosis of pregnancy (Pregnancy Value Set) any time during the measurement year. • Members in hospice or using hospice services any time during the measurement year. Refer to *General Guideline 8: Members in Hospice.* • Members who died any time during the measurement year. Refer to *General Guideline 9: Deceased Members.*

Administrative Specification

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

Hybrid Specification

Denominator	A systematic sample drawn from the eligible population for the total age band (3–17 years). The total sample is stratified by age to report rates for the 3–11 and 12–17 age stratifications. Organizations may reduce the sample size using the current year's administrative rate or the prior year's audited, product line-specific rate for the lowest of the three indicator rates for the Total age band. Refer to the *Guidelines for Calculations and Sampling* for information on reducing the sample size.
Numerators	
BMI Percentile	BMI percentile during the measurement year as identified by administrative data or medical record review.
Administrative	Refer to *Administrative Specification* to identify positive numerator hits from the administrative data.
Medical record	Documentation must include height, weight and BMI percentile during the measurement year. The height, weight and BMI percentile must be from the same data source. Either of the following meets criteria for BMI percentile: • BMI percentile documented as a value (e.g., 85th percentile). • BMI percentile plotted on age-growth chart. Only evidence of the BMI percentile or BMI percentile plotted on an age-growth chart meets criteria.

Member-collected biometric values (height, weight, BMI percentile) that meet the requirements of *General Guideline 30: Member-Reported Services and Biometric Values* are eligible for use in reporting.

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

Counseling for Nutrition

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

Administrative

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

Medical record

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

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

Counseling for Physical Activity

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

Administrative

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

Medical record

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

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

Note

- *The following notations or examples of documentation do not count as numerator compliant:*
  - ***BMI***
    - *No BMI percentile documented in medical record or plotted on age-growth chart.*
    - *Notation of BMI value only.*
    - *Notation of height and weight only.*
  - ***Nutrition***
    - *No counseling/education on nutrition and diet.*
    - *Counseling/education before or after the measurement year.*
    - *Notation of "health education" or "anticipatory guidance" without specific mention of nutrition.*
    - *A physical exam finding or observation alone (e.g., well-nourished) is not compliant because it does not indicate counseling for nutrition.*
    - *Documentation related to a member's "appetite" does not meet criteria.*
  - ***Physical Activity***
    - *No counseling/education on physical activity.*
    - *Notation of "cleared for gym class" alone without documentation of a discussion.*
    - *Counseling/education before or after the measurement year.*
    - *Notation of "health education" or "anticipatory guidance" without specific mention of physical activity.*
    - *Notation of anticipatory guidance related solely to safety (e.g., wears helmet or water safety) without specific mention of physical activity recommendations.*
    - *Notation solely related to screen time (computer or television) without specific mention of physical activity.*
- *Services may be rendered during a visit other than a well-child visit. These services count if the specified documentation is present, regardless of the primary intent of the visit; however, services specific to the assessment of treatment of an acute or chronic condition do not count toward the Counseling for Nutrition and Counseling for Physical Activity indicators.*
- *For example, the following documentation is specific to the assessment or treatment of an acute or chronic condition and does not meet criteria:*
  - *Notation that a member with chronic knee pain is able to run without limping.*
  - *Notation that a member has exercise-induced asthma.*
  - *Notation that a member with diarrhea is following the BRAT diet.*
  - *Notation that a member has decreased appetite as a result of an acute or chronic condition.*
- *Services rendered for obesity or eating disorders may be used to meet criteria for the Counseling for Nutrition and Counseling for Physical Activity indicators if the specified documentation is present.*
- *Referral to the Special Supplemental Nutrition Program for Women, Infants and Children (WIC) may be used to meet criteria for the Counseling for Nutrition indicator.*
- *The BMI Percentile, Counseling for Nutrition and Counseling for Physical Activity indicators do not require a specific setting; therefore, services rendered during a telephone visit, e-visit or virtual check-in meet criteria.*
- *Refer to Appendix 1 for the definition of* PCP and OB/GYN *and* other prenatal care practitioner.

Data Elements for Reporting

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

Table WCC-4: Data Elements for Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents

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

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

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

SUMMARY OF CHANGES TO MY 2023 HEDIS FOR QRS

- Added instructions to report rates stratified by race and ethnicity.
- Added a required exclusion for members who died during the measurement year.
- Added new data elements tables for race and ethnicity stratification reporting.

HEDIS FOR QRS SPECIFIC GUIDANCE

- In the Draft 2023 Call Letter, CMS proposed to expand required collection and reporting of stratified race and ethnicity data for this measure beginning with MY 2023 (i.e., 2024 ratings year). Refer to the Final 2023 Call Letter and the *2024 QRS and QHP Enrollee Survey Technical Guidance* for reporting this measure.

Finalized Data Submission Requirements for the 2024 Ratings Year

In the Final 2023 Call Letter, CMS finalized the requirement to collect and report race and ethnicity stratifications for the *Well-Child Visits in the First 30 Months of Life* measure.

Description

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

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

Note

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

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

Product line Exchange.

Stratifications 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 Not 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	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.
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: • Members in hospice or using hospice services any time during the measurement year. Refer to *General Guideline 8: Members in Hospice.* • Members who died any time during the measurement year. Refer to *General Guideline 9: Deceased Members.*

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 (Well-Care Value Set) 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 line	Exchange.
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.
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: • Members in hospice or using hospice services any time during the measurement year. *Refer to General Guideline 8: Members in Hospice*. • Members who died any time during the measurement year. Refer to *General Guideline 9: Deceased Members*.

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 (Well-Care Value Set) 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 1 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 for QRS data to NCQA must provide the following data elements.

Table W30-A-4: 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-4: 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-4: 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*	Unknown**	Rate	(Percent)
	Unknown**	Total		

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

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

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Measures Reported Using Electronic Clinical Data Systems

Guidelines for Measures Reported Using Electronic Clinical Data Systems (ECDS)

SUMMARY OF CHANGES TO MY 2023 HEDIS FOR QRS

- Updated the disclaimer under the Description.
- Removed the definitions of "QDE" and "audit requirements" from Guideline 2: HEDIS Definitions and Requirements for ECDS Reporting.
- Added definitions for "dQM," "ELM" and "denominator" to Guideline 2.
- Combined the definitions for "FHIR" and "resources" in Guideline 2.
- Updated the definition of "CQL" in Guideline 2.
- Removed definitions for "structured data" and "semistructured data" from Guideline 4: Types of ECDS Data.
- Updated *Guideline 6: HEDIS Digital Measure Format.*

Finalized ECDS Data Submission Requirements for the 2024 Ratings Year

In the Final 2023 Call Letter, CMS finalized the incorporation of optional Electronic Clinical Data Systems (ECDS) reporting alongside non-ECDS reporting (i.e., administrative reporting [e.g., claims data]) for the *Cervical Cancer Screening* measure for the 2024 ratings year. QHP issuers that submit optional ECDS reporting are required to do so alongside data reported via either the administrative method or the hybrid method.

In the Final 2023 Call Letter, CMS finalized the transition of the *Breast Cancer Screening* measure to ECDS-only reporting for the 2024 ratings year. For measures that are ECDS-only, QHP issuers are required to only report using the ECDS method and do not need to submit data reported via administrative or hybrid methods.

HEDIS for QRS Specific Guidance

- In the Draft 2023 Call Letter, CMS proposed adding three measures specified for ECDS reporting to the 2024 QRS measure set:
  - Adult Immunization Status (AIS-E).
  - Social Need Screening and Intervention (SNS-E).
  - Depression Screening and Follow-Up for Adolescents and Adults (DSF-E).

  Refer to the Final 2023 Call Letter and 2024 *QRS and QHP Enrollee Survey Technical Guidance* for reporting these measures.
- In the Draft 2023 Call Letter, CMS proposed transitioning Breast Cancer Screening (BCS) to the Breast Cancer Screening (BCS-E) measure for the 2024 QRS measure set. Refer to the Final 2023 Call Letter and *2024 QRS and QHP Enrollee Survey Technical Guidance* for reporting this measure.
- In the Draft 2023 Call Letter, CMS proposed expanding the optional ECDS reporting for the Cervical Cancer Screening (CCS) measure alongside Hybrid and Administrative Methods for the 2024 QRS measure set. Refer to the Final 2023 Call Letter and 2024 *QRS and QHP Enrollee Survey Technical Guidance* for reporting this measure.

Description

HEDIS for QRS quality measures reported using ECDS inspire innovative use of electronic clinical data to document high-quality patient care that demonstrates commitment to evidence-based practices. Organizations that report HEDIS for QRS using ECDS encourage exchange of the information needed to provide high-quality services, ensuring that the information reaches the right people at the right time.

The ECDS reporting standard represents a step forward in adapting HEDIS for QRS to accommodate the expansive information available in electronic clinical datasets used for patient care and quality improvement.

ECDS are the network of data containing a plan member's personal health information and records of their experiences within the health care system. They may also support other care-related activities directly or indirectly, including evidence-based decision support, quality management and outcome reporting. Data in these systems are structured such that automated quality measurement queries can be consistently and reliably executed, providing results quickly and efficiently to the team responsible for the care of health plan members.

Health plans that establish an enterprise network of interoperable electronic data systems will foster a member-centered, team-based approach to improving health care quality and better communication across health care service providers. Visit www.ncqa.org/ecds for more information and FAQs about ECDS reporting.

Disclaimer

The specifications included in this publication provide a summary of the measures that may be reported using ECDS. The specifications are for *reference purposes only* and should not be used for programming or reporting of the measures. HEDIS digital measure specifications for programming purposes are available in the NCQA Store as NCQA's Digital Measure Packages. Organizations are accountable for all potential updates included in the Digital Measure Packages, including those published with the Technical Specifications Update for the Quality Rating System.

For reporting HEDIS for QRS measures, organizations can use NCQA's Digital Measure Packages. The packages provided are not specific to the Exchange product line and may include programming that is not relevant for QRS.

Guidelines

HEDIS for QRS measures reported using ECDS follow the *General Guidelines for Data Collection and Reporting,* unless there is an ECDS-specific guideline listed below that overrides those rules. This hierarchy only exists in specific cases where there is an ECDS guideline listed. If no ECDS-specific guideline is listed, then organizations should default to those found in *General Guidelines for Data Collection and Reporting.*

1. Initial Population

The Initial Population for any HEDIS for QRS measure reported using ECDS includes all members who satisfy criteria, including age and participation criteria. Refer to the logic in the digital measure package for criteria used to define the initial population.

2. HEDIS Definitions and Requirements for ECDS Reporting

Master data management	Organizational policies and procedures for governance of quality measure data; specifically, defining creation of a master data file for quality reporting. An organization must use a master data management process to verify data integrity across the multiple data systems used in HEDIS ECDS reporting, ensuring consistent identification and classification of data elements and standardized data reconciliation procedures. Reconciliation procedures include, but are not limited to, validation, deduplication and reliability checks to correct latent data errors related to either the acquisition of encrypted data or ETL (extract, transform and load) integration of data into a master file.
dQM	Digital Quality Measure. A quality measure published as a downloadable package that includes the technical specifications provided as a standard, machine readable, interoperable format. Visit https://www.ncqa.org/dqm for more information.
FHIR	Fast Healthcare Interoperability Resources. A specification standard for exchanging healthcare information electronically that supports the exchange of structured and standardized data.[1] Exchangeable content in FHIR are resources defined and represented in common ways. They are built from data types that define common reusable patterns of elements and share a common set of metadata.

ELM Expression Logical Model.[2] A Unified Modeling Language™ specification for representing measure logic independent of syntax and special-purpose constructs introduced at the syntactic level. It is intended to enable distribution and sharing of computable quality logic.

CQL Clinical Quality Language.[3] A Health Level Seven International (HL7) domain-specific language focused on clinical quality and targeted at measure authors. The CQL specification describes a machine-readable canonical representation called ELM designed to enable sharing of clinical knowledge.

Participation The identifiers and descriptors for each organization's coverage used to define a member's eligibility for measure reporting. Allocation for HEDIS is based on a member's eligibility during the Participation Period.

Denominator What is reported to NCQA for the measure denominator results, defined as "the initial population, minus exclusions" in the narratives for measures reported using ECDS included in this publication and in the human-readable files.

In contrast, digital measure CQL execution defines the denominator as the initial population prior to the removal of members meeting denominator exclusions.

3. Data Collection Methods

Electronic Method Measures reported using ECDS are specified for the Electronic Method of data collection.

Electronic transactional data may be used to identify the Initial Population.

To qualify for HEDIS ECDS reporting, data must use standard layouts, meet the measure technical specification requirements and be accessible by the care team upon request. Organizations meet this requirement if they are able to provide the requested information (e.g., phone, secure email, direct feed, provider portal, file request) to providers who are treating their members. Organizations should have documented processes for tracking these requests to be reviewed as part of the HEDIS audit.

Practitioners or practitioner groups that are accountable for clinical services provided to members must not be prevented from accessing any data used by a health plan for quality measure reporting, regardless of the initial Source System of Record (SSoR).

SSoR HEDIS for QRS measures reported using ECDS are submitted by each SSoR accessed to produce the measure result. The SSoR is the authoritative dataset containing the standardized elements the organization requires to generate and report digital quality measure results.

Datasets for ECDS reporting may natively contain both standard and nonstandard data. Refer to *General Guideline 21: Supplemental Data* for electronic clinical data proof-of-service and verification requirements. Each electronic data source used for HEDIS for QRS ECDS reporting must have:

- Policies and procedures for establishing and maintaining database management systems.

[1]https://www.hl7.org/fhir/overview.html
[2]https://cql.hl7.org/13-f-glossary.html
[3]https://cql.hl7.org/

- Standard layout requirements.
- An automated process for incremental loading of all data elements.

Each SSoR is a data repository where semantic differences in non-standard data have been resolved through integrity testing, and the data has been structured so it can be reliably queried by a HEDIS dQM.

Source priority

When quality data elements to support the measure are identified in multiple data sources, a hierarchy is applied.

Each SSoR used for HEDIS for QRS ECDS reporting is categorized using the following priority:

1. Electronic health record (EHR)/personal health record (PHR) (the system of data origin such as laboratory, pharmacy, pathology, radiology).
2. Health information exchange (HIE)/clinical registry.
3. Case management registry.
4. Administrative.

Organizations compare the list of all unique systems containing relevant member data and assign members based on the highest-ranked data category in the hierarchy. SSoRs are mapped using the data type that is loaded to the master file that identifies member eligibility for each component of a quality measure. The applied hierarchy does not imply relevance or validity of a data source; rather, it is applied in cases where a member's data are in multiple locations.

Members are assigned to only one SSoR category for each measure element (e.g., initial population, denominator, exclusions, numerator).

For example, if administrative data are used to identify the initial population, the member is assigned to the Administrative cohort for the initial population. If a numerator event is identified through a query of the organization's case management system, the member is assigned to that cohort for the numerator even though that member may have been included in the measure's initial population using administrative data.

Organizations must complete data collection for the SSoRs by the supplemental data collection deadline. Refer to *General Guideline 5: Audit Preparation* for information about the timeline. When appropriate, an SSoR can be refreshed according to the organization's scheduled refreshes and accounted appropriately for the measure. Refer to *General Guideline 22: Obtaining Information for the Systematic Sample*.

4. Types of ECDS Data

Organizations may use several data sources to provide complete information about the quality of health services delivered to its members. Data systems that may be eligible for HEDIS for QRS ECDS reporting include, but are not limited to, member eligibility files, EHRs, PHRs, clinical registries, HIEs, administrative claims systems, electronic laboratory reports (ELR), electronic pharmacy systems, immunization information systems (IIS) and disease/case management registries.

The data within these systems come in a variety of formats. The format type determines how the source is audited. Member-reported services are acceptable if the information is recorded, dated and maintained in the member's legal health record. The member-reported data must follow *General Guideline 30: Member-Reported Services and Biometric Values*.

Data sources are categorized using the following criteria:

EHR/PHR

EHRs and PHRs are transactional systems that store clinically relevant information collected directly from or managed by a patient. An EHR contains the medical and treatment histories of patients; a PHR includes both the standard clinical data collected in a provider's office or another care setting, in addition to information curated directly in the PHR by the patient though an application programming interface (API).

This data category includes biometric information and clinical samples obtained directly from a patient as well as clinical findings resulting from samples collected from a patient (e.g., pathology, laboratory and pharmacy records generated from entities not directly connected to the patient's EHR).

HIE/clinical registry

HIEs and clinical registries eligible for this reporting category include state HIEs, IIS, public health agency systems, regional HIEs (RHIO), Patient-Centered Data Homes™ or other registries developed for research or to support quality improvement and patient safety initiatives.

Doctors, nurses, pharmacists, other health care providers and patients can use HIEs to access and share vital medical information, with the goal of creating a complete patient record.[4] HIEs used for ECDS reporting must use standard protocols to ensure security, privacy, data integrity, sender and receiver authentication and confirmation of delivery.

Clinical registries collect information about people with a specific disease or condition, or patients who may be willing to participate in research about a disease. Registries can be sponsored by a government agency, nonprofit organization, health care facility or private company, and decisions regarding use of the data in the registry are the responsibility of the registry's governing committee.[5]

Case management system

A shared database of member information collected through a collaborative process of member assessment, care planning, care coordination or monitoring of a member's functional status and care experience.

Case management systems eligible for this category of ECDS reporting include any system developed to support the organization's case/disease management activities, including activities performed by delegates.

Administrative

Includes data from administrative claims processing systems for all services incurred (paid, suspended, pending and denied) during the period defined by each measure's participation as well as member management files, member eligibility and enrollment files, electronic member rosters, internal audit files, and member call service databases.

5. Member Allocation for HEDIS ECDS Reporting

Member eligibility is determined by participation in the organization during the participation period. Include all eligible members with the measure-specified benefits during the specified participation period. Members must be allocated to a product/product line for HEDIS for QRS ECDS reporting. Unless otherwise specified in the guidance section of the measures, members must be enrolled with no gap of more than 45 days during each year of the specified participation period.

6. HEDIS Digital Measure Format

HEDIS dQMs are published as a package of files required for the successful implementation of the measures, however there are several sections where reporting organizations must program measure components not included in the digital measure package (e.g., product line stratifications). For each measure-specific instance of this, refer to the human-readable file contained in the measure package for guidance.

HEDIS dQMs are published in a format which allows them to be directly utilized by a reporting organization. Each dQM package includes both the human-readable technical documentation and the machine-readable files necessary for implementation. Each HEDIS dQM package includes the following files:

- **Measure-specific human-readable file (in the "Narrative" folder):** A human-readable document representing the measure narrative in a way that is easy to understand for persons not familiar with computer coded files.
  1. *{measure id}_HEDIS_MY{MY}-{version}.html*: Contains a measure header table with text descriptions of the measure elements (initial population, denominator, exclusions, numerator) and the data element types, and references.

     This file also contains human-readable versions of the measure logic expressed in CQL. This portion of the file outlines the population criteria measure logic definitions, functions and relevant value sets formatted for easy review by measure implementors. Each measure section expressed in CQL corresponds with the descriptive text found in the measure header.
- **Technical Release Notes file (in the "Documents: folder):** Contains a comprehensive list of updates made to measures since their prior release. The *Summary of Changes to MY 2023 HEDIS for QRS* section in the *HEDIS for QRS Technical Specifications* publication previews the updates.
- **HEDIS Implementation Guide file (in the "Documents" folder):** Contains a guide to assist with implementation of the HEDIS dQMs, including information on available libraries, data-mapping considerations and developer-level documentation that describes the overall approach for calculating quality measures.
- **ELM files (in the "cql," "libraryCql," "elm" and "libraryElm" folders):** The machine-readable representation of the FHIR/CQL that has been designed for implementation of the quality measure. The ELM file provides the semantics necessary to retrieve the correct data from the measure reporting database.
  1. *{library name or measure ID}-{library or measure version}.cql: A FHIR/CQL representation of all the data and the expressions created in the CQL library.*
  2. *{library name or measure ID}-{library or measure version}.xml*: A standardized, machine-friendly representation of the FHIR/CQL in Extensible Markup Language (XML) format.
  3. *{library name or measure ID}-{library or measure version}.json*: A standardized, machine-friendly representation of the FHIR/CQL in JavaScript Object Notation (JSON) format.
- **Value set files (in the "valuesets" folder):** A FHIR representation of the value sets applicable to the measure in JSON format.

Note: *NCQA recommends that all files in a measure package be housed in the same place and that naming conventions be preserved because the computer-readable files reference the library files by name.*

Complete measure packages for HEDIS digital measures are released by NCQA in conjunction with this publication and are available for download from the NCQA Store.

7. Presentation of Codes in HEDIS Digital Measures

HEDIS dQMs reference single codes and value sets that must be used for HEDIS for QRS reporting.

Value sets

If there is more than one eligible code to identify a data element, a value set is used. Organizations can refer to the Value Set Directory (VSD) for codes in the value sets, which are also in the measure package in JSON format.

Value sets are listed in the *Data criteria (element level)* section of the measure with an accompanying uniform resource identifier (URI). The OID listed in the URI is the key to locating codes in the HEDIS VSD or HEDIS Medication List Directory (MLD). The OID must be used to identify the correct value set to be used for each specific data element in the dQMs for HEDIS for QRS reporting.

Note: *Value sets specified as a medication resource are found in the MLD.*

Direct reference codes

If only a single code is required to identify a data element, the code is listed in the *Data criteria (element level)* section of the human-readable file under the *Direct Reference Codes and Codesystems* heading. These codes are also included in the Direct Reference Codes spreadsheet of the VSD.

