# 2025 HEDIS® QUICK REFERENCE GUIDE

**FOR MORE INFORMATION, VISIT NCQA.ORG**

Marketplace = ● Medicare = ● Medicaid = ●

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mhs™

PRO_2982103E Internal Approved MMDDYYYY



2982103_NA4PPROGDEE

0125.QI.P.FL 4/25

**For a complete list of codes, please visit the NCQA website at ncqa.org, or see the HEDIS value sets. Only subsets of the NCQA-approved codes are listed in this document.**

# 2025 HEDIS® QUICK REFERENCE GUIDE

## WHAT IS HEDIS®?

HEDIS® (Healthcare Effectiveness Data and Information Set) is a set of standardized performance measures developed by the National Committee for Quality Assurance (NCQA) to objectively measure, report, and compare quality across health plans. NCQA develops HEDIS® measures through a committee represented by purchasers, consumers, health plans, healthcare providers, and policy makers.

## HOW ARE RATES CALCULATED?

HEDIS® rates are collected in several ways: administrative data and hybrid (medical record review data). Administrative data consists of claim or encounter data submitted to the health plan.

Hybrid data consists of both administrative data and a sample of medical record data. Hybrid data requires review of a random sample of member medical records to abstract data for services rendered but were not reported to the health plan through claims or encounter data.

Accurate and timely claim/encounter data reduces the need for medical record review. If services are not billed or billed inaccurately, they are not included in the calculation.

## WHAT ARE THE SCORES USED FOR?

As state and federal governments move toward a quality-driven healthcare industry, HEDIS® rates are becoming more important for both health plans and individual providers. State purchasers of healthcare use aggregated HEDIS® rates to evaluate health insurance companies' efforts to improve preventive health outreach for members.

Physician-specific scores are also used to measure your practice's preventive care efforts. Your practice's HEDIS® score determines your rates for physician incentive programs that pay you an increased premium — for example Pay for Performance or Quality Bonus Funds.

## MEDICAL RECORD RETRIEVAL

When administrative data (claim or encounter data submitted to the health plan) is not available, the health plan may use other sources to collect data about their members and about delivery of health services to members. To ease the burden on provider offices and staff, especially during the HEDIS® season, our Quality Improvement team works to capture HEDIS® data through medical record retrieval the entire year.

### Methods of Medical Record Collection During HEDIS® Season (February through April)

Our Quality Improvement team works to capture HEDIS® measures throughout the entire year. Medical records are collected by the following:

- **Remote Access:** Provider offices allow electronic medical record (EMR) access to our clinical quality team during HEDIS® season and for required year around Medicare and Marketplace Risk Adjustment Charts.
- **Fax:** Provider offices can fax records to the Quality Improvement Team for review at: 1-844-265-6885.

## End-of-Year Supplemental Data Collection for Gap Closure (June through 2nd Week of December) *No guarantee medical records will be reviewed the last two weeks of December.

Providers can submit medical records for end-of-year supplemental data collection by the following:

- **MHS Provider Portal:** Provider offices can upload records directly through the provider portal *http://www.mhsindiana.com/login*.
- **Fax:** Provider offices can fax records to the Quality Improvement department by faxing: 1-866-912-4254.

## Other Means of Data Collection to Close Care Gaps

- **Supplemental Data System (SuDS)**
  SuDS is a proprietary application focused on end-to-end SDS process management. Supplemental data allows for discrete events and procedures that occur during patient encounters. Data is captured for gap closure that would not close through claims submission alone. Once the data files are set up and validated, files can be submitted to MHS weekly, bi-weekly, monthly, or quarterly.

- **EMR Sharing Platforms (Azara, EPIC Payor Platform, Healow Insights)**
  These are platforms that help providers and health plans work together more effectively to close patient care gaps. It is automated within the provider's EMR system and allows real-time data exchange securely via electronic connection.

- **Web-based Application (Availity)**
  Availity is a Clinical Quality Validation (CQV) system that providers log on via the internet. It is not within a providers EMR system. Its functionality is primarily the same as other platforms which is to close care gaps.

## HOW CAN I IMPROVE MY HEDIS® SCORES?

- ✓ Speak with your patients about the availability of a transportation benefit (if applicable).
- ✓ Ensure that patients are aware of the option for mail-order prescription refills.
- ✓ Submit supplemental data throughout the measurement year.
- ✓ Conduct preventive care visits annually and ensure your patients are up to date with their recommended screenings (i.e., mammograms, colonoscopies, etc.).
- ✓ Assist members with scheduling preventive services while in the office.
- ✓ Have members address their own reminder post cards for future appointments before leaving the office.
- ✓ Submit claim/encounter data for each service rendered.
- ✓ Make sure that chart documentation reflects all services billed.
- ✓ Ensure that all claim/encounter data is submitted in an accurate and timely manner.
- ✓ Include CPT II codes to provide additional details and reduce medical record requests.
- ✓ Respond timely to medical records requests.
- ✓ Speak with members about any barriers to medication adherence.
- ✓ Early Engagement with Pharmacy Adherence is key — once a member loses days on a prescription, those days cannot be recovered.
- ✓ Consider utilizing RxEffect — a free online portal for our network providers that will prioritize medication adherence for high-risk Medicare and Marketplace patients. This will save on resources as it lists your patients at highest risk for non-adherence.

# MHS QUALITY PROVIDER INCENTIVE PROGRAMS

### PAY-FOR-PERFORMANCE (P4P)

The P4P program's goal is to enhance care quality through Primary Medical Provider driven pay for performance with a focus on preventive and screening services. The program runs from January 1st to December 31st of the measurement year. Monthly performance scorecards and care gap reports will be placed on the MHS Provider Portal via "Provider Analytics." Based on program performance, providers are eligible to earn compensation in addition to what you are paid through your participating provider agreement.

### RISK MANAGEMENT: Continuity of Care (CoC) Program

The CoC program is designed to support provider outreach to members for annual visits and chronic condition management, which will help us better identify members who are eligible for case management. Providers earn bonus payments for proactively coordinating preventive medicine and for thoroughly addressing patients' current conditions to improve health and clinical quality of care. *Please contact your Provider Engagement Administrator (PEA) for details.

### PARTNERSHIP FOR QUALITY (P4Q)

This initiative aims to recognize and reward Primary Care Physicians (PCPs) for improving healthcare quality and closing gaps in care for our Medicare population. Providers can earn a bonus by successfully closing care gaps by scheduling and conducting appointments, reviewing medications, performing/ordering preventive services, and strategizing a plan for maintaining your patient's well-being. Monthly performance scorecards and care gap reports will be placed on the MHS Provider Portal via "Provider Analytics." Care gap reports will also be provided by your Quality Practice Advisor.

## GLOSSARY OF TERMS

**Numerator:** The number of members who meet compliance criteria based on NCQA technical specifications for appropriate care, treatment, or service.