*Adult Immunization Status (AIS-E)**

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

SUMMARY OF CHANGES TO MY 2023 HEDIS FOR QRS

- This is the first year this measure is reported.

HEDIS FOR QRS SPECIFIC GUIDANCE

- In the Draft 2023 Call Letter, CMS proposed to add this measure to the 2024 QRS measure set. Refer to the Final 2023 Call Letter and *2024 QRS and QHP Enrollee Survey Technical Guidance* for reporting this measure.

Finalized Data Submission Requirements for the 2024 Ratings Year

In the Final 2023 Call Letter, CMS finalized the addition of the *Adult Immunization Status* measure to the QRS measure set. CMS will collect the *Adult Immunization Status* measure for the 2024 ratings year.

Description	The percentage of members 19 years of age and older who are up to date on recommended routine vaccines for influenza, tetanus and diphtheria (Td) or tetanus, diphtheria and acellular pertussis (Tdap), zoster and pneumococcal.
Measurement period	January 1–December 31.
Clinical recommendation statement	The Advisory Committee on Immunization Practices recommends annual influenza vaccination; and tetanus, diphtheria and acellular pertussis (Tdap) and/or tetanus and diphtheria (Td) vaccine; herpes zoster vaccine; and pneumococcal vaccination for adults at various ages.
Citations	Murthy, N., Wodi, A.P., Bernstein, H., McNally, V., Cineas, S., Ault, K. 2022. "Advisory Committee on Immunization Practices Recommended Immunization Schedule for Adults Aged 19 Years and Older—United States, 2022." MMWR Morb Mortal Wkly Rep 71:229–233. DOI: http://dx.doi.org/10.15585/mmwr.mm7107a1
Characteristics	
Scoring **Type** **Stratification**	Proportion. Process. • Influenza. – Product line: ▪ Exchange – Age (as of the start of the measurement period): ▪ 19–65 years. ▪ 66 years and older. – Race: ▪ Race—White. ▪ Race—Black or African American. ▪ Race—American Indian or Alaska Native. ▪ Race—Asian.

	▪ Race—Native Hawaiian or Other Pacific Islander. ▪ Race—Some Other Race. ▪ Race—Two or More Races. ▪ Race—Asked but No Answer. ▪ Race—Unknown. – Ethnicity: ▪ Ethnicity—Hispanic or Latino. ▪ Ethnicity—Not Hispanic or Latino. ▪ Ethnicity—Asked but No Answer. ▪ Ethnicity—Unknown. • Td/Tdap. – Product line: ▪ Exchange. – Age (as of the start of the measurement period): ▪ 19–65 years. ▪ 66 years and older. – Race: ▪ Race—White. ▪ Race—Black or African American. ▪ Race—American Indian or Alaska Native. ▪ Race—Asian. ▪ Race—Native Hawaiian or Other Pacific Islander. ▪ Race—Some Other Race. ▪ Race—Two or More Races. ▪ Race—Asked but No Answer. ▪ Race—Unknown. – Ethnicity: ▪ Ethnicity—Hispanic or Latino. ▪ Ethnicity—Not Hispanic or Latino. ▪ Ethnicity—Asked but No Answer. ▪ Ethnicity—Unknown. • Zoster. – Product line: ▪ Exchange. – Age (as of the start of the measurement period): ▪ 50–65 years. ▪ 66 years and older. – Race: ▪ Race—White. ▪ Race—Black or African American. ▪ Race—American Indian or Alaska Native. ▪ Race—Asian. ▪ Race—Native Hawaiian or Other Pacific Islander.

	▪ Race—Some Other Race. ▪ Race—Two or More Races. ▪ Race—Asked but No Answer. ▪ Race—Unknown. – Ethnicity: ▪ Ethnicity—Hispanic or Latino. ▪ Ethnicity—Not Hispanic or Latino. ▪ Ethnicity—Asked but No Answer. ▪ Ethnicity—Unknown. • Pneumococcal. – Product line: ▪ Exchange. – Age (as of the start of the measurement period): ▪ 66 years and older. – Race: ▪ Race—White. ▪ Race—Black or African American. ▪ Race—American Indian or Alaska Native. ▪ Race—Asian. ▪ Race—Native Hawaiian or Other Pacific Islander. ▪ Race—Some Other Race. ▪ Race—Two or More Races. ▪ Race—Asked but No Answer. ▪ Race—Unknown. – Ethnicity: ▪ Ethnicity—Hispanic or Latino. ▪ Ethnicity—Not Hispanic or Latino. ▪ Ethnicity—Asked but No Answer. ▪ Ethnicity—Unknown.
Risk adjustment	None.
Improvement notation	A higher rate indicates better performance.
Guidance	**Allocation:** The member was enrolled with a medical benefit throughout the participation period. When identifying members in hospice, the requirements described in *General Guideline 8* for identification of hospice members using the monthly membership detail data files are not included in the measure calculation logic and need to be programmed manually. **Requirements:** All measure rates are specified based on clinical guideline recommendations for the age group included in the rate.

	Reporting: Product line stratifications are not included in the measure calculation logic and need to be programmed manually.
Definitions	
Participation	The identifiers and descriptors for each organization's coverage used to define members' eligibility for measure reporting. Allocation for reporting is based on eligibility during the participation period.
Participation period	The measurement period.
Initial population	**Initial population 1** Members 19 years and older at the start of the measurement period who also meet the criteria for participation. **Initial population 2** Same as the initial population 1. **Initial population 3** Members 50 years and older at the start of the measurement period who also meet the criteria for participation. **Initial population 4** Members 66 years and older at the start of the measurement period who also meet the criteria for participation.
Exclusions	**Exclusions 1** Members in hospice or using hospice services any time during the measurement period. **Exclusions 2** Same as exclusions 1. **Exclusions 3** Same as exclusions 1. **Exclusions 4** Same as exclusions 1.
Denominator	**Denominator 1** The initial population 1, minus exclusions. **Denominator 2** Same as denominator 1. **Denominator 3** The initial population 3, minus exclusions. **Denominator 4** The initial population 4, minus exclusions.

Numerator	**Numerator 1—Immunization Status: Influenza** • Members who received an influenza vaccine on or between July 1 of the year prior to the measurement period and June 30 of the measurement period, ***or*** • Members with anaphylaxis due to the influenza vaccine any time before or during the measurement period. **Numerator 2—Immunization Status: Td/Tdap** • Members who received at least one Td vaccine or one Tdap vaccine between 9 years prior to the start of the measurement period and the end of the measurement period, ***or*** • Members with a history of at least one of the following contraindications any time before or during the measurement period: – Anaphylaxis due to the diphtheria, tetanus or pertussis vaccine. – Encephalitis due to the diphtheria, tetanus or pertussis vaccine. **Numerator 3—Immunization Status: Zoster** • Members who received at least one dose of the herpes zoster live vaccine or two doses of the herpes zoster recombinant vaccine at least 28 days apart, any time on or after the member's 50th birthday and before or during the measurement period, ***or*** • Members with anaphylaxis due to the herpes zoster vaccine any time before or during the measurement period. **Numerator 4—Immunization Status: Pneumococcal** • Members who were administered at least one dose of an adult pneumococcal vaccine on or after the member's 19th birthday and before or during the measurement period, ***or*** • Members with anaphylaxis due to the pneumococcal vaccine any time before or during the measurement period.
Data criteria (element level)	
Value Sets: • **AISE_HEDIS_MY2023-2.0.0** – Adult Influenza Immunization (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1913) – Adult Influenza Vaccine Procedure (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1914) – Adult Pneumococcal Immunization (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.2405) – Adult Pneumococcal Vaccine Procedure (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.2406) – Anaphylaxis Due to Diphtheria, Tetanus or Pertussis Vaccine (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.2240) – Anaphylaxis Due to Herpes Zoster Vaccine (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.2379)	

  - Encephalitis Due to Diphtheria, Tetanus or Pertussis Vaccine (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.2241)
  - Herpes Zoster Live Immunization (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1915)
  - Herpes Zoster Live Vaccine Procedure (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1917)
  - Herpes Zoster Recombinant Immunization (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1916)
  - Herpes Zoster Recombinant Vaccine Procedure (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1918)
  - Influenza Virus LAIV Immunization (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1974)
  - Influenza Virus LAIV Vaccine Procedure (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1973)
  - Td Immunization (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1923)
  - Td Vaccine Procedure (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1924)
  - Tdap Immunization (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1791)
  - Tdap Vaccine Procedure (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1792)
- **NCQA_Hospice-2.0.0**
  - Hospice Encounter (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1761)
  - Hospice Intervention (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1762)
- **NCQA_Stratification-1.0.0**
  - American Indian or Alaska Native Detailed Race (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.2365)
  - Asian Detailed Race (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.2366)
  - Black or African American Detailed Race (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.2367)
  - Hispanic or Latino Detailed Ethnicity (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.2368)
  - Native Hawaiian or Other Pacific Islander Detailed Race (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.2369)
  - White Detailed Race (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.2370)

Direct reference codes and codesystems:

- **AISE_HEDIS_MY2023-2.0.0**
  - codesystem "SNOMEDCT": 'http://snomed.info/sct/731000124108'
  - code "Anaphylaxis caused by vaccine product containing Influenza virus antigen (disorder)": '471361000124100' from "SNOMEDCT" display 'Anaphylaxis caused by vaccine product containing Influenza virus antigen (disorder)'
  - code "Anaphylaxis caused by vaccine product containing Streptococcus pneumoniae antigen (disorder)": '471141000124102' from "SNOMEDCT" display 'Anaphylaxis caused by vaccine product containing Streptococcus pneumoniae antigen (disorder)'
- **NCQA_Terminology-2.0.0**
  - codesystem "ActCode": 'http://terminology.hl7.org/CodeSystem/v3-ActCode'
  - codesystem "ConditionClinicalStatusCodes": 'http://terminology.hl7.org/CodeSystem/condition-clinical'

- codesystem "NullFlavor": 'http://terminology.hl7.org/CodeSystem/v3-NullFlavor'
- codesystem "RaceAndEthnicityCDC": 'https://www.hl7.org/fhir/us/core/CodeSystem-cdcrec'
- code "active": 'active' from "ConditionClinicalStatusCodes"
- code "American Indian or Alaska Native": '1002-5' from "RaceAndEthnicityCDC" display 'American Indian or Alaska Native'
- code "Asian": '2028-9' from "RaceAndEthnicityCDC" display 'Asian'
- code "Asked but no answer": 'ASKU' from "NullFlavor" display 'Asked but no answer'
- code "Black or African American": '2054-5' from "RaceAndEthnicityCDC" display 'Black or African American'
- code "Hispanic or Latino": '2135-2' from "RaceAndEthnicityCDC" display 'Hispanic or Latino'
- code "managed care policy": 'MCPOL' from "ActCode"
- code "Native Hawaiian or Other Pacific Islander": '2076-8' from "RaceAndEthnicityCDC" display 'Native Hawaiian or Other Pacific Islander'
- code "Non Hispanic or Latino": '2186-5' from "RaceAndEthnicityCDC" display 'Non Hispanic or Latino'
- code "Other": 'OTH' from "NullFlavor" display 'Other'
- code "retiree health program": 'RETIRE' from "ActCode"
- code "subsidized health program": 'SUBSIDIZ' from "ActCode"
- code "Unknown": 'UNK' from "NullFlavor" display 'Unknown'
- code "White": '2106-3' from "RaceAndEthnicityCDC" display 'White'

Data Elements for Reporting

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

Table AIS-E-A-4: Data Elements for Adult Immunization Status

Metric	Age	Data Element	Reporting Instructions
Influenza	19-65	InitialPopulation	For each Metric and Stratification
TdTdap	66+	ExclusionsByEHR	For each Metric and Stratification
	Total	ExclusionsByCaseManagement	For each Metric and Stratification
		ExclusionsByHIERegistry	For each Metric and Stratification
Zoster	50-65	ExclusionsByAdmin	For each Metric and Stratification
	66+	Exclusions	(Sum over SSoRs)
	Total	Denominator	For each Metric and Stratification
		NumeratorByEHR	For each Metric and Stratification
Pneumococcal	66+	NumeratorByCaseManagement	For each Metric and Stratification
		NumeratorByHIERegistry	For each Metric and Stratification
		NumeratorByAdmin	For each Metric and Stratification
		Numerator	(Sum over SSoRs)
		Rate	(Percent)

Table AIS-E-B-4: Data Elements for Adult Immunization Status: Stratifications by Race

Metric
Influenza
TdTdap
Zoster
Pneumococcal

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

Table AIS-E-C-4: Data Elements for Adult Immunization Status: Stratifications by Ethnicity

Metric
Influenza
TdTdap
Zoster
Pneumococcal

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

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

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

Breast Cancer Screening (BCS-E)

SUMMARY OF CHANGES TO MY 2023 HEDIS FOR QRS

- Refer to the Technical Release Notes file in the Digital Measures Package for a comprehensive list of changes.
- Added new data elements tables for race and ethnicity stratification reporting

HEDIS FOR QRS SPECIFIC GUIDANCE

- In the Draft 2023 Call Letter, CMS proposed to transition Breast Cancer Screening (BCS) reported via the Administrative Method to the Breast Cancer Screening (BCS-E) measure reported via the ECDS method, beginning with MY 2023 (2024 ratings year). Refer to the Final 2023 Call Letter and the *2024 QRS and QHP Enrollee Survey Technical Guidance* for reporting this measure.
- In the Draft 2023 Call Letter, CMS proposed to expand required collection and reporting of stratified race and ethnicity data for this measure beginning with MY 2023 (2024 ratings year). Refer to the Final 2023 Call Letter and the 2024 *QRS and QHP Enrollee Survey Technical Guidance* for reporting this measure.

Finalized Data Submission Requirements for the 2024 Ratings Year

In the Final 2023 Call Letter, CMS finalized the transition of the *Breast Cancer Screening* measure to ECDS-only reporting for the 2024 ratings year. For the 2024 ratings year, CMS will collect *Breast Cancer Screening* measure data reported via the ECDS method. CMS will not collect *Breast Cancer Screening* measure data reported via the administrative or hybrid methods.

In the Final 2023 Call Letter, CMS finalized the requirement to collect and report race and ethnicity stratifications for the *Breast Cancer Screening* measure.

Description	The percentage of women 50–74 years of age who had a mammogram to screen for breast cancer.
Measurement period	January 1–December 31.
Clinical recommendation statement	The U.S. Preventive Services Task Force recommends screening women 50–74 years of age for breast cancer every 2 years. (B recommendation)
Citations	U.S. Preventive Services Task Force. 2016. "Screening for Breast Cancer: U.S. Preventive Services Task Force Recommendation Statement. *Ann Intern Med* 164(4):279–96.
Characteristics	
Scoring	Proportion.
Type	Process.
Stratification	• Breast Cancer Screening. – Product line: ▪ Exchange. – Race: ▪ Race—White. ▪ Race—Black or African American. ▪ Race—American Indian or Alaska Native. ▪ Race—Asian. ▪ Race—Native Hawaiian or Other Pacific Islander.

	▪ Race—Some Other Race. ▪ Race—Two or More Races. ▪ Race—Asked but No Answer. ▪ Race—Unknown. – Ethnicity: ▪ Ethnicity—Hispanic or Latino. ▪ Ethnicity—Not Hispanic or Latino. ▪ Ethnicity—Asked but No Answer. ▪ Ethnicity—Unknown.
Risk adjustment	None.
Improvement notation	A higher rate indicates better performance.
Guidance	Non-administrative data may be used for the frailty and advanced illness exclusion. **Allocation:** The member was enrolled with a medical benefit throughout the participation period. No more than one gap in enrollment of up to 45 days for each full calendar year of the participation period (i.e., the measurement period and the year prior to the measurement period). No gaps in enrollment are allowed from October 1 two years prior to the measurement period through December 31 two years prior to the measurement period. When identifying members in hospice, the requirements described in *General Guideline 8* for identification of hospice members using the monthly membership detail data files are not included in the measure calculation logic and need to be programmed manually. **Reporting:** For all plans, the race and ethnicity stratifications are mutually exclusive and the sum of all categories in each stratification is the total population. SES and product line stratifications are not included in the measure calculation logic and need to be programmed manually. The race and ethnicity stratifications are reported by data source—direct or indirect.
Definitions	
Participation	The identifiers and descriptors for each organization's coverage used to define members' eligibility for measure reporting. Allocation for reporting is based on eligibility during the participation period.
Participation Period	October 1 two years prior to the measurement period through the end of the Measurement Period.

<table>
<tr><td>Initial Population</td><td>Women 52–74 years of age by the end of the Measurement Period who also meet the criteria for Participation.</td></tr>
<tr><td>Exclusions</td><td>

Members in hospice or using hospice services any time during the measurement period.
Members who had a bilateral mastectomy or both right and left unilateral mastectomies any time during the member's history through the end of the measurement period. Any of the following meet the criteria for bilateral mastectomy:

Bilateral mastectomy (Bilateral Mastectomy Value Set).
Unilateral mastectomy (Unilateral Mastectomy Value Set) with a bilateral modifier (Bilateral Modifier Value Set) (same procedure).
Unilateral mastectomy found in clinical data (Clinical Unilateral Mastectomy Value Set) with a bilateral modifier (Clinical Bilateral Modifier Value Set) (same procedure).

Note: The "clinical" mastectomy value sets identify mastectomy; the word "clinical" refers to the data source, not to the type of mastectomy.
History of bilateral mastectomy (History of Bilateral Mastectomy Value Set).

Any combination of codes from the table below that indicate a mastectomy on both the left and right side on the same or different dates of service.
<table>
<tr><th>Left Mastectomy
(any of the following)</th><th>Right Mastectomy
(any of the following)</th></tr>
<tr><td>Unilateral mastectomy (Unilateral Mastectomy Value Set) with a left-side modifier (Left Modifier Value Set) (same procedure)</td><td>Unilateral mastectomy (Unilateral Mastectomy Value Set) with a right-side modifier (Right Modifier Value Set) (same procedure)</td></tr>
<tr><td>Unilateral mastectomy found in clinical data (Clinical Unilateral Mastectomy Value Set) with a left-side modifier (Clinical Left Modifier Value Set) (same procedure)</td><td>Unilateral mastectomy found in clinical data (Clinical Unilateral Mastectomy Value Set) with a right-side modifier (Clinical Right Modifier Value Set) (same procedure)</td></tr>
<tr><td>Absence of the left breast (Absence of Left Breast Value Set)</td><td>Absence of the right breast (Absence of Right Breast Value Set)</td></tr>
<tr><td>Left unilateral mastectomy (Unilateral Mastectomy Left Value Set)</td><td>Right unilateral mastectomy (Unilateral Mastectomy Right Value Set)</td></tr>
</table>

Members 66 years of age and older by the end of the measurement period, with frailty and advanced illness. Members must meet BOTH of the following frailty and advanced illness criteria to be excluded:

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 period.
Any of the following during the measurement period or the year prior to the measurement period (count services that occur over both years):

</td></tr>
</table>

	▪ 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 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 period.
Denominator	The initial population, minus exclusions.
Numerator	One or more mammograms (Mammography Value Set) any time on or between October 1 two years prior to the measurement period and the end of the measurement period.
Data criteria (element level)	
Value Sets: • **BCSE_HEDIS_MY2023-2.0.0** – Absence of Left Breast (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1329) – Absence of Right Breast (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1330) – Bilateral Mastectomy (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1042) – Bilateral Modifier (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1043) – Clinical Bilateral Modifier (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1951) – Clinical Left Modifier (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1949) – Clinical Right Modifier (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1950) – Clinical Unilateral Mastectomy (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1948)	

- History of Bilateral Mastectomy (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1331)
- Left Modifier (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1148)
- Mammography (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1168)
- Right Modifier (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1230)
- Unilateral Mastectomy (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1256)
- Unilateral Mastectomy Left (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1334)
- Unilateral Mastectomy Right (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1335)

- **NCQA_AdvancedIllnessandFrailty-2.0.0**
  - Acute Inpatient (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1810)
  - Advanced Illness (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1465)
  - Dementia Medications (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1729)
  - ED (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1086)
  - Frailty Device (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1530)
  - Frailty Diagnosis (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1531)
  - Frailty Encounter (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1532)
  - Frailty Symptom (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1533)
  - Nonacute Inpatient (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1189)
  - Observation (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1191)
  - Online Assessments (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1446)
  - Outpatient (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1202)
  - Telephone Visits (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1246)
- **NCQA_Claims-2.0.0**
  - Inpatient Stay (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1395)
  - Nonacute Inpatient Stay (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1398)
- **NCQA_Hospice-2.0.0**
  - Hospice Encounter (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1761)
  - Hospice Intervention (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1762)
- **NCQA_PalliativeCare-2.0.0**
  - Palliative Care Assessment (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.2225)
  - Palliative Care Encounter (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1450)
  - Palliative Care Intervention (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.2224)
- **NCQA_Stratification-1.0.0**
  - American Indian or Alaska Native Detailed Race (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.2365)
  - Asian Detailed Race (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.2366)
  - Black or African American Detailed Race (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.2367)
  - Hispanic or Latino Detailed Ethnicity (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.2368)
  - Native Hawaiian or Other Pacific Islander Detailed Race (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.2369)

- White Detailed Race (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.2370)

Direct reference codes and codesystems:

- **NCQA_PalliativeCare-2.0.0**
  - codesystem "ICD-10-CM": 'http://hl7.org/fhir/sid/icd-10-cm'
  - code "Encounter for palliative care": 'Z51.5' from "ICD-10-CM" display 'Encounter for palliative care'
- **NCQA_Terminology-2.0.0**
  - codesystem "ActCode": 'http://terminology.hl7.org/CodeSystem/v3-ActCode'
  - codesystem "ClaimTypeCodes": 'http://terminology.hl7.org/CodeSystem/claim-type'
  - codesystem "ConditionClinicalStatusCodes": 'http://terminology.hl7.org/CodeSystem/condition-clinical'
  - codesystem "NullFlavor": 'http://terminology.hl7.org/CodeSystem/v3-NullFlavor'
  - codesystem "RaceAndEthnicityCDC": 'https://www.hl7.org/fhir/us/core/CodeSystem-cdcrec'
  - code "active": 'active' from "ConditionClinicalStatusCodes"
  - code "American Indian or Alaska Native": '1002-5' from "RaceAndEthnicityCDC" display 'American Indian or Alaska Native'
  - code "Asian": '2028-9' from "RaceAndEthnicityCDC" display 'Asian'
  - code "Asked but no answer": 'ASKU' from "NullFlavor" display 'Asked but no answer'
  - code "Black or African American": '2054-5' from "RaceAndEthnicityCDC" display 'Black or African American'
  - code "Hispanic or Latino": '2135-2' from "RaceAndEthnicityCDC" display 'Hispanic or Latino'
  - code "Institutional": 'institutional' from "ClaimTypeCodes"
  - code "managed care policy": 'MCPOL' from "ActCode"
  - code "Native Hawaiian or Other Pacific Islander": '2076-8' from "RaceAndEthnicityCDC" display 'Native Hawaiian or Other Pacific Islander'
  - code "Non Hispanic or Latino": '2186-5' from "RaceAndEthnicityCDC" display 'Non Hispanic or Latino'
  - code "Other": 'OTH' from "NullFlavor" display 'Other'
  - code "Pharmacy": 'pharmacy' from "ClaimTypeCodes"
  - code "Professional": 'professional' from "ClaimTypeCodes"
  - code "retiree health program": 'RETIRE' from "ActCode"
  - code "subsidized health program": 'SUBSIDIZ' from "ActCode"
  - code "Unknown": 'UNK' from "NullFlavor" display 'Unknown'
  - code "White": '2106-3' from "RaceAndEthnicityCDC" display 'White'

Data Elements for Reporting

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

Table BCS-E-A-4: Data Elements for Breast Cancer Screening

Metric	Data Element	Reporting Instructions
BreastCancerScreening	InitialPopulation	Report once
	ExclusionsByEHR	Report once
	ExclusionsByCaseManagement	Report once
	ExclusionsByHIERegistry	Report once
	ExclusionsByAdmin	Report once
	Exclusions	(Sum over SSoRs)
	Denominator	Report once
	NumeratorByEHR	Report once
	NumeratorByCaseManagement	Report once
	NumeratorByHIERegistry	Report once
	NumeratorByAdmin	Report once
	Numerator	(Sum over SSoRs)
	Rate	(Percent)

Table BCS-E-B-4: Data Elements for Breast Cancer Screening: Stratifications by Race

Metric
BreastCancerScreening

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

Table BCS-E-C-4: Data Elements for Breast Cancer Screening: Stratifications by Ethnicity

Metric
BreastCancerScreening

Ethnicity	Source	Data Element	Reporting Instructions
HispanicOrLatino	Direct	InitialPopulation	For each Stratification
NotHispanicOrLatino	Indirect	Exclusions	For each Stratification
AskedButNoAnswer*	Total	Denominator	For each Stratification
Unknown**		Numerator	For each Stratification
		Rate	(Percent)

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

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

Cervical Cancer Screening (CCS-E)

SUMMARY OF CHANGES TO MY 2023 HEDIS FOR QRS

- This is the first year this measure is reported using ECDS.

HEDIS FOR QRS SPECIFIC GUIDANCE

- In the Draft 2023 Call Letter, CMS proposed to expand optional ECDS reporting for the Cervical Cancer Screening (CCS-E) measure alongside the Hybrid and Administrative Methods required collection beginning with MY 2023 (2024 ratings year). Refer to the Final 2023 Call Letter and the *2024 QRS and QHP Enrollee Survey Technical Guidance* for reporting this measure.

Description	The percentage of women 21–64 years of age who were screened for cervical cancer using any of the following criteria: • Women 21–64 years of age who had cervical cytology performed within the last 3 years. • Women 30–64 years of age who had cervical high-risk human papillomavirus (hrHPV) testing performed within the last 5 years. • Women 30–64 years of age who had cervical cytology/high-risk human papillomavirus (hrHPV) cotesting within the last 5 years.
Measurement period	January 1–December 31.
Clinical recommendation statement	The U.S. Preventive Services Task Force (USPSTF) recommends screening for cervical cancer every 3 years with cervical cytology alone in women aged 21–29 years. (A recommendation) The USPSTF recommends screening every 3 years with cervical cytology alone, every 5 years with hrHPV testing alone or every 5 years with hrHPV testing in combination with cytology (cotesting) in women aged 30–65 years. (A recommendation) The USPSTF recommends against screening for cervical cancer in women younger than 21 years. (D recommendation) The USPSTF recommends against screening for cervical cancer in women older than 65 years who have had adequate prior screening and are not otherwise at high risk for cervical cancer. (D recommendation) The USPSTF recommends against screening for cervical cancer in women who have had a hysterectomy with removal of the cervix and do not have a history of a high-grade precancerous lesion or cervical cancer. (D recommendation)
Citations	U.S. Preventive Services Task Force. 2018. “Screening for Cervical Cancer: U.S. Preventive Services Task Force Recommendation Statement.” *JAMA* 320(7): 674–86.

Characteristics	
Scoring	Proportion.
Type	Process.
Stratification	• Cervical Cancer Screening. – Product line: ▪ Exchange.
Risk adjustment	None.
Improvement notation	A higher rate indicates better performance.
Guidance	**Allocation:** The member was enrolled with a medical benefit throughout the participation period. No more than one gap in enrollment of up to 45 days during each year of the participation period. The member must be enrolled on the last day of the measurement period. When identifying members in hospice, the requirements described in *General Guideline 8* for identification of hospice members using the monthly membership detail data files are not included in the measure calculation logic and need to be programmed manually. **Reporting:** Product line stratifications are not included in the measure calculation logic and need to be programmed manually.
Definitions	
Participation	The identifiers and descriptors for each organization's coverage used to define members' eligibility for measure reporting. Allocation for reporting is based on eligibility during the participation period.
Participation period	The measurement period.
Initial population	Women 24–64 years of age by the end of the measurement period who also meet criteria for participation.
Exclusions	• Hysterectomy with no residual cervix, cervical agenesis or acquired absence of cervix any time during the member's history through the end of the measurement period. • Members in hospice or using hospice services any time during the measurement period. • Members receiving palliative care any time during the measurement period.
Denominator	The initial population, minus exclusions.

Numerator	The number of women who were screened for cervical cancer. Either of the following meets criteria: • Women 24–64 years of age by the end of the measurement period who had cervical cytology during the measurement period or the 2 years prior to the measurement period. • Women 30–64 years of age by the end of the measurement period who had cervical high-risk human papillomavirus (hrHPV) testing during the measurement period or the 4 years prior to the measurement period and who were 30 years or older on the date of the test. ***Note:*** *Evidence of hrHPV testing within the last 5 years also captures patients who had cotesting; therefore, additional methods to identify cotesting are not necessary.*

Data criteria (element level)

Value Sets:

- **CCSE_HEDIS_MY2023-2.0.0**
  - Absence of Cervix Diagnosis (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1522)
  - Cervical Cytology Lab Test (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1525)
  - Cervical Cytology Result or Finding (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1524)
  - High Risk HPV Lab Test (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1527)
  - High Risk HPV Test Result or Finding (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1526)
  - Hysterectomy With No Residual Cervix (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1523)
- **NCQA_Hospice-2.0.0**
  - Hospice Encounter (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1761)
  - Hospice Intervention (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1762)
- **NCQA_PalliativeCare-2.0.0**
  - Palliative Care Assessment (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.2225)
  - Palliative Care Encounter (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1450)
  - Palliative Care Intervention (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.2224)

Direct reference codes and codesystems:

- **NCQA_PalliativeCare-2.0.0**
  - codesystem "ICD-10-CM": 'http://hl7.org/fhir/sid/icd-10-cm'
  - code "Encounter for palliative care": 'Z51.5' from "ICD-10-CM" display 'Encounter for palliative care'
- **NCQA_Terminology-2.0.0**
  - codesystem "ActCode": 'http://terminology.hl7.org/CodeSystem/v3-ActCode'
  - codesystem "ConditionClinicalStatusCodes": 'http://terminology.hl7.org/CodeSystem/condition-clinical'
  - code "active": 'active' from "ConditionClinicalStatusCodes"
  - code "managed care policy": 'MCPOL' from "ActCode"

- code "retiree health program": 'RETIRE' from "ActCode"
- code "subsidized health program": 'SUBSIDIZ' from "ActCode"

Data Elements for Reporting

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

Table CCS-E-4:Data Elements for Cervical Cancer Screening

Metric	Data Element	Reporting Instructions
CervicalCancerScreening	InitialPopulation	Report once
	ExclusionsByEHR	Report once
	ExclusionsByCaseManagement	Report once
	ExclusionsByHIERegistry	Report once
	ExclusionsByAdmin	Report once
	Exclusions	(Sum over SSoRs)
	Denominator	Report once
	NumeratorByEHR	Report once
	NumeratorByCaseManagement	Report once
	NumeratorByHIERegistry	Report once
	NumeratorByAdmin	Report once
	Numerator	(Sum over SSoRs)
	Rate	(Percent)

Childhood Immunization Status (CIS-E)

SUMMARY OF CHANGES TO MY 2023 HEDIS FOR QRS

- Refer to the Technical Release Notes file in the Digital Measures Package for a comprehensive list of changes.

HEDIS FOR QRS SPECIFIC GUIDANCE

- HEDIS for QRS reports only Combination 10 and related antigens.

Description	The percentage of children 2 years of age who had four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV); one measles, mumps and rubella (MMR); three haemophilus influenza type B (HiB); three hepatitis B (HepB), one chicken pox (VZV); four pneumococcal conjugate (PCV); one hepatitis A (HepA); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday. The measure calculates a rate for each vaccine and one combination rate.
Measurement period	January 1–December 31.
Clinical recommendation statement	This measure looks for childhood vaccinations that should be completed by age 2, in accordance with the Centers for Disease Control and Prevention Advisory Committee on Immunization Practices (ACIP) recommended child and adolescent immunization schedule (ACIP 2020).
Citations	Wodi, A.P., N. Murthy, H. Bernstein, V. McNally, S. Cineas, K. Ault. 2022. “Advisory Committee on Immunization Practices Recommended Immunization Schedule for Children and Adolescents Aged 18 Years or Younger — United States, 2022.” *MMWR Morb Mortal Wkly Rep* 71:234–7. DOI: http://dx.doi.org/10.15585/mmwr.mm7107a2
Characteristics	
Scoring	Proportion.
Type	Process.
Stratification	• DTaP. – Product line: ▪ Exchange. • IPV. – Product line: ▪ Exchange. • MMR. – Product line: ▪ Exchange.

	• HiB. – Product line: ▪ Exchange. • Hepatitis B. – Product line: ▪ Exchange. • VZV. – Product line: ▪ Exchange. • Pneumococcal Conjugate. – Product line: ▪ Exchange. • Hepatitis A. – Product line: ▪ Exchange. • Rotavirus. – Product line: ▪ Exchange. • Influenza. – Product line: ▪ Exchange. • Combination 10. – Product line: ▪ Exchange.
Risk adjustment	None.
Improvement notation	A higher rate indicates better performance.
Guidance	**Allocation:** The child was enrolled with a medical benefit throughout the participation period. • No more than one gap in enrollment of up to 45 days during the 12 months prior to the member's second birthday. • The child must be enrolled on their second birthday. When identifying members in hospice, the requirements described in *General Guideline 8* for identification of hospice members using the monthly membership detail data files are not included in the measure calculation logic and need to be programmed manually. **Reporting:** Product line stratifications are not included in the measure calculation logic and need to be programmed manually

Definitions	
Participation	The identifiers and descriptors for each organization's coverage used to define members' eligibility for measure reporting. Allocation for reporting is based on eligibility during the Participation Period.
Participation Period	12 months prior to the member's second birthday.
Initial Population	**Initial population 1** Children who turn 2 years of age during the measurement period and also meet the criteria for participation. **Initial population 2** Same as the initial population 1. **Initial population 3** Same as the initial population 1. **Initial population 4** Same as the initial population 1. **Initial population 5** Same as the initial population 1. **Initial population 6** Same as the initial population 1. **Initial population 7** Same as the initial population 1. **Initial population 8** Same as the initial population 1. **Initial population 9** Same as the initial population 1. **Initial population 10** Same as the initial population 1. **Initial population 13** Same as the initial population 1.
Exclusions	**Exclusions 1** • Members in hospice or using hospice services any time during the Measurement Period. • Any of the following on or before the child's second birthday: – Severe combined immunodeficiency. – Immunodeficiency. – HIV. – Lymphoreticular cancer, multiple myeloma or leukemia. – Intussusception.

	Exclusions 2 Same as exclusions 1. **Exclusions 3** Same as exclusions 1. **Exclusions 4** Same as exclusions 1. **Exclusions 5** Same as exclusions 1. **Exclusions 6** Same as exclusions 1. **Exclusions 7** Same as exclusions 1. **Exclusions 8** Same as exclusions 1. **Exclusions 9** Same as exclusions 1. **Exclusions 10** Same as exclusions 1. **Exclusions 13** Same as exclusions 1.
Denominator	**Denominator 1** The initial population, minus exclusions. **Denominator 2** Same as denominator 1. **Denominator 3** Same as denominator 1. **Denominator 4** Same as denominator 1. **Denominator 5** Same as denominator 1. **Denominator 6** Same as denominator 1. **Denominator 7** Same as denominator 1. **Denominator 8** Same as denominator 1. **Denominator 9** Same as denominator 1.

	Denominator 10 Same as denominator 1. **Denominator 13** Same as denominator 1.
Numerator	**Numerator 1—DTaP** Children with any of the following on or before the child's second birthday meet criteria: • At least four DTaP vaccinations, with different dates of service. Do not count a vaccination administered prior to 42 days after birth. • Anaphylaxis due to the diphtheria, tetanus or pertussis vaccine. • Encephalitis due to the diphtheria, tetanus or pertussis vaccine. **Numerator 2—IPV** Children with either of the following on or before their second birthday meet criteria: • At least three IPV vaccinations with different dates of service. Do not count a vaccination administered prior to 42 days after birth. • Anaphylaxis due to the IPV vaccine. **Numerator 3—MMR** Children with either of the following meet criteria: • At least one MMR vaccination on or between the child's first and second birthdays. • Anaphylaxis due to the MMR vaccine on or before the child's second birthday. • All of the following any time on or before the child's second birthday (on the same or different date of service): – History of measles illness. – History of mumps illness. – History of rubella illness. **Numerator 4—HiB** Children with either of the following on or before the child's second birthday meet criteria: • At least three HiB vaccinations, with different dates of service. Do not count a vaccination administered prior to 42 days after birth. • Anaphylaxis due to the HiB vaccine. **Numerator 5—Hepatitis B** Children with any of the following on or before the child's second birthday meet criteria: • At least three hepatitis B vaccinations, with different dates of service. – One of the three vaccinations can be a newborn hepatitis B vaccination during the 8-day period that begins on the date of birth and ends 7 days after the date of birth. For example, if the member's date of birth is December 1, the newborn hepatitis B vaccination must be on or between December 1 and December 8.

- History of hepatitis B illness.
- Anaphylaxis due to the hepatitis B vaccine.

Numerator 6—VZV
Children with any of the following meet criteria:

- At least one VZV vaccination, with a date of service on or between the child's first and second birthdays.
- History of varicella zoster (e.g., chicken pox) illness on or before the child's second birthday.
- Anaphylaxis due to the VZV vaccine on or before the child's second birthday.

Numerator 7—Pneumococcal Conjugate
Children with either of the following on or before their second birthday meet criteria:

- At least four pneumococcal conjugate vaccinations, with different dates of service on or before the child's second birthday. Do not count a vaccination administered prior to 42 days after birth.
- Anaphylaxis due to the pneumococcal vaccine.

Numerator 8—Hepatitis A
Children with any of the following meet criteria:

- At least one hepatitis A vaccination with a date of service on or between the child's first and second birthdays.
- History of hepatitis A illness on or before the child's second birthday.
- Anaphylaxis due to the hepatitis A vaccine on or before the child's second birthday.

Numerator 9—Rotavirus
Children with any of the following meet criteria:

- At least two doses of the two-dose rotavirus vaccine on different dates of service on or before the child's second birthday. Do not count a vaccination administered prior to 42 days after birth.
- At least three doses of the three-dose rotavirus vaccine on different dates of service on or before the child's second birthday. Do not count a vaccination administered prior to 42 days after birth.
- At least one dose of the two-dose rotavirus vaccine and at least two doses of the three-dose rotavirus vaccine, all on different dates of service, on or before the child's second birthday. Do not count a vaccination administered prior to 42 days after birth.
- Anaphylaxis due to the rotavirus vaccine on or before the child's second birthday.

Numerator 10—Influenza
Children with either of the following on or before their second birthday meet criteria:

- At least two influenza vaccinations with different dates of service. Do not count a vaccination administered prior to 6 months (180 days) after birth.
  - An influenza vaccination recommended for children 2 years and older (e.g., LAIV) administered on the child's second birthday meets criteria for one of the two required vaccinations.

	• Anaphylaxis due to the influenza vaccine. **Numerator 13—Combination 10** Members who are numerator compliant for DTaP, IPV, MMR, HiB, hepatitis B, VZV, pneumococcal, hepatitis A, rotavirus and influenza indicators.

Data criteria (element level)

Value Sets:

- **CISE_HEDIS_MY2023-2.0.0**
  - Anaphylaxis Due to Diphtheria, Tetanus or Pertussis Vaccine (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.2240)
  - Disorders of the Immune System (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1139)
  - DTaP Immunization (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1744)
  - DTaP Vaccine Procedure (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1745)
  - Encephalitis Due to Diphtheria, Tetanus or Pertussis Vaccine (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.2241)
  - Haemophilus Influenzae Type B (HiB) Immunization (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1753)
  - Haemophilus Influenzae Type B (HiB) Vaccine Procedure (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1754)
  - Hepatitis A (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1117)
  - Hepatitis A Immunization (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1757)
  - Hepatitis A Vaccine Procedure (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1758)
  - Hepatitis B (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1266)
  - Hepatitis B Immunization (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1759)
  - Hepatitis B Vaccine Procedure (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1760)
  - HIV (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1110)
  - HIV Type 2 (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1406)
  - Inactivated Polio Vaccine (IPV) Immunization (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1765)
  - Inactivated Polio Vaccine (IPV) Procedure (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1766)
  - Influenza Immunization (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1767)
  - Influenza Vaccine Procedure (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1768)
  - Influenza Virus LAIV Immunization (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1974)
  - Influenza Virus LAIV Vaccine Procedure (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1973)
  - Intussusception (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1415)
  - Malignant Neoplasm of Lymphatic Tissue (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1319)

- Measles (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1171)
- Measles, Mumps and Rubella (MMR) Immunization (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1773)
- Measles, Mumps and Rubella (MMR) Vaccine Procedure (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1774)
- Mumps (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1181)
- Newborn Hepatitis B Vaccine Administered (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1397)
- Pneumococcal Conjugate Immunization (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1781)
- Pneumococcal Conjugate Vaccine Procedure (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1782)
- Rotavirus (2 Dose Schedule) Immunization (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1785)
- Rotavirus (3 Dose Schedule) Immunization (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1786)
- Rotavirus Vaccine (2 Dose Schedule) Procedure (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1787)
- Rotavirus Vaccine (3 Dose Schedule) Procedure (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1788)
- Rubella (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1232)
- Severe Combined Immunodeficiency (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1416)
- Varicella Zoster (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1258)
- Varicella Zoster (VZV) Immunization (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1793)
- Varicella Zoster (VZV) Vaccine Procedure (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1794)

- **NCQA_Hospice-2.0.0**
  - Hospice Encounter (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1761)
  - Hospice Intervention (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1762)

Direct Reference Codes and Codesystems:

- **CISE_HEDIS_MY2023-2.0.0**
  - codesystem "SNOMEDCT": 'http://snomed.info/sct'
  - code "Anaphylaxis caused by rotavirus vaccine (disorder)": '428331000124103' from "SNOMEDCT" display 'Anaphylaxis caused by rotavirus vaccine (disorder)'
  - code "Anaphylaxis caused by vaccine containing Human alphaherpesvirus 3 antigen (disorder)": '471341000124104' from "SNOMEDCT" display 'Anaphylaxis caused by vaccine containing Human alphaherpesvirus 3 antigen (disorder)'
  - code "Anaphylaxis caused by vaccine product containing Hepatitis A virus antigen (disorder)": '471311000124103' from "SNOMEDCT" display 'Anaphylaxis caused by vaccine product containing Hepatitis A virus antigen (disorder)'
  - code "Anaphylaxis caused by vaccine product containing human poliovirus antigen (disorder)": '471321000124106' from "SNOMEDCT" display 'Anaphylaxis caused by vaccine product containing human poliovirus antigen (disorder)'

- code "Anaphylaxis caused by vaccine product containing Influenza virus antigen (disorder)": '471361000124100' from "SNOMEDCT" display 'Anaphylaxis caused by vaccine product containing Influenza virus antigen (disorder)'
- code "Anaphylaxis caused by vaccine product containing Measles morbillivirus and Mumps orthorubulavirus and Rubella virus antigens (disorder)": '471331000124109' from "SNOMEDCT" display 'Anaphylaxis caused by vaccine product containing Measles morbillivirus and Mumps orthorubulavirus and Rubella virus antigens (disorder)'
- code "Anaphylaxis caused by vaccine product containing Streptococcus pneumoniae antigen (disorder)": '471141000124102' from "SNOMEDCT" display 'Anaphylaxis caused by vaccine product containing Streptococcus pneumoniae antigen (disorder)'
- code "Anaphylaxis due to Haemophilus influenzae type b vaccine (disorder)": '433621000124101' from "SNOMEDCT" display 'Anaphylaxis due to Haemophilus influenzae type b vaccine (disorder)'
- code "Anaphylaxis due to Hepatitis B vaccine (disorder)": '428321000124101' from "SNOMEDCT" display 'Anaphylaxis due to Hepatitis B vaccine (disorder)'

- **NCQA_Terminology-2.0.0**
  - codesystem "ActCode": 'http://terminology.hl7.org/CodeSystem/v3-ActCode'
  - codesystem "ConditionClinicalStatusCodes": 'http://terminology.hl7.org/CodeSystem/condition-clinical'
  - codesystem "coverage-type": 'http://terminology.hl7.org/CodeSystem/v3-ActCode’
  - code "active": 'active' from "ConditionClinicalStatusCodes"
  - code "managed care policy": 'MCPOL' from "coverage-type"
  - code "retiree health program": 'RETIRE' from "coverage-type"
  - code "subsidized health program": 'SUBSIDIZ' from "coverage-type"

Data Elements for Reporting

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

Table CIS-E-4: Data Elements for Childhood Immunization Status

Metric	Data Element	Reporting Instructions
DTaP	InitialPopulation	Repeat per Metric
IPV	ExclusionsByEHR	Repeat per Metric
MMR	ExclusionsByCaseManagement	Repeat per Metric
HiB	ExclusionsByHIERegistry	Repeat per Metric
HepatitisB	ExclusionsByAdmin	Repeat per Metric
VZV	Exclusions	(Sum over SSoRs)
PneumococcalConjugate	Denominator	Repeat per Metric
HepatitisA	NumeratorByEHR	For each Metric
Rotavirus	NumeratorByCaseManagement	For each Metric
Influenza	NumeratorByHIERegistry	For each Metric
Combo10	NumeratorByAdmin	For each Metric
	Numerator	(Sum over SSoRs)
	Rate	(Percent)

Colorectal Cancer Screening (COL-E)

SUMMARY OF CHANGES TO MY 2023 HEDIS FOR QRS

- Refer to the Technical Release Notes file in the Digital Measures Package for a comprehensive list of changes.

HEDIS FOR QRS SPECIFIC GUIDANCE

- In the Final 2022 Call Letter, CMS finalized the incorporation of the 45–49 years age band. CMS anticipates introducing this additional age band into scoring beginning with MY 2023 (2024 ratings year).

Description	The percentage of members 45–75 years of age who had appropriate screening for colorectal cancer.
Measurement period	January 1–December 31.
Clinical recommendation statement	The U.S. Preventive Services Task Force "recommends screening for colorectal cancer in all adults aged 50 to 75 years (A recommendation) and all adults aged 45 to 49 years (B recommendation)." Potential screening methods include an annual guaiac-based fecal occult blood test (gFOBT), annual fecal immunochemical test (FIT), multitargeted stool DNA with FIT test (sDNA FIT) every 3 years, colonoscopy every 10 years, CT colonography every 5 years, flexible sigmoidoscopy every 5 years or flexible sigmoidoscopy every 10 years, with FIT every year.
Citations	U.S. Preventive Services Task Force. 2021. "Screening for Colorectal Cancer: U.S. Preventive Services Task Force Recommendation Statement." *JAMA* 325(19):1965–77. doi:10.1001/jama.2021.6238
Characteristics	
Scoring	Proportion.
Type	Process.
Stratification	• Colorectal Cancer Screening. – Product line: ▪ Exchange. – Age ▪ 46–49 years. ▪ 50–75 years. – Race: ▪ Race—White. ▪ Race—Black or African American. ▪ Race—American Indian or Alaska Native. ▪ Race—Asian. ▪ Race—Native Hawaiian or Other Pacific Islander.

	▪ Race—Some Other Race. ▪ Race—Two or More Races. ▪ Race—Asked but No Answer. ▪ Race—Unknown. – Ethnicity: ▪ Ethnicity—Hispanic or Latino. ▪ Ethnicity—Not Hispanic or Latino. ▪ Ethnicity—Asked but No Answer. ▪ Ethnicity—Unknown.
Risk adjustment	None.
Improvement notation	A higher rate indicates better performance.
Guidance	Non-administrative data may be used for the frailty and advanced illness exclusion. **Allocation:** The member was enrolled with a medical benefit throughout the participation period. When identifying members in hospice, the requirements described in *General Guideline 8* for identification of hospice members using the monthly membership detail data files are not included in the measure calculation logic and need to be programmed manually. **Reporting:** For all plans, the race and ethnicity stratifications are mutually exclusive and the sum of all categories in each stratification is the total population. SES and product line stratifications are not included in the measure calculation logic and need to be programmed manually. The race and ethnicity stratifications are reported by data source—direct or indirect.
Definitions	
Participation	The identifiers and descriptors for each organization's coverage used to define members' eligibility for measure reporting. Allocation for reporting is based on eligibility during the participation period.
Participation Period	The measurement period and the year prior to the measurement period.
Initial Population	Members 46–75 years as of the end of the measurement period who also meet the criteria for participation.
Exclusions	• Members in hospice or using hospice services any time during the measurement period. • Members with colorectal cancer or a total colectomy any time during the member's history through the end of the Measurement Period.

	• Members 66 years of age and older by the end of the measurement period, with frailty and advanced illness. • Members receiving palliative care during the measurement period.
Denominator	• The initial population, minus exclusions.
Numerator	Members with one or more screenings for colorectal cancer. Any of the following meet criteria: • Fecal occult blood test during the measurement period. • Flexible sigmoidoscopy during the measurement period or the 4 years prior to the measurement period. • Colonoscopy during the measurement period or the 9 years prior to the measurement period. • CT colonography during the measurement period or the 4 years prior to the measurement period. • Stool DNA (sDNA) with FIT test during the measurement period or the 2 years prior to the measurement period.
Data criteria (element level)	

Value Sets:

- **COLE_HEDIS_MY2023-1.0.0**
  - Colonoscopy (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1064)
  - Colorectal Cancer (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1065)
  - CT Colonography (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1421)
  - Flexible Sigmoidoscopy (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1102)
  - FOBT Lab Test (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1959)
  - FOBT Test Result or Finding (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1960)
  - History of Colonoscopy (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1910)
  - History of Flexible Sigmoidoscopy (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1911)
  - History of Total Colectomy (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1912)
  - sDNA FIT Lab Test (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1749)
  - sDNA FIT Test Result or Finding (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1750)
  - Total Colectomy (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1250)
- **NCQA_AdvancedIllnessandFrailty-2.0.0**
  - Acute Inpatient (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1810)
  - Advanced Illness (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1465)
  - Dementia Medications (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1729)
  - ED (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1086)
  - Frailty Device (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1530)

  - Frailty Diagnosis (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1531)
  - Frailty Encounter (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1532)
  - Frailty Symptom (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1533)
  - Nonacute Inpatient (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1189)
  - Observation (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1191)
  - Online Assessments (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1446)
  - Outpatient (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1202)
  - Telephone Visits (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1246)
- **NCQA_Claims-2.0.0**
  - Inpatient Stay (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1395)
  - Nonacute Inpatient Stay (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1398)
- **NCQA_Hospice-2.0.0**
  - Hospice Encounter (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1761)
  - Hospice Intervention (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1762)
- **NCQA_PalliativeCare-2.0.0**
  - Palliative Care Assessment (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.2225)
  - Palliative Care Encounter (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1450)
  - Palliative Care Intervention (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.2224)
- **NCQA_Stratification-1.0.0**
  - American Indian or Alaska Native Detailed Race (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.2365)
  - Asian Detailed Race (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.2366)
  - Black or African American Detailed Race (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.2367)
  - Hispanic or Latino Detailed Ethnicity (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.2368)
  - Native Hawaiian or Other Pacific Islander Detailed Race (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.2369)
  - White Detailed Race (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.2370)

Direct Reference Codes and Codesystems:

- **NCQA_PalliativeCare-2.0.0**
  - codesystem "ICD-10": 'http://hl7.org/fhir/sid/icd-10-cm'
  - code "Encounter for palliative care": 'Z51.5' from "ICD-10" display 'Encounter for palliative care'
- **NCQA_Terminology-2.0.0**
  - codesystem "ActCode": 'http://terminology.hl7.org/CodeSystem/v3-ActCode'
  - codesystem "ClaimTypeCodes": 'http://terminology.hl7.org/CodeSystem/claim-type'
  - codesystem "ConditionClinicalStatusCodes": 'http://terminology.hl7.org/CodeSystem/condition-clinical'
  - codesystem "NullFlavor": 'http://terminology.hl7.org/CodeSystem/v3-NullFlavor'
  - codesystem "RaceAndEthnicityCDC": 'https://www.hl7.org/fhir/us/core/CodeSystem-cdcrec'
  - code "active": 'active' from "ConditionClinicalStatusCodes"

- code "American Indian or Alaska Native": '1002-5' from "RaceAndEthnicityCDC" display 'American Indian or Alaska Native'
- code "Asian": '2028-9' from "RaceAndEthnicityCDC" display 'Asian'
- code "Asked but no answer": 'ASKU' from "NullFlavor" display 'Asked but no answer'
- code "Black or African American": '2054-5' from "RaceAndEthnicityCDC" display 'Black or African American'
- code "Hispanic or Latino": '2135-2' from "RaceAndEthnicityCDC" display 'Hispanic or Latino'
- code "Institutional": 'institutional' from "ClaimTypeCodes"
- code "managed care policy": 'MCPOL' from "ActCode"
- code "Native Hawaiian or Other Pacific Islander": '2076-8' from "RaceAndEthnicityCDC" display 'Native Hawaiian or Other Pacific Islander'
- code "Non Hispanic or Latino": '2186-5' from "RaceAndEthnicityCDC" display 'Non Hispanic or Latino'
- code "Other": 'OTH' from "NullFlavor" display 'Other'
- code "Professional": 'professional' from "ClaimTypeCodes"
- code "retiree health program": 'RETIRE' from "ActCode"
- code "subsidized health program": 'SUBSIDIZ' from "ActCode"
- code "Unknown": 'UNK' from "NullFlavor" display 'Unknown'
- code "White": '2106-3' from "RaceAndEthnicityCDC" display 'White'

Data Elements for Reporting

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

Table COL-E-A-4: Data Elements for Colorectal Cancer Screening

Metric	Age	Data Element	Reporting Instructions
ColorectalCancerScreening	46-49	InitialPopulation	For each Stratification
	50-75	ExclusionsByEHR	For each Stratification
	Total	ExclusionsByCaseManagement	For each Stratification
		ExclusionsByHIERegistry	For each Stratification
		ExclusionsByAdmin	For each Stratification
		Exclusions	(Sum over SSoRs)
		Denominator	For each Stratification
		NumeratorByEHR	For each Stratification
		NumeratorByCaseManagement	For each Stratification
		NumeratorByHIERegistry	For each Stratification
		NumeratorByAdmin	For each Stratification
		Numerator	(Sum over SSoRs)
		Rate	(Percent)

Table COL-E-B-4: Data Elements for Colorectal Cancer Screening: Stratifications by Race

Metric
ColorectalCancerScreening

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

Table COL-E-C-4: Data Elements for Colorectal Cancer Screening: Stratifications by Ethnicity

Metric
ColorectalCancerScreening

Ethnicity	Source	Data Element	Reporting Instructions
HispanicOrLatino	Direct	InitialPopulation	For each Stratification
NotHispanicOrLatino	Indirect	Exclusions	For each Stratification
AskedButNoAnswer*	Total	Denominator	For each Stratification
Unknown**		Numerator	For each Stratification
		Rate	(Percent)

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

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

*Depression Screening and Follow-Up for Adolescents and Adults (DSF-E)**

***Adapted with financial support from the Centers for Medicare & Medicaid Services (CMS).**

SUMMARY OF CHANGES TO MY 2023 HEDIS FOR QRS

- This is the first year this measure is reported.

HEDIS FOR QRS SPECIFIC GUIDANCE

- In the Draft 2023 Call Letter, CMS proposed to add this measure to the 2024 QRS measure set. Refer to the Final 2023 Call Letter and the *2024 QRS and QHP Enrollee Survey Technical Guidance* for reporting this measure.

Finalized Data Submission Requirements for the 2024 Ratings Year

In the Final 2023 Call Letter, CMS proposed the addition of the *Depression Screening and Follow-Up for Adolescents and Adults* measure to the QRS measure set. CMS did not finalize the proposed addition of the *Depression Screening and Follow-Up for Adolescents and Adults* measure for the 2024 ratings year.

Description	The percentage of members 12 years of age and older who were screened for clinical depression using a standardized instrument and, if screened positive, received follow-up care. • *Depression Screening.* The percentage of members who were screened for clinical depression using a standardized instrument. • *Follow-Up on Positive Screen.* The percentage of members who received follow-up care within 30 days of a positive depression screen finding.
Measurement period	January 1–December 31.
Clinical recommendation statement	The U.S. Preventive Services Task Force (USPSTF) recommends screening for depression among adolescents 12–18 years and the general adult population, including pregnant and postpartum women. (B recommendation) The USPSTF also recommends that screening be implemented with adequate systems in place to ensure accurate diagnosis, effective treatment and appropriate follow-up. (B recommendation)
Citations	U.S. Preventive Services Task Force. 2016. "Screening for Depression in Children and Adolescents: U.S. Preventive Services Task Force Recommendation Statement." *Annals of Internal Medicine* 164:360–6. U.S. Preventive Services Task Force. 2016. "Screening for Major Depressive Disorder in Adults: US Preventive Services Task Force Recommendation Statement." *Journal of the American Medical Association* 315(4):380–7.
Characteristics	
Scoring	Proportion.
Type	Process.

Stratification	• Depression Screening. – Product line: ▪ Exchange. – Age (as of the start of the measurement period): ▪ 12–17 years. ▪ 18–64 years. ▪ 65 years and older. • Follow-Up on Positive Screen. – Product line: ▪ Exchange. – Age (as of the start of the measurement period): ▪ 18–64 years. ▪ 65 years and older.
Risk adjustment	None.
Improvement notation	A higher rate indicates better performance.
Guidance	**Allocation:** The member was enrolled with a medical benefit throughout the participation period. When identifying members in hospice, the requirements described in *General Guideline 8* for identification of hospice members using the monthly membership detail data files are not included in the measure calculation logic and need to be programmed manually. **Requirements:** • This measure requires the use of an age-appropriate screening instrument. The member's age is used to select the appropriate depression screening instrument. • Depression screening captured in health risk assessments or other types of health assessments are allowed if the questions align with a specific instrument that is validated for depression screening. For example, if a health risk assessment includes questions from the PHQ-2, it counts as screening if the member answered the questions and a total score is calculated. **Reporting:** The total is the sum of the age stratifications. Product line stratifications are not included in the measure calculation logic and need to be programmed manually.
Definitions	
Participation	The identifiers and descriptors for each organization's coverage used to define members' eligibility for measure reporting. Allocation for HEDIS for QRS reporting is based on eligibility during the participation period.

Participation period

The measurement period.

Depression screening instrument

A standard assessment instrument that has been normalized and validated for the appropriate patient population. Eligible screening instruments with thresholds for positive findings include:

Instruments for Adolescents (≤17 years)	Positive Finding
Patient Health Questionnaire (PHQ-9)®	Total score ≥10
Patient Health Questionnaire Modified for Teens (PHQ-9M)®	Total score ≥10
Patient Health Questionnaire-2 (PHQ-2)®[1]	Total score ≥3
Beck Depression Inventory-Fast Screen (BDI-FS)®[1,2]	Total score ≥8
Center for Epidemiologic Studies Depression Scale—Revised (CESD-R)	Total score ≥17
Edinburgh Postnatal Depression Scale (EPDS)	Total score ≥10
PROMIS Depression	Total score (T Score) ≥60

[1]Brief screening instrument. All other instruments are full-length.
[2]Proprietary; may be cost or licensing requirement associated with use.

Instruments for Adolescents (18+ years)	Positive Finding
Patient Health Questionnaire (PHQ-9)®	Total score ≥10
Patient Health Questionnaire-2 (PHQ-2)®[1]	Total score ≥3
Beck Depression Inventory-Fast Screen (BDI-FS)®[1,2]	Total score ≥8
Beck Depression Inventory (BDI-II)	Total score ≥20
Center for Epidemiologic Studies Depression Scale-Revised (CESD-R)	Total score ≥17
Duke Anxiety-Depression Scale (DUKE-AD)®[2]	Total score ≥30
Geriatric Depression Scale Short Form (GDS)[1]	Total score ≥5
Geriatric Depression Scale Long Form (GDS)	Total score ≥10
Edinburgh Postnatal Depression Scale (EPDS)	Total score ≥10

<table>
<tr><td></td><td>
<table>
<tr><th>Instruments for Adults (18+ years)</th><th>Positive Finding</th></tr>
<tr><td>My Mood Monitor (M-3)®</td><td>Total score ≥5</td></tr>
<tr><td>PROMIS Depression</td><td>Total score (T Score) ≥60</td></tr>
<tr><td>Clinically Useful Depression Outcome Scale (CUDOS)</td><td>Total score ≥31</td></tr>
</table>
[1]Brief screening instrument. All other instruments are full-length.
[2]Proprietary; may be cost or licensing requirement associated with use.
</td></tr>
<tr><td>Initial population</td><td>Initial population 1
Members 12 years of age and older at the start of the measurement period who also meet criteria for participation.

Initial population 2
Same as the initial population 1.</td></tr>
<tr><td>Exclusions</td><td>Exclusions 1
• Members with a history of bipolar disorder any time during the member's history through the end of the year prior to the measurement period.
• Members with depression that starts during the year prior to the measurement period.
• Members in hospice or using hospice services any time during the measurement period.

Exclusions 2
Same as exclusions 1.</td></tr>
<tr><td>Denominator</td><td>Denominator 1
The initial population, minus exclusions.

Denominator 2
All members from numerator 1 with a positive depression screen finding between January 1 and December 1 of the measurement period.</td></tr>
<tr><td>Numerator</td><td>Numerator 1—Depression Screening
Members with a documented result for depression screening, using an age-appropriate standardized instrument, performed between January 1 and December 1 of the measurement period.

Numerator 2—Follow-Up on Positive Screen
Members who received follow-up care on or up to 30 days after the date of the first positive screen (31 total days).