**Denominator:** The number of members who qualify for the measure criteria, based on NCQA technical specifications.

**Measurement year (MY):** In most cases, the 12-month period between which a service was rendered; January 1 through December 31.

**Prior Year (PY):** The year prior to the Measurement Year.

**Reporting year:** The period when data is collected and reported. The service dates are from the measurement year, which is usually the year prior. In some cases, the service dates may go back more than one year.

**Frailty:** At least two indications of frailty with different dates of service during the MY.

**Advanced Illness:** Either of the following during the MY or PY:

- Advanced illness on at least two different dates of service or dispensed dementia medication

## PRIMARY METHODS FOR CALCULATING HEDIS® DATA

Admin

**Administrative:** Is data that is captured from claims, encounters, pharmacy, labs, Immunization registries, and Health Information Exchange. HEDIS® rates are calculated for the entire eligible population who qualify for a HEDIS measure.

Hybrid

**Hybrid:** A combination of administrative data and medical record review randomly selected. This includes members whose care meets the measure standard based on administrative data such as claims and labs.

ECDS

**Electronic Clinical Data Systems (ECDS):** HEDIS® quality measures reported using ECDS means secure sharing of patient medical information electronically between systems. Measures that leverage clinical data captured routinely during care delivery that can reduce the burden on

providers to collect data for quality reporting. The data sources for ECDS are Electronic Health Records, Health Information Exchanges, Case Management Systems, and Administrative Claims.

CAHPS

**Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey:** Every year, a random sample of members are surveyed about their experience with their doctors, services, and health plan.

**Line of Business Key:**

Medicaid

**Medicaid (MHS Indiana):** Indicates HEDIS® measures that apply to the Medicaid membership.

ambetter.

**Marketplace (Ambetter):** Indicates HEDIS® measures that apply to the Marketplace membership.

wellcare

**Medicare (Wellcare):** Indicates HEDIS® measures that apply to the Medicare membership.

## MHS RESOURCES AND LINKS

***Member Services:*** www.mhsindiana.com/members.html
***Health Indiana Plan (HIP), Hoosier Care Connect (HCC), and Hoosier Healthwise (HHW):*** 1-877-647-4848; TTY 1-800-743-3333
***Ambetter:*** 1-877-687-1182; TTY 1-800-743-3333
***Wellcare by Allwell:*** 1-855-766-1541; TTY 711

- Assistance with finding a provider.
- Member coverage and benefits
- ID cards
- View claims.
- Prior Authorization Approvals
- 24 Hour Nurse Advice Line: 1-877-647-4848
- Notification of pregnancy: 1-877-647-4848 Ext. 20309
- Crisis Support: Text MHS to 741741 or the National Suicide Prevention Lifeline: 988

**Community Connect**
Ability to search and connect to support for MHS members across Indiana for financial assistance, food pantries, medical care, and other free or reduced-cost help. Search by zip code.
*All information can be found on the MHS website.*
*https://www.mhsindiana.com*

**Provider Resource** page on MHS linked *here*.
Provider Quick links to:
- Pre-Auth Check
- Submit claim/ Check Claim Status
- Pharmacy

**Demographic Update Tool** to edit provider information.

**Pay for Performance** (P4P) notification sign up.
Provider News

**Quality Programs**
**Interpreter/Translation Services (MHS Provider Services)**
**1-877-647-4848**
**Provider Portal** login link *here*.
- Click on **Patient** and select member's name to access patient's medical records.
- Click on the **Provider Analytics** link to be directed to your Quality dashboard and P4P Scorecard
- Click on **Authorization** to create or view status of submitted prior authorizations.
- Click on **Claims** to review status of submitted claims.
- **Medically Frailty Reporting:** 1-877-647-4848

All information can be found on the MHS website**.**
*https://www.mhsindiana.com*
**Provider Education & Training Link:** https://www.mhsindiana.com/providers/provider-training.html
**Care Management Information:** *https://www.mhsindiana.com/members/care-connect/benefits-services/care-management.html*

**Updates to HEDIS® Measures:** (effective for calendar year 2025) This guide has been updated with information from the release of the HEDIS® 2025 Volume 2 Technical Specifications by NCQA and is subject to change.

**Retired Measures:**
AMM – Antidepressant Medication Management

**Revised Measures:**
CHL - Chlamydia Screening in Women title changed to Chlamydia Screening
CCS – Cervical Cancer Screening is now CCS-E,
CIS - Childhood Immunization Status is now CIS-E
IMA - Immunizations for Adolescents is now IMA-E
ADD - Follow-up Care for Children Prescribed ADHD Medication is now ADD-E

**New Measure(s):**
DBM-E Documented Assessment after Mammogram
FMA-E Follow-up After Abnormal Mammogram Assessment
BPC-E Blood Pressure Control for Patients with Hypertension

For additional information or questions related to HEDIS®, please contact your Quality Practice Advisor/Associate Quality Practice Advisor.

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

*Product Lines:* ***Medicaid***, ***Marketplace***, ***Medicare***

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

## ELIGIBLE POPULATION

Members 3 months of age and older

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

## TIMELINE/LOOKBACK PERIOD

July 1, PY - June 30, MY

## TIPS

- A higher rate indicates appropriate URI treatment.
- The AAB measure is calculated per episode; therefore, a member can have more than one episode during the intake period. If a member has more than one eligible episode in a 31-day period, the first episode is used.
- Exclude the following AAB episode dates:
  - Result in an inpatient stay.
  - An antibiotic prescription (new or refill) was dispensed during the 30 days prior to or was active on the episode date.
  - A claim/encounter with a diagnosis for a co-morbid condition during the 12 months prior through the episode date.
  - A claim/encounter with a diagnosis of pharyngitis or other competing diagnosis on or during the three days following the episode date.
- Educate members on the difference between viral and bacterial infections and risks of antibiotic overuse.
- Educate members on managing symptoms of a URI (increase fluid intake, throat lozenges, over the counter pain relievers and cold medicine, saline nasal drops, decongestants, antihistamines, humidifiers).

### QUALIFYING EVENT/DIAGNOSIS

An outpatient, telephone, ED, e-visit, or virtual check-in during the intake period with a diagnosis of bronchitis/bronchiolitis.

### EXCLUSIONS

- Members who used hospice during the MY
- Members who died during the MY.

## (AAP) Adults' Access to Preventive/ Ambulatory Health Services

*Product Lines:* ***Medicaid***, ***Marketplace***, ***Medicare***

The Percentage of members 20 years of age and older who had an ambulatory or preventive care visit:

- During the MY - Medicare & Medicaid
- During the MY or 2 years prior to the MY – Commercial

### ELIGIBLE POPULATION

Members who are 20 years or older during the MY.
Three age stratifications and total are reported:

- 20 - 44 years
- 45 years - 64 years
- 65 years and older
- Total

### TIMELINE

January 1, MY - December 31, MY
*Commercial: January 1, two years prior to MY – December 31, MY.*

### TIPS

- Educate patients on the importance of preventive visits.
- Send patients appointment reminders (postcards, phone calls, emails, text messages).
- Have patients address their own appointment reminder postcards.
- Patient outreach to schedule visits or schedule visits before patients leave the office.
- Leverage synchronous telehealth visits, Asynchronous telehealth (e-visits and virtual check-in's), and telephone visits to close care gaps.
- Administrative and Supplemental data are used.