Any of the following on or up to 30 days after the first positive screen:
• An outpatient, telephone, e-visit or virtual check-in follow-up visit with a diagnosis of depression or other behavioral health condition.
• A depression case management encounter that documents assessment for symptoms of depression or a diagnosis of depression or other behavioral health condition.</td></tr>
</table>

	• A behavioral health encounter, including assessment, therapy, collaborative care or medication management. • A dispensed antidepressant medication. ***OR*** • Documentation of additional depression screening on a full-length instrument indicating either no depression or no symptoms that require follow-up (i.e., a negative screen) on the same day as a positive screen on a brief screening instrument. ***Note:*** *For example, if there is a positive screen resulting from a PHQ-2 score, documentation of a negative finding from a PHQ-9 performed on the same day qualifies as evidence of follow-up.*

Data criteria (element level)

Value Sets:

- **DSFE_HEDIS_MY2023-2.0.0**
  - Bipolar Disorder (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1044)
  - Depression (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1390)
  - Other Bipolar Disorder (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1399)
- **NCQA_Hospice-2.0.0**
  - Hospice Encounter (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1761)
  - Hospice Intervention (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1762)
- **NCQA_Screening-1.0.0**
  - Antidepressant Medications (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1503)
  - Behavioral Health Encounter (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1383)
  - Depression Case Management Encounter (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1389)
  - Depression or Other Behavioral Health Condition (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1501)
  - Follow Up Visit (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1385)
  - Symptoms of Depression (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.2392)

Direct reference codes and codesystems:

- **DSFE_HEDIS_MY2023-2.0.0**
  - codesystem "LOINC": 'http://loinc.org'
  - code "Beck Depression Inventory Fast Screen total score [BDI]": '89208-3' from "LOINC" display 'Beck Depression Inventory Fast Screen total score [BDI]'
  - code "Beck Depression Inventory II total score [BDI]": '89209-1' from "LOINC" display 'Beck Depression Inventory II total score [BDI]'
  - code "Center for Epidemiologic Studies Depression Scale-Revised total score [CESD-R]": '89205-9' from "LOINC" display 'Center for Epidemiologic Studies Depression Scale-Revised total score [CESD-R]'
  - code "Edinburgh Postnatal Depression Scale [EPDS]": '71354-5' from "LOINC" display 'Edinburgh Postnatal Depression Scale [EPDS]'

- code "Final score [DUKE-AD]": '90853-3' from "LOINC" display 'Final score [DUKE-AD]'
- code "Geriatric depression scale (GDS) short version total": '48545-8' from "LOINC" display 'Geriatric depression scale (GDS) short version total'
- code "Geriatric depression scale (GDS) total": '48544-1' from "LOINC" display 'Geriatric depression scale (GDS) total'
- code "Patient Health Questionnaire 2 item (PHQ-2) total score [Reported]": '55758-7' from "LOINC" display 'Patient Health Questionnaire 2 item (PHQ-2) total score [Reported]'
- code "Patient Health Questionnaire 9 item (PHQ-9) total score [Reported]": '44261-6' from "LOINC" display 'Patient Health Questionnaire 9 item (PHQ-9) total score [Reported]'
- code "Patient Health Questionnaire-9: Modified for Teens total score [Reported.PHQ.Teen]": '89204-2' from "LOINC" display 'Patient Health Questionnaire-9: Modified for Teens total score [Reported.PHQ.Teen]'
- code "PROMIS-29 Depression score T-score": '71965-8' from "LOINC" display 'PROMIS-29 Depression score T-score'
- code "Total score [CUDOS]": '90221-3' from "LOINC" display 'Total score [CUDOS]'
- code "Total score [M3]": '71777-7' from "LOINC" display 'Total score [M3]'

- **NCQA_Screening-1.0.0**
  - codesystem "ICD-10-CM": 'http://hl7.org/fhir/sid/icd-10-cm'
  - code "Exercise counseling": 'Z71.82' from "ICD-10-CM" display 'Exercise counseling'
- **NCQA_Terminology-2.0.0**
  - codesystem "ActCode": 'http://terminology.hl7.org/CodeSystem/v3-ActCode'
  - codesystem "ConditionClinicalStatusCodes": 'http://terminology.hl7.org/CodeSystem/condition-clinical'
  - code "active": 'active' from "ConditionClinicalStatusCodes"
  - code "managed care policy": 'MCPOL' from "ActCode"
  - code "retiree health program": 'RETIRE' from "ActCode"
  - code "subsidized health program": 'SUBSIDIZ' from "ActCode"

Data Elements for Reporting

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

Table DSF-E-4: Data Elements for Depression Screening and Follow-Up for Adolescents and Adults

Metric	Age	Data Element	Reporting Instructions
Screening	12-17	InitialPopulation	For each Metric and Stratification
FollowUp	18-64	ExclusionsByEHR	For each Metric and Stratification
	65+	ExclusionsByCaseManagement	For each Metric and Stratification
	Total	ExclusionsByHIERegistry	For each Metric and Stratification
		ExclusionsByAdmin	For each Metric and Stratification
		Exclusions	(Sum over SSoRs)
		Denominator	For each Metric and Stratification
		NumeratorByEHR	For each Metric and Stratification
		NumeratorByCaseManagement	For each Metric and Stratification
		NumeratorByHIERegistry	For each Metric and Stratification
		NumeratorByAdmin	For each Metric and Stratification
		Numerator	(Sum over SSoRs)
		Rate	(Percent)

*Immunizations for Adolescents (IMA-E)**

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

SUMMARY OF CHANGES TO MY 2023 HEDIS FOR QRS

- Refer to the Technical Release Notes file in the Digital Measures Package for a comprehensive list of changes.
- Added new data elements tables for race and ethnicity stratification reporting.

HEDIS FOR QRS SPECIFIC GUIDANCE

- In the Draft 2023 Call Letter, CMS proposed to expand required collection and reporting of stratified race and ethnicity data for this measure beginning with MY 2023 (2024 ratings year). Refer to the Final 2023 Call Letter and the *2024 QRS and QHP Enrollee Survey Technical Guidance* for reporting this measure.
- HEDIS for QRS only reports Combination 2 and related antigens.

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.
Measurement period	January 1–December 31.
Clinical recommendation statement	*HPV*: The Advisory Committee on Immunization Practices (ACIP) recommends routine HPV vaccination for adolescents at age 11 or 12 years; vaccination may be given starting at age 9 years. In a two-dose schedule of HPV vaccine, the minimum interval between the first and second doses is 5 months. Persons who initiated vaccination with 9vHPV, 4vHPV or 2vHPV before their 15th birthday and received 2 doses of any HPV vaccine at the recommended dosing schedule (0, 6–12 months), or received three doses of any HPV vaccine at the recommended dosing schedule (0, 1–2, 6 months), are considered adequately vaccinated (Meites, Kempe, and Markowitz 2016). *Tdap*: ACIP recommends a single dose of vaccine be administered at age 11 or 12 years (Liang et al. 2018). *Meningococcal*: ACIP recommends a single dose of vaccine be administered at age 11 or 12 years (Cohn et al. 2013).
Citations	Cohn, A.C., J.R. MacNeil, T.A. Clark, I.R. Ortega-Sanchez, E.Z. Briere, H.C. Meissner, C.J. Baker, N.E. Messonnier, Centers for Disease Control and Prevention (CDC). 2013. “Prevention and Control of Meningococcal Disease: Recommendations of the Advisory Committee on Immunization Practices (ACIP).” *MMWR Recomm Rep* 62(RR-2):1–28.

Jiang, J.L., T. Tiwari, P. Moro, N.E. Messonnier, A. Reingold, M. Sawyer, T.A. Clark. 2018. "Prevention of Pertussis, Tetanus, and Diphtheria with Vaccines in the United States: Recommendations of the Advisory Committee on Immunization Practices (ACIP)." *MMWR Morb Mortal Wkly Rep* 67(2):1–44. DOI: 10.15585/mmwr.rr6702a1.

Meites, E., A. Kempe, L.E. Markowitz. 2016. "Use of a 2-Dose Schedule for Human Papillomavirus Vaccination—Updated Recommendations of the Advisory Committee on Immunization Practices." *MMWR Morb Mortal Wkly Rep* 65:1405–08. DOI: 10.15585/mmwr.mm6549a5.

Characteristics

Scoring

Proportion.

Type

Process.

Stratification

- Meningococcal Serogroups A, C, W, Y.
  - Product line:
    - Exchange.
  - Race:
    - Race—White.
    - Race—Black or African American.
    - Race—American Indian or Alaska Native.
    - Race—Asian.
    - Race—Native Hawaiian or Other Pacific Islander.
    - Race—Some Other Race.
    - Race—Two or More Races.
    - Race—Asked but No Answer.
    - Race—Unknown.
  - Ethnicity:
    - Ethnicity—Hispanic or Latino.
    - Ethnicity—Not Hispanic or Latino.
    - Ethnicity—Asked but No Answer.
    - Ethnicity—Unknown.
- Tdap.
  - Product line:
    - Exchange.
  - Race:
    - Race—White.
    - Race—Black or African American.
    - Race—American Indian or Alaska Native.
    - Race—Asian.
    - Race—Native Hawaiian or Other Pacific Islander.
    - Race—Some Other Race.
    - Race—Two or More Races.
    - Race—Asked but No Answer.
    - Race—Unknown.

	– Ethnicity: ▪ Ethnicity—Hispanic or Latino. ▪ Ethnicity—Not Hispanic or Latino. ▪ Ethnicity—Asked but No Answer. ▪ Ethnicity—Unknown. • HPV. – Product line: ▪ Exchange. – Race: ▪ Race—White. ▪ Race—Black or African American. ▪ Race—American Indian or Alaska Native. ▪ Race—Asian. ▪ Race—Native Hawaiian or Other Pacific Islander. ▪ Race—Some Other Race. ▪ Race—Two or More Races. ▪ Race—Asked but No Answer. ▪ Race—Unknown. – Ethnicity: ▪ Ethnicity—Hispanic or Latino. ▪ Ethnicity—Not Hispanic or Latino. ▪ Ethnicity—Asked but No Answer. ▪ Ethnicity—Unknown. • Combination 2: Meningococcal, Tdap, HPV. – Product line: ▪ Exchange. – Race: ▪ Race—White. ▪ Race—Black or African American. ▪ Race—American Indian or Alaska Native. ▪ Race—Asian. ▪ Race—Native Hawaiian or Other Pacific Islander. ▪ Race—Some Other Race. ▪ Race—Two or More Races. ▪ Race—Asked but No Answer. ▪ Race—Unknown. – Ethnicity: ▪ Ethnicity—Hispanic or Latino. ▪ Ethnicity—Not Hispanic or Latino. ▪ Ethnicity—Asked but No Answer. ▪ Ethnicity—Unknown.
Risk adjustment	None.

Improvement notation	A higher rate indicates better performance.
Guidance	• To align with 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). **Allocation:** The member was enrolled with a medical benefit throughout the participation period. No more than one gap in enrollment of up to 45 days during the participation period. The member must be enrolled on their 13th birthday. When identifying members in hospice, the requirements described in *General Guideline 8* for identification of hospice members using the monthly membership detail data files are not included in the measure calculation logic and need to be programmed manually. **Reporting:** Product line stratifications are not included in the measure calculation logic and need to be programmed manually. For all plans, the race and ethnicity stratifications are mutually exclusive and the sum of all categories in each stratification is the total population. The race and ethnicity stratifications are reported by data source—direct or indirect.
Definitions	
Participation **Participation Period**	The identifiers and descriptors for each organization's coverage used to define members' eligibility for measure reporting. Allocation for reporting is based on eligibility during the Participation Period. 12 months prior to the member's 13th birthday.
Initial Population	**Initial population 1** Adolescents who turn 13 years of age during the measurement period who also meet criteria for participation. **Initial population 2** Same as the initial population 1. **Initial population 3** Same as the initial population 1. **Initial population 5** Same as the initial population 1.

Exclusions	**Exclusions 1** Members in hospice or using hospice services any time during the measurement period. **Exclusions 2** Same as exclusions 1. **Exclusions 3** Same as exclusions 1. **Exclusions 5** Same as exclusions 1.
Denominator	**Denominator 1** The initial population, minus exclusions. **Denominator 2** Same as denominator 1. **Denominator 3** Same as denominator 1. **Denominator 5** Same as denominator 1.
Numerator	**Numerator 1—Meningococcal Serogroups A, C, W, Y** Members with either of the following meet criteria: • At least one meningococcal serogroups A, C, W, Y vaccine, with a date of service on or between the member's 11th and 13th birthdays. • Anaphylaxis due to the meningococcal vaccine any time on or before the member's 13th birthday. **Numerator 2—Tdap** Members with any of the following meet criteria: • At least one tetanus, diphtheria toxoids and acellular pertussis (Tdap) vaccine, with a date of service on or between the member's 10th and 13th birthdays. • Anaphylaxis due to the tetanus, diphtheria or pertussis vaccine any time on or before the member's 13th birthday. • Encephalitis due to the tetanus, diphtheria or pertussis vaccine any time on or before the member's 13th birthday. **Numerator 3—HPV** Members with any of the following meet criteria: • At least two HPV vaccines, 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, with different dates of service on or between the member's 9th and 13th birthdays.

	• Anaphylaxis due to the HPV vaccine any time on or before the member's 13th birthday. **Numerator 5—Combination 2: Meningococcal, Tdap, HPV** Adolescents who are Numerator compliant for all three indicators (Meningococcal, Tdap, HPV).

Data criteria (element level)

Value Sets:

- **IMAE_HEDIS_MY2023-2.0.0**
  - Anaphylaxis Due to Diphtheria, Tetanus or Pertussis Vaccine (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.2240)
  - Encephalitis Due to Diphtheria, Tetanus or Pertussis Vaccine (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.2241)
  - HPV Immunization (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1763)
  - HPV Vaccine Procedure (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1764)
  - Meningococcal Immunization (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1777)
  - Meningococcal Vaccine Procedure (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1778)
  - Tdap Immunization (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1791)
  - Tdap Vaccine Procedure (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1792)
- **NCQA_Hospice-2.0.0**
  - Hospice Encounter (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1761)
  - Hospice Intervention (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1762)
- **NCQA_Stratification-1.0.0**
  - American Indian or Alaska Native Detailed Race (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.2365)
  - Asian Detailed Race (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.2366)
  - Black or African American Detailed Race (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.2367)
  - Hispanic or Latino Detailed Ethnicity (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.2368)
  - Native Hawaiian or Other Pacific Islander Detailed Race (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.2369)
  - White Detailed Race (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.2370)

Direct Reference Codes and Codesystems:

- **IMAE_HEDIS_MY2023-2.0.0**
  - codesystem "SNOMEDCT": 'http://snomed.info/sct'
  - code "Anaphylaxis due to human papillomavirus vaccine (disorder)": '428241000124101' from "SNOMEDCT" display 'Anaphylaxis due to human papillomavirus vaccine (disorder)'
  - code "Anaphylaxis due to meningococcal vaccine (disorder)": '428301000124106' from "SNOMEDCT" display 'Anaphylaxis due to meningococcal vaccine (disorder)'
- **NCQA_Terminology-2.0.0**
  - codesystem "ActCode": 'http://terminology.hl7.org/CodeSystem/v3-ActCode'

- codesystem "ConditionClinicalStatusCodes": 'http://terminology.hl7.org/CodeSystem/condition-clinical'
- codesystem "NullFlavor": 'http://terminology.hl7.org/CodeSystem/v3-NullFlavor'
- codesystem "RaceAndEthnicityCDC": 'https://www.hl7.org/fhir/us/core/CodeSystem-cdcrec' – code "active": 'active' from "ConditionClinicalStatusCodes"
- code "American Indian or Alaska Native": '1002-5' from "RaceAndEthnicityCDC" display 'American Indian or Alaska Native'
- code "Asian": '2028-9' from "RaceAndEthnicityCDC" display 'Asian'
- code "Asked but no answer": 'ASKU' from "NullFlavor" display 'Asked but no answer'
- code "Black or African American": '2054-5' from "RaceAndEthnicityCDC" display 'Black or African American'
- code "Hispanic or Latino": '2135-2' from "RaceAndEthnicityCDC" display 'Hispanic or Latino' – code "managed care policy": 'MCPOL' from "ActCode"
- code "Native Hawaiian or Other Pacific Islander": '2076-8' from "RaceAndEthnicityCDC" display 'Native Hawaiian or Other Pacific Islander'
- code "Non Hispanic or Latino": '2186-5' from "RaceAndEthnicityCDC" display 'Non Hispanic or Latino'
- code "Other": 'OTH' from "NullFlavor" display 'Other'
- code "retiree health program": 'RETIRE' from "ActCode"
- code "subsidized health program": 'SUBSIDIZ' from "ActCode"
- code "Unknown": 'UNK' from "NullFlavor" display 'Unknown'
- code "White": '2106-3' from "RaceAndEthnicityCDC" display 'White'

Data Elements for Reporting

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

Table IMA-E-A-4: Data Elements for Immunizations for Adolescents

Metric	Data Element	Reporting Instructions
Meningococcal	InitialPopulation	Repeat per Metric
Tdap	Exclusions	Repeat per Metric
HPV	Denominator	Repeat per Metric
Combo2	NumeratorByEHR	For each Metric
	NumeratorByCaseManagement	For each Metric
	NumeratorByHIERegistry	For each Metric
	NumeratorByAdmin	For each Metric
	Numerator	(Sum over SSoRs)
	Rate	(Percent)

Table IMA-E-B-4: Data Elements for Immunizations for Adolescents: Stratifications by Race

Metric
Meningococcal
Tdap
HPV
Combo2

Race	Source	Data Element	Reporting Instructions
White	Direct	InitialPopulation	For each Stratification, repeat per Metric
BlackOrAfricanAmerican	Indirect	Exclusions	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 IMA-E-C-4: Data Elements for Immunizations for Adolescents: Stratifications by Ethnicity

Metric
Meningococcal
Tdap
HPV
Combo2

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

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

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

Social Need Screening and Intervention (SNS-E)

SUMMARY OF CHANGES TO MY 2023 HEDIS FOR QRS

- This is the first year this measure is reported.

HEDIS FOR QRS SPECIFIC GUIDANCE

- In the Draft 2023 Call Letter, CMS proposed to add this measure to the 2024 QRS measure set. Refer to the Final 2023 Call Letter and the *2024 QRS and QHP Enrollee Survey Technical Guidance* for reporting this measure.

Finalized Data Submission Requirements for the 2024 Ratings Year

In the Final 2023 Call Letter, CMS proposed the addition of the *Social Need Screening and Intervention* measure to the QRS measure set. CMS did not finalize the proposed addition of the *Social Need Screening and Intervention* measure for the 2024 ratings year.

Description	The percentage of members who were screened, using prespecified instruments, at least once during the measurement period for unmet food, housing and transportation needs, and received a corresponding intervention if they screened positive. • *Food Screening.* The percentage of members who were screened for food insecurity. • *Food Intervention.* The percentage of members who received a corresponding intervention within 1 month of screening positive for food insecurity. • *Housing Screening.* The percentage of members who were screened for housing instability, homelessness or housing inadequacy. • *Housing Intervention.* The percentage of members who received a corresponding intervention within 1 month of screening positive for housing instability, homelessness or housing inadequacy. • *Transportation Screening.* The percentage of members who were screened for transportation insecurity. • *Transportation Intervention.* The percentage of members who received a corresponding intervention within 1 month of screening positive for transportation insecurity.
Measurement period	January 1–December 31.
Clinical recommendation statement	**American Academy of Family Physicians:** The AAFP urges health insurers and payors to provide appropriate payment to support health care practices to identify, monitor, assess, and address SDoH. **American Academy of Pediatrics:** The AAP recommends surveillance for risk factors related to social determinants of health during all patient encounters. **American Diabetes Association:** Assess food insecurity, housing insecurity/homelessness, financial barriers and social capital/social community support to inform treatment decisions, with referral to appropriate local community resources.

Citations	American Academy of Family Physicians. 2019. "Advancing Health Equity by Addressing the Social Determinants of Health in Family Medicine (Position Paper)." https://www.aafp.org/about/policies/all/social-determinants-health-family-medicine-position-paper.html American Academy of Pediatrics. 2016. "Poverty and Child Health in the United States." https://pediatrics.aappublications.org/content/137/4/e20160339#sec-12 American Diabetes Association. 2022. "Standards of Medical Care in Diabetes-2022." Diabetes Care 45(Suppl 1): S4–7. DOI:10.2337/dc22-Srev The Gravity Project. "Terminology Workstream Dashboard." The Gravity Project Confluence, n.d. https://confluence.hl7.org/display/GRAV/Terminology+Workstream+Dashboard
Characteristics	
Scoring	Proportion.
Type	Process.
Stratification	• Food Screening. – Product line: ▪ Exchange. – Age (as of the start of the measurement period): ▪ ≤17 years. ▪ 18–64 years. ▪ 65 and older. • Food Intervention. – Product line: ▪ Exchange. – Age (as of the start of the measurement period): ▪ ≤17 years. ▪ 18–64 years. ▪ 65 and older. • Housing Screening. – Product line: ▪ Exchange. – Age (as of the start of the measurement period): ▪ ≤17 years. ▪ 18–64 years. ▪ 65 and older. • Housing Intervention. – Product line: ▪ Exchange.

	– Age (as of the start of the measurement period): ▪ ≤17 years. ▪ 18–64 years. ▪ 65 and older. • Transportation Screening. – Product line: ▪ Exchange. – Age (as of the start of the measurement period): ▪ ≤17 years. ▪ 18–64 years. ▪ 65 and older. • Transportation Intervention. – Product line: ▪ Exchange. – Age (as of the start of the measurement period): ▪ ≤17 years. ▪ 18–64 years. ▪ 65 and older.
Risk adjustment	None.
Improvement notation	A higher rate indicates better performance.
Guidance	**Allocation:** The member was enrolled with a medical benefit throughout the participation period. When identifying members in hospice, the requirements described in *General Guideline 8* for identification of hospice members using the monthly membership detail data files are not included in the measure calculation logic and need to be programmed manually. **Reporting:** The total is the sum of the age stratifications. Product line stratifications are not included in the measure calculation logic and need to be programmed manually.
Definitions	
Participation	The identifiers and descriptors for each organization's coverage used to define members' eligibility for measure reporting. Allocation for reporting is based on eligibility during the participation period.
Participation period	The measurement period.