### QUALIFYING EVENT/DIAGNOSIS
None

### EXCLUSIONS
- Members who used hospice during the MY
- Members who died during the MY.

## (ADD-E) Follow-up Care for Children Prescribed ADHD Medication

*Product Lines:* ***Medicaid***, ***Marketplace***

The percentage of children newly prescribed attention-deficit/hyperactivity disorder (ADHD) medication who had at least three follow-up care visits with a practitioner with prescribing authority within a 300-day (10 month) period, one within 30 days of ADHD medication dispensed.

### Two rates are reported:

1. **Initiation Phase** – One follow-up visit during the first 30 days of the IPSD. *(Index Prescription Start Date)*

2. **Continuation and Maintenance** – the child remained on the medication for at least 210 days (about 7 months) and had at least 2 follow-up visits within 270 days (about 9 months), (9 months) after the first 30-day Initiation Phase ended. (days 31-300 of IPSD)

### ELIGIBLE POPULATION
Children 6 – 12 years of age with newly prescribed ADHD medication.

### TIMELINE/INTAKE PERIOD
March 1, PY - the last day of February of MY

### TIPS
- The following visits meet criteria:
  - Initiation Phase – An outpatient or BH outpatient visit, health and behavior assessment or intervention, intensive outpatient encounter or partial hospitalization, community mental health center, telehealth visit, telephone visit with a practitioner with prescribing authority.

- Continuation and Maintenance Phase – Compliant for Initiation phase and Outpatient or BH outpatient visit, health and behavior assessment or intervention, intensive outpatient encounter or partial hospitalization, community mental health center, telehealth visit, *e-visit, or *virtual check-in with any practitioner. *Only one of the two visits during continuation phase may be an e-visit or virtual check-in

- Negative Medication History – no other ADHD medications dispensed in the 120 days (about 4 months) prior to the date of IPSD *(Index Prescription Start Date)*

### QUALIFYING EVENT/ELIGIBLE ENCOUNTER

The earliest dispensing date for an ADHD medication with a negative medication history for 120 days (about 4 months) prior to IPSD.

### REQUIRED EXCLUSIONS

- Members with a diagnosis of narcolepsy anytime in their history through the end of the MY.
- Members who used hospice during the MY.
- Members who died during the MY.

## (AMR) Asthma Medication Ratio

*Product Lines:* ***Medicaid***, ***Marketplace***

The percentage of members 5-64 years of age identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater during the MY.

### ELIGIBLE POPULATION

Members 5 – 64 years of age were identified as having persistent asthma.

### TIMELINE/LOOKBACK PERIOD

May 1, PY - April 30, MY

### TIPS

The following criteria identifies members as having persistent asthma.

If they meet at least one of the following criteria during both the MY and PY:

- ✓ An ED visit or acute inpatient encounter with primary diagnosis of asthma at discharge.
- ✓ At least four outpatient or telephone visits, e-visits, or virtual check-ins on different dates of service with a diagnosis of asthma and at least two asthma medication dispensing events (controller or reliever).
- ✓ At least four asthma medication dispensing events (controller or reliever)
  ***OR***
- ✓ Members who had at least four asthma medication dispensing events where leukotriene modifiers or antibody inhibitors were the sole asthma medication dispensed during the MY or PY with at least one diagnosis of asthma from any setting in the same year as the leukotriene modifier or antibody inhibitor.

**CALCULATING MEDICATION RATIO:** Controller Medications/Total Asthma Medications (controllers + reliever medications) prescribed during measurement year.

$$\frac{\textbf{Asthma Controller Medications}}{\textbf{Total Asthma Medications}\ \textit{(Controllers + Reliever Medications)}} = \textbf{Ratio}\ \textit{(50\% or more is compliant)}$$

Units – Each individual medication 30 day or less is identified as a unit.

**DISPENSING EVENTS ARE DEFINED AS:**

**Oral Medication**

- One Rx of oral medication lasting 30 days or less counts as one dispensing event. If longer than 30 days, divide the number of days' supply by 30 and round it down.
  - Ex: 100-day Rx is 3 units/three dispensing events. 100/30 = 3.33.
- Multiple medication Rx's on the same day are counted separately.
  - Ex: Oral Rx A x 60 days, Oral Rx B x 30 days, Oral C x 30 days all dispensed on same day = 4 units and 4 dispensing events)

**Inhalers**

- Inhalers of the same medication dispensed on the same day count as one event.
- Different inhaler meds dispensed on the same day count as different events.

- Ex: Inhaler A x 3 on same-day count as 3 units/1 event, but Inhaler A x 2 and Inhaler B x 1 dispensed on same-day count as 3 units/2 events.

**Injections**

- Each injection counts as one event whether same medication or different.
  - Ex: injection A x 2 and Injection B x 1 count as 3 events.

| EXAMPLES OF CONTROLLERS AND RELIEVERS | |
|---|---|
| **CONTROLLERS** | |
| **INHALERS** | **ORAL/INJECTIONS** |
| | ***ORAL MEDICATIONS*** |
| Budesonide-formoterol | Montelukast |
| Fluticasone-salmeterol | Zafirlukast |
| Fluticasone-vilanterol | Zileuton |
| Formoterol-mometasone | Theophylline |
| Beclomethasone | |
| Budesonide | ***INJECTIONS*** |
| Ciclesonide | Omalizumab |
| Fluticasone | Dupilumab |
| Flunisolide | Benralizumab |
| Mometasone | Mepolizumab |
| | Reslizumab |
| **RELIEVERS** | |
| **INHALERS** | |
| Albuterol | |
| *Albuterol-budesonide | |
| Levalbuterol | |

## QUALIFYING EVENT/DIAGNOSIS

The event that qualifies a member as having persistent asthma. (See criteria above)

### REQUIRED EXCLUSIONS

- Members who had a diagnosis that requires a different treatment approach than members with asthma anytime during the MY.
- Members identified as having persistent asthma who had no asthma controller/reliever medications dispensed during the MY.
- Members who used hospice during the MY
- Members who died during the MY.

**NCQA MY25 changed to measure – Medication added.*

## (APM-E) Metabolic Monitoring for Children and Adolescents on Antipsychotics

*Product Lines:* ***Medicaid***, ***Marketplace***

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

### Three rates are reported:

1. **Blood glucose testing**
   - Glucose lab or HbA1c lab test
2. **Cholesterol testing**
   - Cholesterol or LDL-C lab test
3. **Blood glucose/HbA1c and cholesterol/LDL-C testing**

### ELIGIBLE POPULATION

Children and adolescents 1 – 17 years of age who had two or more antipsychotic prescriptions. Two age stratifications and the total are reported.