Food insecurity	Uncertain, limited or unstable access to food that is: adequate in quantity and in nutritional quality; culturally acceptable; safe and acquired in socially acceptable ways.
Housing instability	Currently consistently housed but experiencing any of the following circumstances in the past 12 months: being behind on rent or mortgage, multiple moves, cost burden or risk of eviction.
Homelessness	Currently living in an environment that is not meant for permanent human habitation (e.g., cars, parks, sidewalks, abandoned buildings, on the street), not having a consistent place to sleep at night, or because of economic difficulties, currently living in a shelter, motel, temporary or transitional living situation.
Housing inadequacy	Housing does not meet habitability standards.
Transportation insecurity	Uncertain, limited or no access to safe, reliable, accessible, affordable and socially acceptable transportation infrastructure and modalities necessary for maintaining one's health, well-being or livelihood.
Food insecurity instruments	Eligible screening instruments with thresholds for positive findings include:

Food Insecurity Instruments	Screening Item LOINC Codes	Positive Finding LOINC Codes
Accountable Health Communities (AHC) Health-Related Social Needs (HRSN) Screening Tool	88122-7	LA28397-0 LA6729-3
	88123-5	LA28397-0 LA6729-3
American Academy of Family Physicians (AAFP) Social Needs Screening Tool	88122-7	LA28397-0 LA6729-3
	88123-5	LA28397-0 LA6729-3
Health Leads Screening Panel®[1]	95251-5	LA33-6
Hunger Vital Sign™[1] (HVS)	88124-3	LA19952-3
Protocol for Responding to and Assessing Patients' Assets, Risks and Experiences [PRAPARE]®[1]	93031-3	LA30125-1
Safe Environment for Every Kid (SEEK)®[1]	95400-8	LA33-6
	95399-2	LA33-6

	<table><tr><th>Food Insecurity Instruments</th><th>Screening Item LOINC Codes</th><th>Positive Finding LOINC Codes</th></tr><tr><td>U.S. Household Food Security Survey [U.S. FSS]</td><td>95264-8</td><td>LA30985-8 LA30986-6</td></tr><tr><td>U.S. Adult Food Security Survey [U.S. FSS]</td><td>95264-8</td><td>LA30985-8 LA30986-6</td></tr><tr><td>U.S. Child Food Security Survey [U.S. FSS]</td><td>95264-8</td><td>LA30985-8 LA30986-6</td></tr><tr><td>U.S. Household Food Security Survey–Six-Item Short Form [U.S. FSS]</td><td>95264-8</td><td>LA30985-8 LA30986-6</td></tr><tr><td>We Care Survey</td><td>96434-6</td><td>LA32-8</td></tr><tr><td>WellRx Questionnaire</td><td>93668-2</td><td>LA33-6</td></tr></table> [1]Proprietary; may be cost or licensing requirement associated with use.
Housing instability, homelessness and housing inadequacy screening instruments	Eligible screening instruments with thresholds for positive findings include: <table><tr><th>Housing Instability and Homelessness Instruments</th><th>Screening Item LOINC Codes</th><th>Positive Finding LOINC Codes</th></tr><tr><td>Accountable Health Communities (AHC) Health-Related Social Needs (HRSN) Screening Tool</td><td>71802-3</td><td>LA31994-9 LA31995-6</td></tr><tr><td>American Academy of Family Physicians (AAFP) Social Needs Screening Tool</td><td>99550-6</td><td>LA33-6</td></tr><tr><td rowspan="3">Children’s Health Watch Housing Stability Vital Signs™1</td><td>98976-4</td><td>LA33-6</td></tr><tr><td>98977-2</td><td>≥3</td></tr><tr><td>98978-0</td><td>LA33-6</td></tr><tr><td>Health Leads Screening Panel®1</td><td>99550-6</td><td>LA33-6</td></tr><tr><td rowspan="2">Protocol for Responding to and Assessing Patients' Assets, Risks and Experiences [PRAPARE]®1</td><td>93033-9</td><td>LA33-6</td></tr><tr><td>71802-3</td><td>LA30190-5</td></tr><tr><td>We Care Survey</td><td>96441-1</td><td>LA33-6</td></tr><tr><td>WellRx Questionnaire</td><td>93669-0</td><td>LA33-6</td></tr></table> [1]Proprietary; may be cost or licensing requirement associated with use.

Housing Inadequacy Instruments	Screening Item LOINC Codes	Positive Finding LOINC Codes
Accountable Health Communities (AHC) Health-Related Social Needs (HRSN) Screening Tool	96778-6	LA31996-4 LA28580-1 LA31997-2 LA31998-0 LA31999-8 LA32000-4 LA32001-2
American Academy of Family Physicians (AAFP) Social Needs Screening Tool	96778-6	LA32691-0 LA28580-1 LA32693-6 LA32694-4 LA32695-1 LA32696-9 LA32001-2

Transportation insecurity screening instruments

Eligible screening instruments with thresholds for positive findings include:

Transportation Insecurity Instruments	Screening Item LOINC Codes	Positive Finding LOINC Codes
Accountable Health Communities (AHC) Health-Related Social Needs (HRSN) Screening Tool	93030-5	LA33-6
American Academy of Family Physicians (AAFP) Social Needs Screening Tool	99594-4	LA33-6
Comprehensive Universal Behavior Screen (CUBS)	89569-8	LA29232-8 LA29233-6 LA29234-4
Health Leads Screening Panel®1	99553-0	LA33-6
Protocol for Responding to and Assessing Patients' Assets, Risks and Experiences [PRAPARE]®1	93030-5	LA30133-5 LA30134-3
PROMIS®1	92358-1	LA30024-6 LA30026-1 LA30027-9
WellRx Questionnaire	93671-6	LA33-6

[1]Proprietary; may be cost or licensing requirement associated with use.

Interventions

An intervention corresponding to the type of need identified on or up to 30 days after the date of the first positive screening during the measurement period.

- A positive food insecurity screen finding must be met by a food insecurity intervention.
- A positive housing instability or homelessness screen finding must be met by a housing instability or homelessness intervention.

	• A positive housing inadequacy screen finding must be met by a housing inadequacy intervention. • A positive transportation insecurity screen finding must be met by a transportation insecurity intervention. Intervention may include any of the following intervention categories: assistance, assessment, counseling, coordination, education, evaluation of eligibility, provision or referral.
Initial population	**Initial population 1** Members of any age enrolled at the start of the measurement period who also meet criteria for participation. **Initial population 2** Same as the initial population 1. **Initial population 3** Same as the initial population 1. **Initial population 4** Same as the initial population 1. **Initial population 5** Same as the initial population 1. **Initial population 6** Same as the initial population 1.
Exclusions	**Exclusions 1** • Members in hospice or using hospice services any time during the measurement period. • Medicare members 66 years of age and older by the end of the measurement period who meet either of the following: – Enrolled in an Institutional SNP (I-SNP) any time during the measurement period. – Living long-term in an institution any time during the measurement period, 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 period. **Exclusions 2** Same as exclusions 1. **Exclusions 3** Same as exclusions 1. **Exclusions 4** Same as exclusions 1. **Exclusions 5** Same as exclusions 1. **Exclusions 6** Same as exclusions 1.

Denominator	**Denominator 1** The initial population, minus exclusions. **Denominator 2** All members in numerator 1 with a positive food insecurity screen finding between January 1 and December 1 of the measurement period. **Denominator 3** Same as denominator 1. **Denominator 4** All members in numerator 3 with a positive housing instability, homelessness or housing inadequacy screen finding between January 1 and December 1 of the measurement period. **Denominator 5** Same as denominator 1. **Denominator 6** All members in numerator 5 with a positive transportation insecurity screen finding between January 1 and December 1 of the measurement period.
Numerator	**Numerator 1—Food Screening** Members in denominator 1 with a documented result for food insecurity screening performed between January 1 and December 1 of the measurement period. **Numerator 2—Food Intervention** Members in denominator 2 receiving a food insecurity intervention on or up to 30 days after the date of the first positive food insecurity screen (31 days total). **Numerator 3—Housing Screening** Members in denominator 3 with a documented result for housing instability, homelessness or housing inadequacy screening performed between January 1 and December 1 of the measurement period. **Numerator 4—Housing Intervention** Members in denominator 4 receiving an intervention corresponding to the type of housing need identified on or up to 30 days after the date of the first positive housing screen (31 days total). **Numerator 5—Transportation Screening** Members in denominator 5 with a documented result for transportation insecurity screening performed between January 1 and December 1 of the measurement period. **Numerator 6—Transportation Intervention** Members in denominator 6 receiving a transportation insecurity intervention on or up to 30 days after the date of the first positive transportation screen (31 days total).

Data criteria (element level)

Value Sets:

- **NCQA_Hospice-2.0.0**
  - Hospice Encounter (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1761)
  - Hospice Intervention (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1762)
- **SNSE_HEDIS_MY2023-1.0.0**
  - Food Insecurity Procedures (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.2262)
  - Homelessness Procedures (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.2410)
  - Housing Instability Procedures (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.2412)
  - Inadequate Housing Procedures (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.2411)
  - Transportation Insecurity Procedures (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.2264)

Direct reference codes and codesystems:

- **NCQA_Terminology-2.0.0**
  - codesystem "ActCode": 'http://terminology.hl7.org/CodeSystem/v3-ActCode'
  - code "managed care policy": 'MCPOL' from "ActCode"
  - code "retiree health program": 'RETIRE' from "ActCode"
  - code "subsidized health program": 'SUBSIDIZ' from "ActCode"
- **SNSE_HEDIS_MY2023-1.0.0**
  - codesystem "LOINC": 'http://loinc.org'
  - code "Access to transportation/mobility status [CUBS]": '89569-8' from "LOINC" display 'Access to transportation/mobility status [CUBS]'
  - code "Always has enough food for family Caregiver": '96434-6' from "LOINC" display 'Always has enough food for family Caregiver'
  - code "Are you homeless or worried that you might be in the future [WellRx]": '93669-0' from "LOINC" display 'Are you homeless or worried that you might be in the future [WellRx]'
  - code "Are you worried about losing your housing [PRAPARE]": '93033-9' from "LOINC" display 'Are you worried about losing your housing [PRAPARE]'
  - code "At risk": 'LA19952-3' from "LOINC" display 'At risk'
  - code "At risk of becoming homeless Caregiver": '96441-1' from "LOINC" display 'At risk of becoming homeless Caregiver'
  - code "Behind on rent or mortgage in past 12 months": '98976-4' from "LOINC" display 'Behind on rent or mortgage in past 12 months'
  - code "Bug infestation": 'LA32691-0' from "LOINC" display 'Bug infestation'
  - code "Current level of confidence I can use public transportation [PROMIS]": '92358-1' from "LOINC" display 'Current level of confidence I can use public transportation [PROMIS]'
  - code "Delayed medical care due to distance or lack of transportation": '99594-4' from "LOINC" display 'Delayed medical care due to distance or lack of transportation'
  - code "Did you or others you live with eat smaller meals or skip meals because you didn't have money for food in the past 2 months [WellRx]": '93668-2' from "LOINC" display 'Did you or others you live with eat smaller meals or skip meals because you didnt have money for food in the past 2 months'

- code "Do you have trouble finding or paying for transportation [WellRx]": '93671-6' from "LOINC" display 'Do you have trouble finding or paying for transportation [WellRx]'
- code "Food": 'LA30125-1' from "LOINC" display 'Food'
- code "Food insecurity risk [HVS]": '88124-3' from "LOINC" display 'Food insecurity risk [HVS]'
- code "Food security status [U.S. FSS]": '95264-8' from "LOINC" display 'Food security status [U.S. FSS]'
- code "Has lack of transportation kept you from medical appointments, meetings, work, or from getting things needed for daily living": '93030-5' from "LOINC" display 'Has lack of transportation kept you from medical appointments, meetings, work, or from getting things needed for daily living'
- code "Have you or any family members you live with been unable to get any of the following when it was really needed in past 1 year [PRAPARE]": '93031-3' from "LOINC" display 'Have you or any family members you live with been unable to get any of the following when it was really needed in past 1 year [PRAPARE]'
- code "Homeless in past 12 months": '98978-0' from "LOINC" display 'Homeless in past 12 months'
- code "Housing status": '71802-3' from "LOINC" display 'Housing status'
- code "I am a little confident": 'LA30026-1' from "LOINC" display 'I am a little confident'
- code "I am not at all confident": 'LA30024-6' from "LOINC" display 'I am not at all confident'
- code "I am somewhat confident": 'LA30027-9' from "LOINC" display 'I am somewhat confident'
- code "I do not have a steady place to live (I am temporarily staying with others, in a hotel, in a shelter, living outside on the street, on a beach, in a car, abandoned building, bus or train station, or in a park)": 'LA31995-6' from "LOINC" display 'I do not have a steady place to live (I am temporarily staying with others, in a hotel, in a shelter, living outside on the street, on a beach, in a car, abandoned building, bus or train station, or in a park)'
- code "I do not have housing (staying with others, in a hotel, in a shelter, living outside on the street, on a beach, in a car, or in a park)": 'LA30190-5' from "LOINC" display 'I do not have housing (staying with others, in a hotel, in a shelter, living outside on the street, on a beach, in a car, or in a park)'
- code "I have a place to live today, but I am worried about losing it in the future": 'LA31994-9' from "LOINC" display 'I have a place to live today, but I am worried about losing it in the future'
- code "I have no access to transportation, public or private; may have car that is inoperable": 'LA29234-4' from "LOINC" display 'I have no access to transportation, public or private; may have car that is inoperable'
- code "In the last 12 months, did you ever eat less than you felt you should because there wasn't enough money for food [U.S. FSS]": '95251-5' from "LOINC" display 'In the last 12 months, did you ever eat less than you felt you should because there wasnt enough money for food [U.S. FSS]'
- code "Inadequate heat": 'LA32694-4' from "LOINC" display 'Inadequate heat'
- code "Lack of heat": 'LA31998-0' from "LOINC" display 'Lack of heat'
- code "Lead paint or pipes": 'LA31997-2' from "LOINC" display 'Lead paint or pipes'
- code "Lead paint/pipes": 'LA32693-6' from "LOINC" display 'Lead paint/pipes'
- code "Low food security": 'LA30985-8' from "LOINC" display 'Low food security'
- code "Mold": 'LA28580-1' from "LOINC" display 'Mold'
- code "My transportation is available and reliable, but limited and/or inconvenient; drivers are licensed and minimally insured": 'LA29232-8' from "LOINC" display 'My transportation is available and reliable, but limited and/or inconvenient; drivers are licensed and minimally insured'
- code "My transportation is available, but unreliable, unpredictable, unaffordable; may have car but no insurance, license, etc.": 'LA29233-6' from "LOINC" display 'My transportation is available, but unreliable, unpredictable, unaffordable; may have car but no insurance, license, etc.'
- code "No": 'LA32-8' from "LOINC" display 'No'

- code "No or non-working smoke detectors": 'LA32696-9' from "LOINC" display 'No or non-working smoke detectors'
- code "Non-functioning oven/stove": 'LA32695-1' from "LOINC" display 'Non-functioning oven/stove'
- code "Number of residential moves in past 12 months": '98977-2' from "LOINC" display 'Number of residential moves in past 12 months'
- code "Often true": 'LA28397-0' from "LOINC" display 'Often true'
- code "Oven or stove not working": 'LA31999-8' from "LOINC" display 'Oven or stove not working'
- code "Pests such as bugs, ants, or mice": 'LA31996-4' from "LOINC" display 'Pests such as bugs, ants, or mice'
- code "Problems with place where you live": '96778-6' from "LOINC" display 'Problems with place where you live'
- code "Smoke detectors missing or not working": 'LA32000-4' from "LOINC" display 'Smoke detectors missing or not working'
- code "Sometimes true": 'LA6729-3' from "LOINC" display 'Sometimes true'
- code "Very low food security": 'LA30986-6' from "LOINC" display 'Very low food security'
- code "Water leaks": 'LA32001-2' from "LOINC" display 'Water leaks'
- code "Went without health care due to lack of transportation in last 12 months": '99553-0' from "LOINC" display 'Went without health care due to lack of transportation in last 12 months'
- code "Within the past 12 months the food we bought just didn't last and we didn't have money to get more [U.S. FSS]": '88123-5' from "LOINC" display 'Within the past 12 months the food we bought just didnt last and we didnt have money to get more [U.S. FSS]'
- code "Within the past 12 months the food we bought just didn't last and we didn't have money to get more Caregiver [U.S. FSS]": '95399-2' from "LOINC" display 'In the last 12 months, did the food you bought just not last and you didnt have money to get more?'
- code "Within the past 12 months we worried whether our food would run out before we got money to buy more [U.S. FSS]": '88122-7' from "LOINC" display 'Within the past 12 months we worried whether our food would run out before we got money to buy more [U.S. FSS]'
- code "Within the past 12 months we worried whether our food would run out before we got money to buy more Caregiver [U.S. FSS]": '95400-8' from "LOINC" display 'Within the past 12 months we worried whether our food would run out before we got money to buy more Caregiver [U.S. FSS]'
- code "Worried about housing stability in next 2 months": '99550-6' from "LOINC" display 'Worried about housing stability in next 2 months'
- code "Yes": 'LA33-6' from "LOINC" display 'Yes'
- code "Yes, it has kept me from medical appointments or from getting my medications": 'LA30133-5' from "LOINC" display 'Yes, it has kept me from medical appointments or from getting my medications'
- code "Yes, it has kept me from non-medical meetings, appointments, work, or from getting things that I need": 'LA30134-3' from "LOINC" display 'Yes, it has kept me from non-medical meetings, appointments, work, or from getting things that I need'

Data Elements for Reporting

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

Table SNS-E-: Data Elements for Social Need Screening and Intervention

Metric	Age	Data Element	Reporting Instructions
FoodScreening*	0-17	InitialPopulation	For each Metric and Stratification
FoodIntervention	18-64	ExclusionsByEHR	For each Metric and Stratification
HousingScreening*	65+	ExclusionsByCaseManagement	For each Metric and Stratification
HousingIntervention	Total	ExclusionsByHIERegistry	For each Metric and Stratification
TransportationScreening*		ExclusionsByAdmin	For each Metric and Stratification
TransportationIntervention		Exclusions	(Sum over SSoRs)
		Denominator	For each Metric and Stratification
		NumeratorByEHR	For each Metric and Stratification
		NumeratorByCaseManagement	For each Metric and Stratification
		NumeratorByHIERegistry	For each Metric and Stratification
		NumeratorByAdmin	For each Metric and Stratification
		Numerator	(Sum over SSoRs)
		Rate	(Percent)

**These metrics share an initial population. Repeat the initial population, denominator and exclusions data elements for all three screening metrics.*

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Appendix 1: Practitioner Types

APPENDIX 1
PRACTITIONER TYPES

clinical pharmacist

A pharmacist with extensive education in the biomedical, pharmaceutical, socio-behavioral and clinical sciences. Clinical pharmacists are experts in the therapeutic use of medications and are a primary source of scientifically valid information and advice regarding the safe, appropriate and cost-effective use of medications.

Most clinical pharmacists have a Doctor of Pharmacy (PharmD) degree and many have completed one or more years of post-graduate training (e.g., a general and/or specialty pharmacy residency). In some states, clinical pharmacists have prescriptive authority.

mental health provider

A provider who delivers mental health services and meets any of the following criteria:

- An MD or doctor of osteopathy (DO) who is certified as a psychiatrist or child psychiatrist by the American Medical Specialties Board of Psychiatry and Neurology or by the American Osteopathic Board of Neurology and Psychiatry; or, if not certified, who successfully completed an accredited program of graduate medical or osteopathic education in psychiatry or child psychiatry and is licensed to practice patient care psychiatry or child psychiatry, if required by the state of practice.
- An individual who is licensed as a psychologist in their state of practice, if required by the state of practice.
- An individual who is certified in clinical social work by the American Board of Examiners; who is listed on the National Association of Social Worker's Clinical Register; or who has a master's degree in social work and is licensed or certified to practice as a social worker, if required by the state of practice.
- A registered nurse (RN) who is certified by the American Nurses Credentialing Center (a subsidiary of the American Nurses Association) as a psychiatric nurse or mental health clinical nurse specialist, or who has a master's degree in nursing with a specialization in psychiatric/mental health and two years of supervised clinical experience and is licensed to practice as a psychiatric or mental health nurse, if required by the state of practice.
- An individual (normally with a master's or a doctoral degree in marital and family therapy and at least two years of supervised clinical experience) who is practicing as a marital and family therapist and is licensed or a certified counselor by the state of practice, or if licensure or certification is not required by the state of practice, who is eligible for clinical membership in the American Association for Marriage and Family Therapy.
- An individual (normally with a master's or doctoral degree in counseling and at least two years of supervised clinical experience) who is practicing as a professional counselor and who is licensed or certified to do so by the state of practice, or if licensure or certification is not required by the state of practice, is a National Certified Counselor with a Specialty Certification in Clinical Mental Health Counseling from the National Board for Certified Counselors (NBCC).
- A physician assistant who is certified by the National Commission on Certification of Physician Assistants to practice psychiatry.

- A certified Community Mental Health Center (CMHC), or the comparable term (e.g., behavioral health organization, mental health agency, behavioral health agency) used within the state in which it is located, or a Certified Community Behavioral Health Clinic (CCBHC).
  - Only authorized CMHCs are considered mental health providers. To be authorized as a CMHC, an entity must meet one of the following criteria:
    - The entity has been certified by CMS to meet the conditions of participation (CoPs) that community mental health centers (CMHCs) must meet in order to participate in the Medicare program, as defined in the Code of Federal Regulations Title 42. CMS defines a CMHC as an entity that meets applicable licensing or certification requirements for CMHCs in the State in which it is located and provides the set of services specified in section 1913(c)(1) of the Public Health Service Act (PHS Act).
    - The entity has been licensed, operated, authorized, or otherwise recognized as a CMHC by a state or county in which it is located.
  - Only authorized CCBHCs are considered mental health providers. To be authorized as a CCBHC, an entity must meet one of the following criteria:
    - Has been certified by a State Medicaid agency as meeting criteria established by the Secretary for participation in the Medicaid CCBHC demonstration program pursuant to Protecting Access to Medicare Act § 223(a) (42 U.S.C. § 1396a note); or as meeting criteria within the State's Medicaid Plan to be considered a CCBHC.
    - Has been recognized by the Substance Abuse and Mental Health Services Administration, through the award of grant funds or otherwise, as a CCBHC that meets the certification criteria of a CCBHC.

OB/GYN and other prenatal care practitioner

Includes:

- Physicians certified as obstetricians or gynecologists by the American Medical Specialties Board of Obstetrics or Gynecology or the American Osteopathic Association; or, if not certified, who successfully completed an accredited program of graduate medical or osteopathic education in obstetrics and gynecology.
- Certified nurse midwives, nurse practitioners or physician assistants who deliver prenatal care services in a specialty setting (under the direction of an OB/GYN certified or accredited provider).

Ongoing care provider

The practitioner who assumes responsibility for the member's care.