- 1 - 11 years
- 12 - 17 years
- Total

### TIMELINE/LOOKBACK PERIOD

January 1, MY – December 31, MY

### TIPS

- Obtain a baseline and yearly blood sugar and cholesterol testing.
- Educate and inform patents/guardians of the increased side effects of multiple antipsychotics and the effects they may have on the child's health.

- Educate parents/guardians about the risks of obesity and diabetes when taking multiple antipsychotic medications.
- Schedule follow-up visits at the time medication is prescribed.
- Utilize telehealth opportunities.

### QUALIFYING EVENT/ELIGIBLE ENCOUNTER
A prescription dispensed for two or more antipsychotic medications.

### REQUIRED EXCLUSIONS
- Members who had Rx for antidepressant medication within 105 days (about 3 and a half months) prior to IPSD.
- Members who used Hospice during the MY.
- Members who died during the MY.

## (BCS-E) Breast Cancer Screening
*Product Lines:* ***Medicaid***, ***Marketplace***, ***Medicare***

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

### ELIGIBLE POPULATION
Members 50 – 74 years of age during the MY.

### TIMELINE/LOOKBACK PERIOD
October 1, two years prior - December 31, MY.

### TIPS
- Acceptable documentation for supplemental data medical record review must include documentation that a mammogram (all types – screening, diagnostic, film, digital, or digital tomosynthesis) was performed and the date.
- Documentation of breast cancer screening in the medical record is acceptable (member reported included) if it includes the date of screening, results, and procedure completed.
- A result is not required if documentation of the screening is part of the members medical history. If no result is present, it is assumed negative unless otherwise documented.

- Breast biopsy, ultrasound, and MRI do not meet criteria.
- BCS (Breast Cancer Screening) was retired MY23 and is now only reported as BCS-E.

### QUALIFYING EVENT/DIAGNOSIS
None

### REQUIRED EXCLUSIONS
- Members who had a bilateral mastectomy or both right and left unilateral mastectomies at any time during the member's history through the end of the MY
- Members who had gender-affirming chest surgery (CPTII code 19318) with a diagnosis of gender dysphoria anytime during the members history through the end of the MY.
- Members 66 yrs of age and older during the MY with both frailty and advanced illness.
- Members who used hospice during the MY.
- Members who died during the MY.

## (BPC-E) Blood Pressure Control for Patients with Hypertension

*Product Lines:* ***Medicaid***, ***Marketplace***, ***Medicare***

The percent of members who are diagnosed with Hypertension and whose Blood Pressure was <140/90.

### ELIGIBLE POPULATION
Members 18-85 years old

### TIMELINE/LOOKBACK PERIOD
January 1 – December 31

### TIPS
- Retake BP reading if it is high after patient rests for 5 minutes.
- Use correct cuff size on arm.

### REQUIRED EXCLUSIONS

- Members in Hospice Care.
- Members who die during the Measurement Year.
- Members receiving Palliative Care.
- Members with a non-acute inpatient admission during the Measurement Year.
- Members who are diagnosed with End Stage Renal Disease.

## (BPD) Blood Pressure Control for Patients with Diabetes

*Product Lines:* ***Medicaid***, ***Marketplace***, ***Medicare***

The Percentage of members 18-75 years of age with diabetes type I or II and had adequate control of Blood Pressure (<140/90) during the MY.

### ELIGIBLE POPULATION

Members 18-75 years of age during the MY with Type I or II diabetes.

### TIMELINE/LOOKBACK PERIOD

January 1, MY - December 31, MY

### TIPS

- The final BP reading of the MY will be used.
- Retake blood pressure at end of visit when the patient is more relaxed if blood pressure reading is > 140/90.
- Use proper cuff size and proper positioning (seated in chair, both feet on floor, arm supported with elbow at heart level).
- If multiple blood pressures are taken during the same visit, the lowest systolic and the lowest diastolic blood pressure reading are used. Do not round up/down, average, or give a range.
- Member reported blood pressure readings taken with a digital device meet criteria if the reading is documented in the record with the date it was taken.
- Members are identified as having diabetes by claim/encounter or pharmacy data.
- Blood Pressure readings from outpatient visits, telehealth visits, e-visits, or virtual check-ins are used.

## BLOOD PRESSURES FROM THE FOLLOWING VISITS ARE ACCEPTABLE

A blood pressure reading on the same visit as vaccination administration, TB test, eye exam using dilating agents, EKG, Injections (allergy, insulin, B-12, steroid, Toradol, Depo-Provera, testosterone, lidocaine), IV hydration, blood transfusion, or stress test (when there is no medication or diet change).

A blood pressure reading on same date of service as an IUD insertion, PAP Smear, or any gynecological procedure that did not require a change in diet or medication the day before or the day of the visit.

A blood pressure reading from an Urgent Care visit, a telehealth visit (member reported result using a digital device only), or from a consult note sent to the provider.

A blood pressure reading on same date of service as a wart or mole removal, or other procedure that did not require a change in diet or medication the day before or the day of the visit.

A blood pressure reading from a visit on the same day as a fasting blood test lab is drawn.

Blood pressure readings on the same date as an eye exam using dilating agents.

A patient who forgot to take medication on the same date as the blood pressure reading is not considered a change in medication and BP can be used from that date of service.

| BLOOD PRESSURES FROM THE FOLLOWING ARE NOT ACCEPTABLE |
| --- |
| A blood pressure reading on the same day is a therapeutic procedure that requires a change in diet or medication on the same day or day before.<br><br>Examples: Dialysis, infusions, IV or oral chemotherapy, any other therapeutic procedures requiring a medication regimen. |
| A blood pressure reading on the same day as a surgical procedure or diagnostic test that requires a change in diet or medication on the same day or day before.<br><br>Examples: Surgery-NPO, Colonoscopy-change in medication and diet the day before the procedure. |
| A blood pressure reading from an Inpatient stay (acute and nonacute).<br><br>A Blood pressure reading from Emergency Department visits. |
| A blood pressure reading taken during a procedure where the member received lidocaine and epinephrine are both used. |
| A blood pressure reading taken from a visit where an Albuterol Nebulizer treatment was administered (*PRN albuterol inhaler-OK).<br><br>A blood pressure reading from a visit for chemotherapy or dialysis – both require medication regimen. |
| A blood pressure average, range, or threshold. |

A CPTII code or electronic record transmission must be used to close the care gap since BPD requires a compliant result, < 140/90. Two separate codes, one for systolic and one for diastolic, are required.

| SYSTOLIC CPTII CODES | DIASTOLIC CPTII CODES |
|---|---|
| 140 mmHg or higher – 3077F | 3044F – 90 mmHg or higher |
| 130-139 mmHg – 3075F | 3079F – 80-89 mmHg |
| Less than 130 mmHg – 3074F | 3078F – Less than 80 |

*Supplemental data may be submitted for abstraction as an alternative.

## QUALIFYING EVENT/DIAGNOSIS

Members identified as having diabetes by either:

- Claims/encounter data - with at least **two** diagnoses of diabetes on different dates of service during the MY or PY.

***or***

- Pharmacy claims data + Claims/encounter data - dispensed insulin or hypoglycemics/antihyperglycemics **and** at least one diagnosis of diabetes during the MY or PY.

## REQUIRED EXCLUSIONS

- Members 66 years of age and older during MY who were enrolled in an Institutional SNP or Living long-term in an institution anytime during the MY.
- Members 66 years of age and older with frailty and advanced illnesses.
- Members who received palliative care during the MY.
- Members who used hospice during the MY.
- Members who died during the MY.

# (CBP) Controlling High Blood Pressure

*Product Lines:* ***Medicaid, Marketplace, Medicare***

The Percentage of members 18 - 85 years of age who had a diagnosis of hypertension and had adequate control of blood pressure (<140/90 mm HG) during the MY.

## ELIGIBLE POPULATION

Members 18-85 years of age during the MY with a diagnosis of hypertension.

## TIMELINE/LOOKBACK PERIOD

January 1, MY - December 31, MY

## TIPS

- The final BP reading of the MY will be used.
- Retake blood pressure at end of visit when the patient is more relaxed if blood pressure reading is > 140/90.
- Use proper cuff size and proper positioning (seated in chair, both feet on floor, arm supported with elbow at heart level).
- If multiple blood pressures are taken during the same visit, the lowest systolic and the lowest diastolic blood pressure reading are used. Do not round up/down, average, or give a range.
- Members reported blood pressure readings meet criteria when a digital device is used, and the reading is documented in the record with the date it was taken.
- Blood Pressure readings from outpatient visits, telehealth visits, e-visits, or virtual check-ins are used.

## BLOOD PRESSURES FROM THE FOLLOWING VISITS ARE ACCEPTABLE

A blood pressure reading on the same visit as vaccination administration, TB test, eye exam using dilating agents, EKG, Injections (allergy, insulin, B-12, steroid, Toradol, Depo-Provera, testosterone, lidocaine), IV hydration, blood transfusion, or stress test (when there is no medication or diet change).

A blood pressure reading on same date of service as an IUD insertion, PAP Smear, or any gynecological procedure that did not require a change in diet or medication the day before or the day of the visit.

A blood pressure reading from an Urgent Care visit, a telehealth visit (member reported result using a digital device only), or from a consult note sent to the provider.

A blood pressure reading on same date of service as a wart or mole removal, or other procedure that did not require a change in diet or medication the day before or the day of the visit.

A blood pressure reading from a visit on the same day as a fasting blood test lab is drawn.

Blood pressure readings on the same date as an eye exam using dilating agents.

A patient who forgot to take medication on the same date as the blood pressure reading is not considered a change in medication and BP can be used from that date of service.

| BLOOD PRESSURES FROM THE FOLLOWING ARE NOT ACCEPTABLE |
| --- |
| A blood pressure reading on the same day is a therapeutic procedure that requires a change in diet or medication on the same day or day before.<br><br>Examples: Dialysis, infusions, IV or oral chemotherapy, any other therapeutic procedures requiring a medication regimen. |
| A blood pressure reading on the same day as a surgical procedure or diagnostic test that requires a change in diet or medication on the same day or day before.<br><br>Examples: Surgery-NPO, Colonoscopy-change in medication and diet the day before the procedure. |
| A blood pressure reading from an Inpatient stay (acute and nonacute).<br><br>A Blood pressure reading from Emergency Department visits. |
| A blood pressure reading taken during a procedure where the member received lidocaine and epinephrine are both used. |
| A blood pressure reading taken from a visit where an Albuterol Nebulizer treatment was administered (*PRN albuterol inhaler-OK).<br><br>A blood pressure reading from a visit for chemotherapy or dialysis – both require medication regimen. |
| A blood pressure average, range, or threshold. |

CPTII code must be used to close the care gap since BPD requires a compliant result, < 140/90, to meet criteria. A separate code for systolic and diastolic are required.

| SYSTOLIC CPTII CODES | DIASTOLIC CPTII CODES |
|---|---|
| 140 mmHg or higher – 3077F | 3044F – 90 mmHg or higher |
| 130-139 mmHg – 3075F | 3079F – 80-89 mmHg |
| Less than 130 mmHg – 3074F | 3078F – Less than 80 |

*Supplemental data may be submitted for abstraction as an alternative.

## QUALIFYING EVENT/DIAGNOSIS

Members who had at least two outpatient visits on different dates of service with a diagnosis of hypertension between January 1, PY - June 30, MY.

## REQUIRED EXCLUSIONS

- Members with end-stage renal disease (ESRD), dialysis, nephrectomy, or kidney transplant any time during their history through December 31, MY.
- Members with a diagnosis of pregnancy anytime during the MY.
- Members 66 years of age and older during MY who were enrolled in an Institutional SNP or Living long-term in an institution anytime during the MY.
- Members 66-80 years with frailty and advanced illnesses during the MY.
- Members who received palliative care during the MY.
- Members who used hospice during the MY.
- Members who died during the MY.

# (CCS-E) Cervical Cancer Screening

*Product Lines:* ***Medicaid***, ***Marketplace***

**The percentage of members 21 – 64 years of age who were recommended for routine cervical cancer screening and were screened for cervical cancer using the following criteria:

- Members 21 - 64 years of age - cervical cytology screening in the past 3 years.
- Members 30 - 64 years of age - cervical high-risk human papillomavirus (hrHPV) testing in the past 5 years.
- Members 30 - 64 years of age – cervical cytology/hrHPV co-testing in the past 5 years.

## ELIGIBLE POPULATION

Members 21 to 64 years of age who were recommended for routine cervical cancer screening during the MY.

## TIMELINE/LOOKBACK PERIOD

**Members 21 – 64 years of age**

January 1, two years prior - December 31, MY.

**Members 30 – 64 years of age**

January 1, four years prior - December 31, MY.

## TIPS

Documentation in the medical record must include the date of cervical cancer screening was performed and the result.

**ACCEPTABLE DOCUMENTATION**

- ✓ A lab source of "vagina" is acceptable for a cervical cytology screening if the lab report indicates the sample was satisfactory for evaluation/endocervical component present.
- ✓ Cervical cytology or hrHPV testing with a result.
- ✓ Documentation of the progress notes of a Pap/HPV co-test or an HPV (30-64yrs only) with results and the date of service.
- ✓ Documentation of a "simple hysterectomy," "total hysterectomy," or "full hysterectomy."
- ✓ Documentation of "vaginal hysterectomy" or "Laparoscopic Assisted Vaginal Hysterectomy (LAVH) with "no residual cervix documented.