PCP

Primary care practitioner. A physician or nonphysician (e.g., nurse practitioner, physician assistant, certified nurse midwife) who offers primary care medical services.

Licensed practical nurses and registered nurses are not considered PCPs. Only certified Federally Qualified Health Centers (FQHC) are considered PCPs. This must be reviewed and approved by an auditor.

- To be certified as an FQHC, an entity must meet any one of the following criteria:

  - Is receiving a grant under Section 330 of the Public Health Service (PHS) Act (42 United States Code Section 254a) or is receiving funding from such a grant and meets other requirements.
  - Is not receiving a grant under Section 330 of the PHS Act but is determined by the Secretary of the Department of Health & Human Services (HHS) to meet the requirements for receiving such a grant (qualifies as a "FQHC look-alike") based on the recommendation of the Health Resources and Services Administration.
  - Was treated by the Secretary of HHS for purposes of Medicare Part B as a comprehensive Federally-funded health center as of January 1, 1990.
  - Is operating as an outpatient health program or facility of a tribe or tribal organization under the Indian Self Determination Act or as an urban Indian organization receiving funds under Title V of the Indian Health Care Improvement Act as of October 1991.
- For certification as an FQHC, the entity must meet all of the following criteria (in addition to one of the criteria above):
  - Provide comprehensive services and have an ongoing quality assurance program.
  - Meet other health and safety requirements.
  - Not be concurrently approved as a Rural Health Clinic (RHC).
    - Only certified RHCs are considered PCPs. This must be reviewed and approved by an auditor.
    - To be certified as an RHC, the entity must meet CMS requirements to qualify for payment via an all-inclusive rate (AIR) for medically-necessary primary health services and qualified preventive health services furnished by an RHC practitioner.

prescribing practitioner	A practitioner with prescribing privileges, including nurse practitioners, physician assistants and other non-MDs who have the authority to prescribe medications.

Appendix 2: Data Element Definitions

APPENDIX 2

DATA ELEMENT DEFINITIONS

Data Element	Description	Admin	Hybrid	Meaning
CollectionMethod	Data collection methodology (Administrative or Hybrid)	✓	✓	Method used to collect HEDIS data. The Administrative Method is from transactional data for the eligible population and the Hybrid Method is from medical record or electronic medical record and transactional data for the sample. Only reported for measures allowing both the Administrative and the Hybrid Method.
Benefit	Benefit	✓	✓	For measures requiring a benefit other than Medical, the Benefit flag is reported in the Metadata section of the submission XML.
EligiblePopulation	Eligible population	✓	✓	Members who meet all criteria for the population. This is the universe of members for each measure.
ExclusionAdminRequired	Number of required exclusions	✓	✓	Number of members excluded from the eligible population based on transaction data because they did meet the required exclusion criteria (labeled "required exclusions" in the specification).
NumeratorByAdminElig	Number of numerator events by administrative data in eligible population	-	✓	The number of members in the eligible population who met the numerator criteria. This may or may not include supplemental data, it depends on when an organization loads its supplemental data for reporting.
CYAR	Current year's administrative rate	-	✓	This is a calculated field in IDSS. NumeratorByAdminElig / EligiblePopulation *This rate may or may not include numerator events by supplemental data.*
MinReqSampleSize	Minimum required sample size (MRSS)	-	✓	When selecting the sample, this is the required number of members in the sample. Organizations can reduce their samples using Tables 2 in the sampling guidelines.
OversampleRate	Oversampling rate	-	✓	The percentage of additional records used only to replace exclusions and valid data errors in the denominator reported as a proportion Organizations that need more than a 20% oversample must contact NCQA. The oversample rate should reflect the true percentage that an organization needs to maintain the MRSS and should not result in an amount larger than the eligible population.
OversampleRecordsNumber	Number of oversample records	-	✓	This is a calculated field in IDSS. MinReqSampleSize * OversampleRate (rounded up to next whole number) Oversample records should be used only to replace cases taken out of the sample because of valid data errors, false positives, etc., otherwise, not all records will be reported in the final denominator.

Data Element	Description	Admin	Hybrid	Meaning
ExclusionValidDataErrors	Number of original sample records excluded because of valid data errors	-	✓	If medical record review shows that the member does not meet the criteria outlined in the eligible population, that member is considered a valid data error. If an administrative exclusion is found during data refresh, the member is also considered a valid data error.
ExclusionEmployeeOrDep	Number of employee/ dependent medical records excluded	-	✓	Number of records in the sample excluded because the member was an organization employee or a dependent of an organization employee. Employees/dependents are only excluded from the sample, they are not removed from the eligible population.
OversampleRecsAdded	Records added from the oversample list	-	✓	Replacement records for members in the denominator who had an exclusion or valid data error. This number should not exceed the number of oversample records and should be accounted for in the exclusion categories above.
Denominator	Denominator	-	✓	This population is the denominator used to report the measure. MRSS – exclusions + members added from the oversample list.
NumeratorByAdmin	Numerator events by administrative data	✓	✓	The number of members in the denominator who met numerator criteria using transactional data.
NumeratorBySupplemental	Numerator events by supplemental data	✓	✓	The number of members in the denominator who met numerator criteria using supplemental data (includes standard and nonstandard data). This data element is collected for only EOC and EOC-like measures.
NumeratorByMedicalRecords	Numerator events by medical records		✓	The number of members in the denominator who met numerator criteria using medical record data.
Numerator	Numerator	✓	✓	The number of members in the denominator who met numerator criteria as an aggregate across all data sources. This is reported in the Race Ethnicity Stratification Tables.
Rate	Reported rate	✓	✓	This is a calculated field in IDSS. *Administrative Method:* NumeratorByAdmin ÷ EligiblePopulation. *Hybrid Method*: (Numerator events by administrative data + numerator events by medical records) ÷ denominator. Measures that collect numerator events by supplemental data: *Administrative:* (Numerator events by administrative data + numerator events by supplemental data) ÷ eligible population. *Hybrid:* (Numerator events by administrative data + numerator events by supplemental data + numerator events by medical records) ÷ denominator.

Reporting Instruction Explanations

Reporting Instructions	Explanation
Metadata	For Measures requiring a benefit other than Medical, the Benefit flag is reported in the Metadata section of the submission XML.
For each Metric	Report independent values for each metric.
For each Stratification*	Report independent values for each stratification.
For each Metric and Stratification*	Report independent values for each metric and stratification.
Report once	For single Indicator measures.
Repeat per Metric	The same value is repeated across all Metrics. Used e.g., when the same Eligible Population or Denominator is used for the calculation of multiple rates within a measure (e.g., CIS, IMA).
Repeat per Stratification*	The same value is repeated across all Stratifications. This is common for measures using the Hybrid collection method where a single sample is drawn for all stratifications. The sample corresponds to the Total stratification but plans only report the individual stratifications. Therefore, plans must repeat the sample data elements for all stratifications.
Repeat per Metric and Stratification*	The same value is repeated across all Metrics and Stratifications. For example, the Hybrid sample data elements for WCC when reporting using the Hybrid collection method.
For each Stratification, repeat per Metric*	Report independent values for each stratification but repeat these for the same stratifications over multiple metrics.
For each Metric, repeat per Stratification*	Report independent values for each Metric but repeat these for all Stratifications within each Metric (e.g., CollectionMethod).
Only for Total	Only used for CYAR in stratified measures. Plans report NumeratorByAdminElig (Number of numerator events by administrative data in eligible population (before exclusions)) for each stratification, but IDSS calculates the CYAR (Current year's administrative rate (before exclusions)), only at the total stratification. Only this total CYAR can be used to reduce the minimum required sample size for measures where this is allowed. Refer to the *Guidelines for Calculations and Sampling* for more information.

*For measures with multiple stratifications, the reporting instructions apply for all stratification combinations.

Standard Administrative Data Element Table

Metric	Stratification (e.g., Age)	Data Element	Reporting Instructions
Added by measure	Added by measure	Benefit*	Added by measure
		EligiblePopulation	
		ExclusionAdminRequired	
		NumeratorByAdmin	
		NumeratorBySupplemental	
		Rate	

*Only applies to measures that require a benefit other than medical.

Standard Hybrid Data Element Table

Metric	Stratification (e.g., Age)	Data Element	Reporting Instructions	A
Added by measure	Added by measure	CollectionMethod	Added by measure	✓
		Benefit*		✓
		EligiblePopulation		✓
		ExclusionAdminRequired		
		NumeratorByAdminElig		
		CYAR		
		MinReqSampleSize		
		OversampleRate		
		OversampleRecordsNumber		
		ExclusionValidDataErrors		
		ExclusionEmployeeOrDep		
		OversampleRecsAdded		
		Denominator		✓
		NumeratorByAdmin		
		NumeratorByMedicalRecords		✓
		NumeratorBySupplemental		✓
		Rate		

*Only applies to measures that require a benefit other than medical.

Standard ECDS Data Element Table

Metric	Stratification (e.g., Age)	Data Elements	Reporting Instructions
Added by Measure	Added by measure	Benefit*	Added by measure
		InitialPopulationByEHR	
		InitialPopulationByCaseManagement	
		InitialPopulationByHIERegistry	
		InitialPopulationByAdmin	
		InitialPopulation	
		ExclusionsByEHR	
		ExclusionsByCaseManagement	
		ExclusionsByHIERegistry	
		ExclusionsByAdmin	
		Exclusions	
		Denominator	
		NumeratorByEHR	
		NumeratorByCaseManagement	
		NumeratorByHIERegistry	
		NumeratorByAdmin	
		Numerator	
		Rate	

*Only applies to measures that require a benefit other than medical.

Note: *Not all measures use metrics, age and initial population/exclusions by data source. Refer to the measure specification for details.*

Standard Data Elements for Stratifications by Race

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

Standard Data Elements for Stratifications by Ethnicity

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

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

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

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3. QRS Clinical Measure Specifications

3.1 NCQA Measure Specifications

3.2 PQA Measure Specifications

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3.2 PQA Measure Specifications

Overview

Pharmacy Quality Alliance (PQA, Inc.)

PQA is a consensus-based, multi-stakeholder membership organization committed to optimizing health by advancing the quality of medication use. Established in 2006, PQA is a 501(c)3 designated non-profit alliance with over 240 member organizations.

PQA Measure Development Process

PQA uses a systematic, transparent, consensus-based process to draft, test, refine, and endorse measures of medication-use quality. PQA evaluates measures against the following standard criteria: importance, scientific acceptability, feasibility, and usability. The end-product of measure development is an evidence-based, precisely specified, valid, reliable, feasible, and usable measure that is linked to national quality goals.

Measure Conceptualization:
The goal of the measure conceptualization phase is to generate and prioritize a list of measure concepts to be developed. This ensures that PQA devotes resources to developing measures that are high-impact and address areas of need. The measure conceptualization phase includes the following activities:

1. Environmental Scan
2. Measure Concept Advisory Group Input
3. Comment Period

Measure Specification:
During the measure specification phase, the goal is to create and refine initial specifications to produce a draft measure that is ready to be tested. The measure specification phase includes the following activities:

1. Initial Specification and Feasibility Testing
2. Technical Expert Panel Input

Measure Testing:
The goal of measure testing is to apply the measure specifications to test data representative of the intended measure population to determine the measure's scientific acceptability. PQA will evaluate whether the measure meets the criteria of reliability (the measure consistently captures true differences in quality, as opposed to differences due to chance variation) and validity (the measure truly captures the intended concept of quality). Beyond scientific acceptability, measure testing may also inform remaining specification questions, such as the appropriateness of exclusions given their frequency in test data. The answers to these questions may result in additional refinement of the measure specifications. The measure testing phase includes the following activities:

1. Testing Plan Development
2. Initial Quality Metrics Expert Panel (QMEP) Review
3. Assess Need for Stratification or Risk Adjustment
4. Measure Testing
5. Face Validity Assessment
6. Final QMEP Review

Measure Endorsement:
After QMEP approval, the me asure is considered by PQA's membership for an endorsement vote. By the time a measure is approved by the QMEP to move forward for endorsement consideration, it has gone

through PQA's consensus-based development process and is found to meet PQA's measure criteria. The measure endorsement process consists of the following activities:

1. Comment Period and Member Webinar
2. Membership Vote

Measure Implementation and Maintenance:
The measure lifecycle does not end when a measure is endorsed. In addition to PQA's role as a measure developer, PQA is a measure steward, which entails responsibility for supporting measures through implementation with outreach and education, supporting measure use with technical assistance, and measure maintenance to ensure that PQA measures remain current, impactful, and appropriate in light of new treatments or new clinical evidence or guidelines.

1. Measure Implementation
2. Technical Assistance
3. Measure Maintenance

Updated: 1/30/2023

General Guidelines for the *Proportion of Days Covered, Annual Monitoring for Persons on Long-Term Opioid Therapy* and *International Normalized Ratio Monitoring for Individuals on Warfarin Measure* Data Collection

Refer to NCQA's "General Guidelines for Data Collection" in Section 3.1 for details that will inform appropriate data collection for the *Proportion of Days Covered, Annual Monitoring for Persons on Long-term Opioid Therapy, and International Normalized Ratio Monitoring for Individuals on Warfarin* measures. All general guidelines apply, with the exception, of the following items specified below.

PQA Posting of the Value Sets

The Value Sets for PQA measures will be available by request from PQA. Please refer to the PQA website in order to obtain the Value Sets, including National Drug Code (NDC) lists, at https://www.pqaalliance.org/QRS.https://www.pqaalliance.org/QRS.

The final Value Sets, including National Drug Code (NDC) lists, for 2024 will be available on March 31, 2023. The NDC lists will include current NDCs from January 1, 2022 through December 31, 2022, and NDCs with obsolete dates of July 1, 2021 or after.

Required Data Elements for PQA Measures

The reporting tables in the measure specifications outline the data elements required for reporting. Refer to *General Guideline 42: Reporting Tables* for more information.

Proportion of Days Covered (PDC): 3 Rates

Summary of Changes

- Added rosuvastatin + ezetimibe to medication table STATINS: Statins.
- Renamed Medication Table, GLP1: GLP-1 Receptor Agonists to GIP/GLP1: GIP/GLP-1 Receptor Agonists
- Added tirzepatide to Medication Table, GIP/GLP1: GIP/GLP-1 Receptor Agonists.

Description

The percentage of members 18 years and older who met the Proportion of Days Covered (PDC) threshold of 80% during the measurement year.

A higher rate indicates better performance.

Report a rate for each of the following:
- Renin Angiotensin System Antagonists (PDC-RASA)
- Diabetes All Class (PDC-DR)
- Statins (PDC-STA)

Definitions

Proportion of Days Covered (PDC)	The proportion of days in the treatment period covered by prescription claims for the same medication or another in its therapeutic category.
PDC Threshold	The PDC level above which the medication has a reasonable likelihood of achieving most of the potential clinical benefit (80% for diabetes and cardiovascular drugs, and many chronic conditions).
Index Prescription Start Date (IPSD)	The earliest date of service for a target medication during the measurement year.
Prescription Claims	Only paid, non-reversed prescription claims are included in the data set to calculate the measure.
Treatment Period	The member's treatment period begins on the IPSD and extends through whichever comes first: the last day of enrollment during the measurement year, death, or the end of the measurement year. The treatment period should be at least 91 days.
Calculating Number of Days Covered for the Numerator	If multiple prescriptions for different target medications (i.e., two or more products within the same therapeutic category, but with different generic ingredients) are dispensed on the same day, count the number of days covered using the prescription with the longest days' supply. If multiple prescriptions for different target medications (i.e., two or more products within the same therapeutic category, but with different generic ingredients) are dispensed on different days with overlapping days' supply, count each day covered by a target medication only once within the treatment period. *For example: if a prescription for simvastatin and a prescription for atorvastatin are filled 5 days apart and each has a 30-day supply, then the total days covered is 35.* If multiple prescriptions for the same target medication (i.e., one or more products

with the same generic ingredient) are dispensed on the same day or different days where the days' supply overlap, adjust the prescription start date to be the day after the previous fill has ended.

For example: if three prescriptions for the same target medication are dispensed on the same day, each with a 30-day supply, then a total of 90 days are covered.

Overlap adjustment should also occur when there is an overlap of a single target drug product to a combination product containing the single target drug (i.e., same generic ingredient) or when there is an overlap of a combination product to another combination product where at least one of the target drugs (i.e., same generic ingredient) is common.

Any days' supply that extends beyond the end of the treatment period are not included when calculating the total number of days covered.

The NDC list for each class of medications includes flags for each target medication. The flags will help determine whether the prescription (NDC) includes the same or different target medication.

Eligible Population

Ages	18 years and older as of the first day of the measurement year.
Continuous Enrollment	The treatment period. Exclude members with more than one 1-day gap in enrollment during the treatment period. Note: This allows for a one-day gap to compensate for discrepancies in the enrollment data. *For example: if a member is eligible from 1/1-4/1 and 4/3-12/31, he/she would still be continuously enrolled despite the one-day gap in eligibility on 4/2.*
Benefit	Medical and Pharmacy.

Administrative Specification

Report each of the rates separately. Members may be counted in the denominator for multiple rates if they have been dispensed the relevant medications; though for each rate, the proportion of days covered should only be counted once per member.

Rate 1: Renin Angiotensin System (RAS) Antagonists (PDC-RASA)

Additional Eligible Population Criteria	Members who filled at least two prescriptions for any RAS Antagonist: ACEI/ARB/direct renin inhibitor or ACEI/ARB/direct renin inhibitor Combination (Medication Table RASA: RAS Antagonists) on different dates of service during the treatment period. The prescriptions can be for the same or different medications.
Denominator	The eligible population.
Required Exclusions	Any members with one or more of the following: • Hospice: Members in hospice are excluded from the eligible population. Refer to General Guideline 8: Members in Hospice. • ESRD: An ESRD diagnosis is defined as having at least one claim with any of the listed ESRD diagnoses, including primary diagnosis or any other

diagnosis fields during the measurement year. See PQA ESRD Value Set.
- Sacubitril/valsartan: A prescription claim for sacubitril/valsartan during the treatment period (Medication Table SAC-VAL Exclusion: Sacubitril/Valsartan).

Table RASA: Renin Angiotensin System (RAS) Antagonists

Direct Renin Inhibitor Medications and Combinations		
• aliskiren (+/- hydrochlorothiazide)		
ARB Medications and Combinations		
• azilsartan (+/- chlorthalidone) • candesartan (+/- hydrochlorothiazide) • eprosartan (+/- hydrochlorothiazide)	• irbesartan (+/- hydrochlorothiazide) • losartan (+/- hydrochlorothiazide) • olmesartan (+/- amlodipine, hydrochlorothiazide)	• telmisartan (+/- amlopdipine, hydrochlorothiazide) • valsartan (+/- amlodipine, hydrochlorothiazide, nebivolol) [a]
ACE Inhibitor Medications and Combination Products		
• benazepril (+/- amlodipine, hydrochlorothiazide) • captopril (+/- hydrochlorothiazide) • enalapril (+/- hydrochlorothiazide) • fosinopril (+/- hydrochlorothiazide)	• lisinopril (+/- hydrochlorothiazide) • moexipril (+/- hydrochlorothiazide) • perindopril (+/- amlodipine)	• quinapril (+/- hydrochlorothiazide) • ramipril • trandolapril (+/- verapamil)

NOTE: Active ingredients are limited to oral formulations only. Excludes nutritional supplement/dietary management combination products.

[a] There are no active NDCs for valsartan/nebivolol.

Table SAC-VAL Exclusion: Sacubitril/Valsartan

ARB/Neprilysin Inhibitor Combination Medication
• sacubitril/valsartan

Numerator The number of members who met the PDC threshold during the measurement year. Follow the steps below for each member to determine whether the member meets the PDC threshold.

Measure Calculation

Step 1 Determine the member's treatment period, defined as the IPSD to the end of the measurement year, disenrollment, or death.

Step 2 Within the treatment period, count the days the member was covered by at least one drug in the class based on the prescription fill date and days of supply. If prescriptions for the same target drug (generic ingredient) overlap, then adjust the prescription start date to be the day after the previous fill has ended. *

Step 3 Divide the number of covered days found in Step 2 by the number of days found in Step 1. Multiply this number by 100 to obtain the PDC (as a percentage) for each member. Then, round the PDC to the nearest hundredth (e.g., 79.996% is rounded to 80.00%, 79.992% is rounded to 79.99%).

Step 4 Count the number of members who had a PDC of 80% or greater and then divide by the total number of eligible members.

**Adjustment of overlap should also occur when there is overlap of a single drug product to a combination product containing the single drug or when there is an*

overlap of a combination product to another combination product where at least one of the target drugs is common.

Rate 2: Diabetes All Class (PDC-DR)

Additional Eligible Population Criteria	Members who filled at least two prescriptions for any of the diabetes mediations listed in the Medication Tables BG: Biguanides, SFU: Sulfonylureas, TZD: Thiazolidinediones, DPP4: DPP-4 Inhibitors, GIP/GLP1: GIP/GLP-1 Receptor Agonists, MEG: Meglitinides, or SGLT2: SGLT2 Inhibitors on different dates of service in the treatment period. The prescriptions can be for the same or different medications and can be from any of these seven tables.
Denominator	The eligible population.
Required Exclusions	Any member with one or more of the following: • Hospice: Members in hospice are excluded from the eligible population. Refer to General Guideline 8: Members in Hospice. • ESRD: An ESRD diagnosis is defined as having at least one claim with any of the listed ESRD diagnoses, including primary diagnosis or any other diagnosis fields during the measurement year. See PQA ESRD Value Set. • Insulin: Any member with ≥1 prescription claim for insulin in the treatment period. See Medication Table INSULINS: Insulin Exclusion.