**UNACCEPTABLE DOCUMENTATION**

- ✓ Specimen noted as "vaginal source" only, "inadequate sample," or "no cervical cells present."
- ✓ Cervical biopsies. These are therapeutic, not diagnostic, procedures.
- ✓ Documentation of hysterectomy, partial hysterectomy, or supracervical hysterectomy, alone without mention of absence of cervix.
- ✓ Documentation of "transgender" alone, without notation specifying the type of transition to support evidence that the member has no cervix.

## QUALIFYING EVENT/DIAGNOSIS

None

## REQUIRED EXCLUSIONS

- Members who had a Hysterectomy with no residual cervix (Full hysterectomy, complete hysterectomy, total hysterectomy, vaginal hysterectomy, laparoscopic-assisted hysterectomy), cervical agenesis, or acquired absence of cervix any time during their history through December 31 of MY.
- Members with Sex Assigned at Birth of Male.
- Members who received palliative care during the MY.
- Members who used hospice during the MY.
- Members who died during MY.

**NCQA MY25 change to measure – CCS is now an ECDS measure.*
***NCQA MY25 change to measure – replaced "women" with "members who were recommended for routine cervical cancer screening."*

# (CHL) Chlamydia Screening

*Product Lines:* ***Medicaid, Marketplace***

The percentage of *members recommended for routine chlamydia screening 16 – 24 years of age who were identified as sexually active and had at least one test for chlamydia during the MY.

## ELIGIBLE POPULATION

*Members recommended for routine chlamydia screening 16 – 24 years of age who are identified as sexually active during the MY.
Two age stratifications plus the total are reported:

- 16 - 20 years
- 21 - 24 years
- Total

## TIMELINE/LOOKBACK PERIOD

January 1, MY - December 31, MY.

## TIPS

- Complete chlamydia screening as routine annual testing for all members recommended for routine chlamydia screening 16 – 24 years of age.
- Meet with teens and young adults separate from parents to allow open conversation.
- Perform chlamydia screening through a urine test at time of visit for pregnancy, pregnancy test, sexual activity counseling, or contraceptive to close the care gap at the time of the qualifying event.
- Educate members about chlamydia symptoms-many experience no symptoms, how chlamydia can damage the reproductive system, and the importance of STI testing for them and their partner.
- Educate members on the importance of using condoms to reduce the risk of contracting chlamydia and/or other sexually transmitted diseases.
- Supplemental data can be used to identify members recommended for routine chlamydia screening.
- Members recommended for routine chlamydia screening is defined as:
  - Administrative Gender: Female any time in the member's history
  - Sex Assigned at birth: (LOINC code 76689-9) Female (LOINC code LA3-6) any time in the member's history.

## QUALIFYING EVENT/DIAGNOSIS

Members who had claim/encounter data indicating sexual activity during the MY.

- Pregnancy
- Pregnancy Test
- Diagnosis or procedure indicating sexual activity

Members who were dispensed prescription contraceptives during the MY.

- Contraceptives
- Diaphragm
- Spermicide

## REQUIRED EXCLUSIONS

- Members who had a prescription for isotretinoin (Retinoid medication) on the same date 6 days after the pregnancy test.
- Members who had an x-ray on the date of through 6 days after the pregnancy test.
- Sex assigned at birth: Identified as Male any time in the member's history.
- Members who used hospice services during the MY.
- Members who died during the MY.

**NCQA MY25 change to measure - from "Chlamydia Screening in Women" to "Chlamydia Screening".*
***NCQA MY25 change to measure - replaced "women" with "members recommended for routine chlamydia screening".*

# (CIS-E) Childhood Immunization Status

*Product Lines:* ***Medicaid, Marketplace***

The percentage of members 2 years of age during the MY who received the following vaccines on or before their 2nd birthday:

| VACCINE | # OF DOSES | MINIMUM AGE |
|---|---|---|
| HBV – Hep B, Hepatis B | 3 | Birth |
| HiB – Hemophilus Influenza Type B | 3 | 42 days |
| IPV – Polio (injectable only) | 3 | 42 days |
| PCV – Pneumococcal Conjugate | 4 | 42 days |
| DTaP - Diphtheria, Tetanus, Acellular & Pertussis | 4 | 42 days |

| VACCINE | # OF DOSES | MINIMUM AGE |
|---|---|---|
| Rotavirus Monovalent – 2 /Pentavalent – 3 | 2 or 3 | 42 days |
| VZV – Chicken Pox, Varicella | 1 | 1 year |
| HAV – Hep A, Hepatitis A | 1 | 1 year |
| MMR – Measles, Mumps, & Rubella | 1 | 1 year |
| Flu - Influenza | 2 | 180 Days |

**Combo 10 includes the total of all 10 vaccines.*

***Combo 3 includes all 10 vaccines except Hepatitis A, Rotavirus, and Influenza*

## ELIGIBLE POPULATION

Members who turn 2 years of age during the MY.

## TIMELINE/LOOKBACK PERIOD

Birth – 2nd birthday.

## TIPS

- If Rotavirus vaccine does not state 2-dose or 3-dose series, assume 3-doses are required. [Rotarix (RV1) = 2 dose; RotaTeq (RV5) = 3 dose].
- LAIV (Live Intranasal Influenza Vaccine) may only be administered on the 2nd birthday.
- Medical Record must include name of vaccine and date given.
- A Certificate of Immunization meets criteria.
- Any of the following documentation does not meet criteria: "UTD"," Up to date on immunizations," "None needed," "Ordered," "Recommended," etc.
- Parent refusal does not exclude members from the measure.

## OPTIONAL EXCLUSIONS

- May exclude child from any of the immunizations if history of Anaphylaxis
  from the vaccine anytime on or before the 2nd birthday.
- May exclude child from MMR, VZV, Hep A, or Hep B if child has a documented history of the illness and date of illness, on or before the 2nd birthday. MMR must include the history of all three illnesses (Measles, Mumps, and Rubella).
- May exclude child from DTaP if child has history of Encephalitis due to the DTaP vaccine.

## REQUIRED EXCLUSIONS

- Members who had a contraindication to the vaccine on or before the 2nd birthday.
  **Ex. Organ and bone marrow transplant patients.*
- Members who used hospice care services anytime during the MY.
- Members who died anytime during the MY.

**NCQA MY25 change to measure - added exclusion organ and bone marrow transplants.*

# (COA) Care for Older Adults

*Product Lines:* ***Medicare - (SNP and MMP only)***

The percentage of members 66 years of age or older during the MY who had the following:

- Medication Review - Either of the following:
  - A medication list in the medical record reviewed by a prescribing practitioner or clinical pharmacist.
  - Documentation that the member is not taking any medication.
- Functional Status Assessment from an outpatient setting.

## ELIGIBLE POPULATION

Members 66 years or older of age during the MY.

## TIMELINE/LOOKBACK PERIOD

January 1, MY - December 31,MY

## TIPS

- COA care gaps can be closed during any type of outpatient setting (annual visit, sick visit, ER visit, telehealth visit, e-visit, etc.).

## ACCEPTABLE DOCUMENTATION

### MEDICATION REVIEW

- ✓ A signed and dated medication list in the progress notes.
- ✓ A medication review completed without the member present.
- ✓ Medication review may be completed during an emergency visit.
- ✓ Documentation in the record that the member does not take any medication.
- ✓ A medication list alone without dosage and/or frequency.

### FUNCTIONAL STATUS ASSESSMENT

- ✓ Activities of Daily (ADL's) were assessed or at least five of the following were assessed:
- Bathing/grooming, dressing, eating, transferring (in and out of bed or chairs), using toilet, walking.
- ✓ Instrumental Activities of Daily Living (IADL) were assessed or at least four of the following were assessed:
- Shopping for groceries, driving/using public transportation, using the telephone, cooking/meal preparation, housework, home repair, laundry, taking medications, handling finances.
- ✓ A standardized functional assessment tool and the results.
- ✓ A functional status assessment from a skilled nursing facility, case management, or a home health OASIS form and the results.
- ✓ A functional status assessment performed during a telephone visit, e-visit, or virtual check-in.

**UNACCEPTABLE DOCUMENTATION**

**MEDICATION REVIEW**

- ✓ A medication list reviewed in an inpatient setting.
- ✓ A medication list from an MDS form.
- ✓ A medication list reviewed by someone other than a prescribing practitioner or clinical pharmacist.
- ✓ Side effects from a medication the member is taking.

**FUNCTIONAL STATUS ASSESSMENT**

- ✓ A functional status assessment limited to an acute or specific condition, event, or body system (lower back, cardiac condition, etc.)
- ✓ A functional status assessment performed during an acute inpatient setting.

### QUALIFYING EVENT/DIAGNOSIS

None

### REQUIRED EXCLUSIONS

- Members who used hospice during the MY.
- Members who died during the MY.

**NCQA MY25 change to measure - Pain Assessment has been removed.*

## (COL-E) Colorectal Cancer Screening

*Product Lines:* ***Medicaid***, ***Marketplace***, ***Medicare***

The percentage of members 45 – 75 years of age had one of the following appropriate preventive screenings for colorectal cancer.

- Fecal Occult Blood Testing (FOBT) – January 1, MY - December 31, MY. (1 year)
- Stool DNA (sDNA) with FIT Test – January 1, two years prior to MY - December 31, MY. (3 years)
- Flexible Sigmoidoscopy – January 1, four years prior to MY - December 31, MY. (5 years)
- CT Colonography (Virtual Colonoscopy) – January 1, four years prior to the MY - December 31, MY. (5 years)
- Colonoscopy – January 1, nine years prior to the MY - December 31, MY. (10 years)

## ELIGIBLE POPULATION

Members 45 – 75 years of age during the MY. Two age stratifications and total are reported.

- 45 - 49 years
- 50 years - 75 years
- Total

## TIMELINE/LOOKBACK PERIOD

January 1, nine years prior to MY - December 31, MY

## TIPS

- Educate members on the importance of colorectal screenings for early detection.
- Assist members with scheduling colonoscopy screening appointments.
- Talk to members about using home screenings for colorectal screening
  and the different options available.

## QUALIFYING EVENT/DIAGNOSIS

None

## REQUIRED EXCLUSIONS

- Members who had colorectal cancer anytime during their history through December 31, MY.
- Members who had a total colectomy anytime in their history through December 31, MY.
- Medicare members 66 years of age or older during the MY who meet either enrolled in an Institutional SNP (I-SNP) or living-term in an institution anytime during the MY
- Members 66 years of age or older during the MY with both frailty and advanced illness.
- Members who received palliative care during the MY.
- Members who used hospice during the MY.
- Members who died during the MY.

# (CWP) Appropriate Testing for Pharyngitis

*Product Lines:* ***Medicaid***, ***Marketplace***, ***Medicare***

The percentage of episodes for members 3 years of age or older diagnosed with pharyngitis who were dispensed an antibiotic and received a group A streptococcus strep test during the 7-day period from 3 days prior through 3 days after the episode date.

## ELIGIBLE POPULATION

Members 3 years of age or older at the time of the episode date. Three age stratifications and total rate are reported:

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

## TIMELINE/LOOKBACK PERIOD

July 1, PY - June 30, MY

## TIPS

- Educate members on the need for proper testing, the difference between viral and bacterial infections, and when antibiotics are appropriate for treatment.
- Episodes include outpatient visits, ED visits, telephone visits, e-visits, virtual check-in.
- All eligible episodes (at least 31 days apart) are considered. A patient can be eligible more than once in the MY.
- If the member has more than one eligible episode in a 31-day period, include only the first eligible episode.
  - Ex: An episode occurring on March 1 – any episodes March - through March 31 are not included.
- A pathology report with acceptable date and result may be submitted to close the care gap however, lab claims should not be used.

### QUALIFYING EVENT/DIAGNOSIS

An outpatient visit, ED visit, telephone visit, e-visit, observation visit, or virtual check-in with a diagnosis of pharyngitis.

### REQUIRED EXCLUSIONS

- The following episode dates are EXCLUDED:
  - Resulted in an inpatient stay.
  - The member had a claim/encounter with any diagnosis for a comorbid condition (on or during the 365 days (about 12 months) prior.
    (Total 366 days)
  - Comorbid conditions include the following diagnoses:
    - HIV
    - Malignant Neoplasms
    - Other Malignant Neoplasms of the skin
    - Emphysema
    - COPD
    - Disorders of the Immune System
  - A new or refill prescription for an antibiotic dispensed 30 days prior or was active on the episode date.
  - Member had a claim/encounter with a competing diagnosis one or three days after the episode date.
  - The member is not continuously enrolled from 30 days prior through 3 days after the episode date. (total 34 days). The members must be continuously enrolled during that time.
- Members who used hospice during the MY.
- Members who died during the MY

## (DBM-E) Documented Assessment After Mammogram

*Product Lines:* ***Medicaid***, ***Marketplace***, ***Medicare***

The percentage of episodes of mammograms documented in the form of a BI-RADS assessment within 14 days of the mammogram.