Medication Tables

Table BG: Biguanides

Biguanide Medications and Combinations
• metformin (+/- alogliptin, canagliflozin, dapagliflozin, empagliflozin, ertugliflozin, glipizide, glyburide, linagliptin, pioglitazone, repaglinide, rosiglitazone, saxagliptin, sitagliptin)

Note: Active ingredients are limited to oral formulations only. Excludes nutritional supplement/dietary management combination products.

Table SFU: Sulfonylureas

Sulfonylurea Medications and Combinations		
• chlorpropamide[a]	• glipizide (+/- metformin)	• tolazamide
• glimepiride (+/- pioglitazone, rosiglitazone) [a]	• glyburide (+/- metformin)	• tolbutamide

NOTE: Active ingredients are limited to oral formulations only (includes all salts and dosage forms).
[a] There are no active NDCs for chlorpropamide, glimepiride/rosiglitazone.

Table TZD: Thiazolidinediones

Thiazolidinedione Medications and Combinations	
• pioglitazone (+/- alogliptin, glimepiride, metformin)	• rosiglitazone (+/- glimepiride, metformin) [a]

NOTE: Active ingredients are limited to oral formulations only.
[a] There are no active NDCs for glimepiride/rosiglitazone.

Table DPP4: DPP-4 Inhibitors

DPP-4 Medications and Combinations		
• alogliptin (+/- metformin, pioglitazone)	• saxagliptin (+/- metformin, dapagliflozin)	• sitagliptin (+/- metformin, ertugliflozin)
• linagliptin (+/- empagliflozin, metformin)		

NOTE: Active ingredients are limited to oral formulations only.

Table GIP/GLP1: GIP/GLP-1 Receptor Agonists

GIP/GLP-1 Receptor Agonists		
• albiglutide	• exenatide	• lixisenatide
• dulaglutide	• liraglutide	• semaglutide
• tirzepatide		

NOTE: Excludes products indicated only for weight loss.

Table MEG: Meglitinides

Meglinitides and Combinations	
• nateglinide	repaglinide (+/--metformin)

NOTE: Active ingredients are limited to oral formulations only.

Table SGLT2: Sodium Glucose Co-Transporter2 (SGLT2) Inhibitors

SGLT2 Inhibitors and Combinations		
• canagliflozin (+/-- metformin)	• empagliflozin (+/- metformin, linagliptin)	• ertugliflozin (+/- sitagliptin, metformin)
• dapagliflozin (+/- metformin, saxagliptin)		

NOTE: Active ingredients are limited to oral formulations only.

Table INSULINS: Insulin Exclusion[a]

Insulins		
• insulin aspart (+/-insulin aspart protamine, niacinamide)	• insulin glargine (+/- lixisenatide)	• insulin lispro (+/- insulin lispro protamine)
• insulin degludec (+/- liraglutide)	• insulin glargine-aglr	• insulin regular (including inhalation powder)
• insulin detemir	• insulin glargine-yfgn	
	• insulin glulisine	
	• insulin isophane (+/- regular insulin)	

NOTE: The active ingredients are limited to inhaled and injectable formulations only.
[a] When a biologic reference product is contained in a medication table, and an associated biosimilar product is also available on the market, the biosimilar product(s) are also included in the associated value sets, unless otherwise noted.

Numerator The number of members who met the PDC threshold during the measurement year. Follow the steps below to determine whether the member meets the PDC threshold.

Measure Calculation

Step 1 Determine the member's treatment period, defined as the IPSD to the end of the measurement year, disenrollment, or death.

Step 2 Step 2 Within the treatment period, count the days the member was covered by at least one diabetes medication (Medication Tables BG, SFU, TZD, DPP4, GIP/GLP1, MEG, or SGLT2) based on the date of service and days' supply on prescription claims. If the days' supply for prescription claims with the same target drug (generic ingredient) overlap, then adjust the prescription claim's start date to be the day after the last days' supply for the previous prescription claim. *

***Step* 3** Divide the number of covered days found in Step 2 by the number of days found in Step 1. Multiply this number by 100 to obtain the PDC (as a percentage) for each member. Then, round the PDC to the nearest hundredth (e.g., 79.996% is rounded to 80.00%, 79.992% is rounded to 79.99%).

Step 4 Count the number of members who had a PDC of 80% or greater and then divide by the total number of eligible members.

**Adjustment of overlap should also occur when there is overlap of a single drug product to a combination product containing the single drug or when there is an*

overlap of a combination product to another combination product where at least one of the target drugs is common.

Rate 3: Statins (PDC-STA)

Additional Eligible Population Criteria

Members with at least two prescription claims for any statin (Medication Table STATINS) on different dates of service in the treatment period. The prescription claims can be for the same or different medications.

Denominator

The eligible population.

Required Exclusions

Any member with one or more of the following:

- Hospice: Members in hospice are excluded from the eligible population. Refer to General Guideline 8: Members in Hospice.
- ESRD: An ESRD diagnosis is defined as having at least one claim with any of the listed ESRD diagnoses, including primary diagnosis or any other diagnosis fields during the measurement year. See PQA ESRD Value Set.

Table STATINS: Statins

Statin Medications		
• atorvastatin (+/- amlodipine)	• pitavastatin	• rosuvastatin (+/-ezetimibe)
• fluvastatin	• pravastatin	• simvastatin (+/-ezetimibe, niacin)
• lovastatin (+/- niacin)		

Note: The active ingredients are limited to oral formulations only.

Numerator

The number of members who met the PDC threshold during the measurement year. Follow the steps below to determine whether the member meets the PDC threshold.

Measure Calculation

Step 1 Determine the member's treatment period, defined as the IPSD to the end of the measurement year, disenrollment, or death.

Step 2 Within the treatment period, count the days the member was covered by at least one drug in the class based on the date of service and days' supply on prescription claims. If the days' supply for prescription claims with the same target drug (generic ingredient) overlap, then adjust the prescription claim's start date to be the day after the last days' supply for the previous prescription claim. *

Step 3 Divide the number of covered days found in Step 2 by the number of days found in Step 1. Multiply this number by 100 to obtain the PDC (as a percentage) for each member. Then, round the PDC to the nearest hundredth (e.g., 79.996% is rounded to 80.00%, 79.992% is rounded to 79.99%).

Step 4 Count the number of members who had a PDC of 80% or greater and then divide by the total number of eligible members.

**Adjustment of overlap should also occur when there is overlap of a single drug product to a combination product containing the single drug or when there is an overlap of a combination product to another combination product where at least one of the target drugs is common.*

Data Elements for Reporting

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

Table PDC: Data Elements for Proportion of Days Covered

Metric	Data Element	Reporting Instructions
RASAntagonists	Benefit	Metadata
Diabetes	EligiblePopulation	For each Metric
Statins	ExclusionAdminRequired	For each Metric
	NumeratorByAdmin	For each Metric
	Rate	(Percent)

International Normalized Ratio Monitoring for Individuals on Warfarin (INR)

Summary of Changes

- Clarified laboratory claims can be used as a data source for the INR test used in the numerator.

Description

The percentage of members 18 years of age and older who had at least one 56-day interval of warfarin therapy and who received at least one international normalized ratio (INR) monitoring test during each 56-day interval with active warfarin therapy.

A higher rate indicates better performance.

Definitions

Warfarin	See Medication Table INR-A: Warfarin.
Prescription Claims	Only paid, non-reversed prescription claims are included in the data set to calculate the measure.
Index Prescription Start Date (IPSD)	The earliest date of service for warfarin during the measurement year.
Treatment Period	The period of time beginning on the IPSD and ending with the last day of supply for warfarin (date of service plus the days' supply for the last prescription claim for warfarin minus 1) during the measurement year. If the days' supply extends beyond the end of the measurement year, the treatment period ends on December 31 of the measurement year. The last prescription claim for warfarin should be used to determine the end of the treatment period even if there is days' supply from a previous prescription claim for warfarin that extends beyond the days' supply for the last prescription claim during the treatment period. *For example: if a member has prescription claims on December 1 for a 5 days' supply and on November 30 for a 10 days' supply, the end of the treatment period is December 5.* If two prescription claims for warfarin occur on the same date of service, the date of service with the longest days' supply is used to determine the end of the treatment period. Gaps in prescription claims for warfarin can occur during the treatment period.
Hospital Stay	Any medical claim indicating a hospital stay (with appropriate revenue code) during the measurement year. See Value Set, Hospital Stay.
INR Test	Any lab or medical claim for an INR test during the measurement year. See Value Set, INR Test.

Eligible Population

Ages	18 years and older as of the first day of the measurement year.
Continuous enrollment	The treatment period.

Exclude members with more than one 1-day gap in enrollment during the treatment period. Note: This allows for a one-day gap to compensate for discrepancies in the enrollment data.

For example: if a member is eligible from 1/1-4/1 and 4/3-12/31, he/she would still be continuously enrolled despite the one-day gap in eligibility on 4/2.

Allowable gap None.

Benefit Medical and Pharmacy.

Required Exclusions

- Exclude members with a laboratory or medical claim for INR home monitoring during the measurement year. See Value Set, INR Home Monitoring Exclusion.

Event/Diagnosis Members dispensed warfarin during the measurement year.

Use the steps below to determine the eligible population.

Step 1 Identify members aged 18 years and older as of the first day of the measurement year.

Step 2 Identify members with ≥1 prescription claims for warfarin (Medication Table INR-A) during the measurement year.

Step 3 Determine each member's treatment period. The member's treatment period begins on the IPSD and extends through the last day of supply for warfarin (date of service plus the days' supply for the last prescription claim for warfarin minus 1) during the measurement year.

Step 4 Identify members with a treatment period that is ≥56 days during the measurement year.

Step 5 Identify members who meet the continuous enrollment criteria.

Step 6 Exclude members with a medical claim for INR home monitoring during the measurement year. See Value Set, INR Home Monitoring Exclusion.

Administrative Specification

Denominator The eligible population.

Numerator Members who received at least one INR monitoring test during or was hospitalized during each 56-day interval during the treatment period.

Use the steps below to determine the members for the numerator.

Step 1 For each member in the denominator, determine the start and end dates for each full 56-day interval.

For example: a member has his/her first prescription claim for warfarin during the measurement year on January 1 and last prescription claim for warfarin during the measurement year on April 1 for a 30-days' supply. As a result, the member's treatment period is from January 1 through April 30, or 120 days. During the treatment period, the member has 2 full intervals. Interval 1 starts on January 1 and ends on February 25. Interval 2 starts on February 26 and ends on April 22.

Note: Only full 56-day intervals are used for evaluating members for the numerator. Days after the last full interval are not included.

Days after the last full interval are not included.

Step 2 For each member in the denominator, determine if there was an INR test (Value Set, INR Test) or a hospital stay of >48 hours (Value Set, Hospital Stay) during each interval.

Note: Hospital stays are only applied to the 56-day interval in which the admission date falls. If hours are not available, hospital stays of at least three days meet the numerator criteria. However, the entire hospital stay does not need to fall within the 56-day interval in which the admission date falls.

For example: a member has their warfarin fill during the measurement year on January 1 and last warfarin fill during the measurement year on April 1 for a 30-days' supply. As a result, his/her treatment period is from January 1 through April 30, or 120 days. During the treatment period, the member has 2 full intervals. Interval 1 starts on January 1 and ends on February 25. Interval 2 starts on February 2/26 and ends on April 22. The member is admitted to the hospital on February 25 and discharged on February 27 and also has an INR test on March 12. The hospital stay from February 25 through February 27 meets the numerator criteria for interval 1 and the INR test meets the numerator criteria for interval 2. The member meets the numerator criteria in each interval and would be counted in the numerator.

Step 3 Count the members with an INR test or hospitalization during all intervals as numerator compliant.

Medication Table

Table INR-A: Warfarin

Warfarin
• warfarin

This measure was developed by IMPAQ International, LLC and Health Services Advisory Group, Inc. (HSAG).

Data Elements for Reporting

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

Table INR: Data Elements for International Normalized Ratio Monitoring for Individuals on Warfarin

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

Annual Monitoring for Persons on Long-Term Opioid Therapy (AMO)

Summary of Changes

- Clarified that laboratory claims can be used as a data source for the drug test screening used in the numerator.

Description

The percentage of members 18 years and older who are prescribed long-term opioid therapy and have not received a drug test at least once during the measurement year.

A lower rate indicates better performance.

Definitions

Opioid Analgesics	Limited to opioid medications indicated for pain. See Medication Table AMO: Opioid Analgesics. Includes opioid medications indicated for pain.
Long-Term Opioid Therapy	≥90 days' cumulative supply of any combination of opioid analgesics (See Medication Table AMO: Opioid Analgesics) during the measurement year identified using prescription claims.
Prescription Claims	Only paid, non-reversed prescription claims are included in the data set to calculate the measure.
Drug Test	Any drug screens/tests for at least one of the following targeted drug classes: amphetamines, barbiturates, benzodiazepines, cannabinoids, cocaine, and opiates/opioids. • ≥1 medical or laboratory claim with specified Healthcare Common Procedure Coding System (HCPCS) codes, Current Procedural Terminology (CPT) codes. See Value Set, Drug Test.

Eligible Population

Ages	18 years and older as of the first day of the measurement year.
Continuous Enrollment	The measurement year.
Allowable Gap	No more than one gap in continuous enrollment of up to 31 days during the measurement year. When enrollment is verified monthly, the member may not have more than a 1-month gap in coverage (i.e., a member whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).
Benefit	Medical and Pharmacy.
Required Exclusions	Exclude members who met ≥1 of the following during the measurement year: • Hospice - Refer to General Guideline 8: Members in Hospice. • Cancer - Any member with non-melanoma skin cancer during the measurement year. See Value Set, Cancer. • Palliative Care - Any member in palliative care during the measurement year. See Value Set, Palliative Care.
Event/Diagnosis	Members who are prescribed long-term opioid therapy.

Use the steps below to determine the eligible population.

Step 1 Identify members aged 18 years and older as of the first day of the measurement year.

Step 2 Identify members who meet the continuous enrollment criteria.

Step 3 Identify members who are prescribed ≥90 days' cumulative supply of any combination of opioid analgesics (Medication Table AMO: Opioid Analgesics) during the measurement year. The cumulative days' supply does not have to be consecutive. Exclude days' supply that extends beyond the end of the measurement year.

NOTE:

- The prescriptions claims can be for the same or different opioids.
- For multiple claims for the same or different opioids with the same date of service, calculate the number of days covered by an opioid using the prescriptions with the longest days' supply.
- For multiple claims for the same or different opioids with different dates of service, sum the days' supply for all the prescription claims, regardless of overlapping days' supply.

Step 4 Exclude members who met ≥1 of the following during the measurement year:

- Hospice - Refer to General Guideline 8: Members in Hospice.
- Cancer - Any member with ≥1 claim for cancer during the measurement year. See Value Set, Cancer.
- Palliative Care - Any member in palliative care during the measurement year. See Value Set, Palliative Care.

Administrative Specification

Denominator The eligible population.

Numerator Members in the denominator who have not received a drug test during the measurement year. See Value Set, Drug Test.

Medication Table

Table AMO: Opioid Analgesics [a,b]

Opioids		
• benzhydrocodone	• hydrocodone	• oxycodone
• buprenorphine	• hydromorphone	• oxymorphone
• butorphanol	• levorphanol	• pentazocine
• codeine	• meperidine	• tapentadol
• dihydrocodeine	• methadone	• tramadol
• fentanyl	• morphine	

[a] Includes opioid medications indicated for pain; includes combination products.

[b] Excludes the following: medications prescribed or provided as part of medication-assisted treatment for opioid use disorder (i.e., buprenorphine sublingual tablets, Probuphine® Implant kit subcutaneous implant, and all buprenorphine/naloxone combination products); and formulations delivered by the intravenous (IV) or epidural (EP) route (IV and EP routes are excluded because they are not commonly prescribed as chronic pain medications).

This measure was developed by IMPAQ International, LLC and Health Services Advisory Group, Inc. (HSAG).

Data Elements for Reporting

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

Table AMO: Annual Monitoring for Persons on Long-Term Opioid Therapy

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

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4. QRS Survey Measure Specifications

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QRS Survey Measure Descriptions

Overview

This section includes descriptions for the QRS survey measures[9] that will be collected as part of the 2024 QHP Enrollee Survey. The QHP Enrollee Survey is largely based on items from the CAHPS® Surveys. For a crosswalk that maps each QRS survey measure to the relevant 2024 QHP Enrollee Survey item(s), please see https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityInitiativesGenInfo/ACA-MQI/ACA-MQI-Landing-Page.html.

Additional details related to the 2023 QHP Enrollee Survey and data collection protocols are included on the CMS QHP Enrollee Survey page of the CMS Marketplace Quality Initiatives website at https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityInitiativesGenInfo/ACA-MQI/Consumer-Experience-Surveys/Surveys-page.html/

QRS Survey Measure Descriptions

Access to Care

This QRS survey measure is based on enrollee responses to the 2024 QHP Enrollee Survey on the following:

- In the last 6 months, when you needed care right away, in an emergency room, doctor's office, or clinic, how often did you get care as soon as you needed? Include in-person, telephone, or video appointments. *(Question #22)*
- In the last 6 months, how often did you get an appointment for a check-up or routine care at a doctor's office or clinic as soon as you needed? Include in-person, telephone, or video appointments. *(Question #23)*
- In the last 6 months, how often was it easy to get the care, tests, or treatment you needed? Include in-person, telephone, or video appointments. *(Question #25)*
- In the last 6 months, how often did you get an appointment to see a specialist as soon as you needed? Include in-person, telephone, or video appointments. *(Question #41)*

Access to Information

This QRS survey measure is based on enrollee responses to the 2024 QHP Enrollee Survey on the following:

- In the last 6 months, how often did written materials or the internet provide the information you needed about how your health plan works? *(Question #3)*
- In the last 6 months, how often were you able to find out from your health plan how much you would have to pay for a health care service or equipment before you got it? *(Question #4)*
- In the last 6 months, how often were you able to find out from your health plan how much you would have to pay for specific prescription medicines? *(Question #5)*

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[9] The following QRS survey measures are HEDIS® measures and are addressed in NCQA's Measure Specifications: Flu Vaccinations for Adults Ages 18-64 and Medical Assistance with Smoking Cessation. Refer to the Final 2023 Call Letter for and *2024 QRS and QHP Enrollee Survey Technical Guidance* for guidance on reporting the Flu Vaccinations for Adults Ages 18 – 64 measure.

Care Coordination

This QRS survey measure is based on enrollee responses to the 2024 QHP Enrollee Survey on the following:

- When you visited your personal doctor for a scheduled appointment in the last 6 months, how often did he or she have your medical records or other information about your care? Include in-person, telephone, or video appointments. *(Question #33)*
- In the last 6 months, when your personal doctor ordered a blood test, x-ray, or other test for you, how often did someone from your personal doctor's office follow up to give you those results? *(Question #34)*
- In the last 6 months, when your personal doctor ordered a blood test, x-ray, or other test for you, how often did you get those results as soon as you needed them? *(Question #35)*
- In the last 6 months, how often did you and your personal doctor talk about all the prescription medicines you were taking? *(Question #36)*
- In the last 6 months, how often did you get the help that you needed from your personal doctor's office to manage your care among these different providers and services?[10] *(Question #39)*
- In the last 6 months, how often did your personal doctor seem informed and up-to-date about the care you got from specialists? *(Question #43)*

Plan Administration

This QRS survey measure is based on enrollee responses to the 2024 QHP Enrollee Survey on the following:

- In the last 6 months, how often did your health plan's customer service give you the information or help you needed? *(Question #6)*
- In the last 6 months, how often did your health plan's customer service staff treat you with courtesy and respect? *(Question #7)*
- In the last 6 months, how often did the time that you waited to talk to your health plan's customer service staff take longer than you expected? *(Question #8)*
- In the last 6 months, how often were the forms from your health plan easy to fill out? *(Question #9)*
- In the last 6 months, how often did the health plan explain the purpose of a form before you filled it out? *(Question #10)*

Rating of All Health Care

This QRS survey measure is based on enrollee responses to the 2024 QHP Enrollee Survey on the following:

- Using any number from 0 to 10, where 0 is the worst health care possible and 10 is the best health care possible, what number would you use to rate all your health care in the last 6 months? Include in-person, telephone, or video appointments. *(Question #27)*

[10] Enrollees must answer affirmatively to the screener question: "In the last 6 months, did you need help from anyone in your personal doctor's office to manage your care among these different providers and services?" in order to respond to this question.

Rating of Health Plan

This QRS survey measure is based on enrollee responses to the 2024 QHP Enrollee Survey on the following:

- Using any number from 0 to 10, where 0 is the worst health plan possible and 10 is the best health plan possible, what number would you use to rate your health plan in the last 6 months? *(Question #20)*

Rating of Personal Doctor

This QRS survey measure is based on enrollee responses to the 2024 QHP Enrollee Survey on the following:

- Using any number from 0 to 10, where 0 is the worst personal doctor possible and 10 is the best personal doctor possible, what number would you use to rate your personal doctor? *(Question #40)*

Rating of Specialist

This QRS survey measure is based on enrollee responses to the 2024 QHP Enrollee Survey on the following:

- We want to know your rating of the specialist you saw most often in the last 6 months. Using any number from 0 to 10, where 0 is the worst specialist possible and 10 is the best specialist possible, what number would you use to rate the specialist? *(Question #44)*