BI-RADS standardizes the reporting of findings into assessment categories for further management.

| BI-RADS CATEGORY | FINDINGS |
|---|---|
| BI-RADS 0 | Incomplete. Needs Additional Imaging Evaluation and/or Prior Mammograms for Comparison, as needing additional imaging. |
| BI-RADS 1 | Negative. |
| BI-RADS 2 | Benign. Recommended for continued routine screening. |
| BI-RADS 3 | Probably Benign. Recommended for mammography surveillance. |
| BI-RADS 4 | Suspicious. |
| BI-RADS 5 | Highly Suggestive of Malignancy. Should be managed using core needle biopsy, also called percutaneous core breast biopsy, as the preferred method for tissue diagnosis. |
| BI-RADS 6 | Known Biopsy - Proven. |

## ELIGIBLE POPULATION

Members 40 - 74 years old

## TIMELINE/LOOKBACK PERIOD

January 1 – December 31

## TIPS

- Educate members on the importance of a follow up after a screening
- Schedule member's mammogram screening during Annual Wellness Visit
- Submit Applicable Codes

## REQUIRED EXCLUSIONS

- Members who die during the Measurement Year
- Members in Hospice Care

# (EED) Eye Exam for Patients with Diabetes

*Product Lines:* ***Medicaid*****,** ***Marketplace*****,** ***Medicare***

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

- A retinal or dilated eye exam by an eye care professional in the MY.
- A negative retinal or dilated eye exam (negative for retinopathy) by an eye care professional in the PY.

## ELIGIBLE POPULATION

Members 18 – 75 years of age with diabetes type 1 or type 2.

## TIMELINE/LOOKBACK PERIOD

January 1, PY - December 31, MY

## TIPS

- Educate members about the effects of poorly controlled diabetes on the eyes and importance of an annual diabetic eye exam.
- Assist members with scheduling their annual diabetic eye exam appointments.

**NCQA retired the Hybrid Method. This measure is now reported using the Administrative Method only.*

- Blindness does not meet criteria for exclusion.

## QUALIFYING EVENT/DIAGNOSIS

Members identified as having diabetes by either:

- Claims/encounter data - with at least **two** diagnoses of diabetes on different dates of service during the MY or PY.

***or***

- Pharmacy claims data + Claims/encounter data - dispensed insulin or hypoglycemics/antihyperglycemics **and** at least one diagnosis of diabetes during the MY or PY.

## REQUIRED EXCLUSIONS

- Bilateral eye enucleation any time during the member's history.
- Members 66 years of age or older as of December 31, MY who were either:
  - enrolled in an institutional SNP (I-SNP) during the MY or
  - lived long-term in an institution identified by the LTI flag during the MY

- Members 66 years of age or older as of December 31, MY with both of the following:
  - Frailty during the MY and Advanced Illness during the MY or PY:
- Members who received palliative care during the MY.
- Members who used hospice during the MY.
- Members who died during the MY.

**NCQA MY25 change to measure – Removed the Hybrid Data Collection Method. Now reported using administrative method only.*

## (FMA-E) Follow Up after Abnormal Mammogram Assessment

*Product Lines:* ***Medicaid***, ***Marketplace***, ***Medicare***

The percentage of members with inconclusive or high-risk BI-RADS assessments that received appropriate follow-up within 90 days of the testing.

BI-RADS standardizes the reporting of findings into assessment categories for further management.

| BI-RADS CATEGORY | FINDINGS |
|---|---|
| BI-RADS 0 | Incomplete. Needs Additional Imaging Evaluation and/or Prior Mammograms for Comparison, as needing additional imaging. |
| BI-RADS 1 | Negative. |
| BI-RADS 2 | Benign. Recommended for continued routine screening. |
| BI-RADS 3 | Probably Benign. Recommended for mammography surveillance. |
| BI-RADS 4 | Suspicious. |
| BI-RADS 5 | Highly Suggestive of Malignancy. Should be managed using core needle biopsy, also called percutaneous core breast biopsy, as the preferred method for tissue diagnosis. |
| BI-RADS 6 | Known Biopsy - Proven. |

### ELIGIBLE POPULATION
Members 40-74 years old

### TIMELINE/LOOKBACK PERIOD
January 1 – December 31

### TIPS
- Educate members on the importance of follow up after a positive screening and that early intervention leads the better outcomes.
- Schedule a follow up visit before Member leaves the office.

### REQUIRED EXCLUSIONS
- Members who die during the Measurement Year
- Members in Hospice Care

## (GSD) Glycemic Status Assessment for Patients with Diabetes

*Product Lines:* ***Medicaid***, ***Marketplace***, ***Medicare***

The Percentage of members 18 - 75 yrs of age with diabetes (type 1 or 2) whose most recent glycemic status HbA1c or glucose management indicator (GMI) was at the following levels during the MY.
Two rates are reported:
- Glycemic Status < 8.0% (a higher score is better)
- Controlled Glycemic Status > 9.0% (a lower score is better)

### ELIGIBLE POPULATION
Members 18 - 75 years of age during the MY with type 1 or type 2 diabetes.

### TIMELINE/LOOKBACK PERIOD
January 1, MY - December 31, MY

### TIPS
- The most recent HbA1C or GMI during the MY is used.
- Use CPTII codes to close the care gaps in claims and reduce the number of records submitted for review.
- Results documented in any section of the medical record, including from an inpatient stay, meet criteria.

- Results must include the date and result when the glycemic status assessment was completed.
- If multiple glycemic status assessments were performed on the same date, the lowest result is used.
- How to improve GSA Scores:
  - Schedule follow up appointments and standing lab orders for HbA1C to monitor changes and adjust therapies as needed.
  - A CPTII code must be used to close the care gap since GSD requires a compliant result to meet criteria.

| HbA1c | |
|---|---|
| HbA1c < 7.0 | 3044F |
| HbA1c 7.0 to < 8.0 | 3051F |
| HbA1c 8.0 to 9.0 | 3052F |
| HbA1c > 9.0 | 3046F |

*Supplemental data may be submitted for abstraction as an alternative.

## QUALIFYING EVENT/DIAGNOSIS

Members identified as having diabetes by either:

- Claims/encounter data - with at least **two** diagnoses of diabetes on different dates of service during the MY or PY.

***or***

- Pharmacy claims data + Claims/encounter data - dispensed insulin or hypoglycemics/antihyperglycemics **and** at least one diagnosis of diabetes during the MY or PY.

## REQUIRED EXCLUSIONS

- Members 66 years of age and older during MY who were either enrolled in an Institutional SNP living long-term in an institution identified by the LTI flag during the MY.
- Members 66 years of age and older with frailty and advanced illnesses during the MY.
- Members who received palliative care during the MY.
- Members who used hospice during the MY.
- Members who died during the MY.

# (IET) Initiation and Engagement of Substance Use Disorder Treatment

*Product Lines:* ***Medicaid, Marketplace, Medicare***

The percentage of members 13 years of age or older with a new episode of substance use disorder who received treatment and engagement.

## Two rates are reported:

1. **Initiation** – Initiation of Substance Use Disorder treatment on or within 14 days of a new Episode.
2. **Engagement** – Two treatment engagement events within 34 days after the initial treatment event for substance use disorder.

## ELIGIBLE POPULATION

Members 13 years and older with a new SUD (substance use disorder) episode.

- 13 - 17 years
- 18 - 64 years
- 65 years and older
- Total

## TIMELINE

November 15, PY - November 14, MY

## TIPS

- Schedule follow up appointments prior to patient leaving the office/facility.
- Substance Use Disorder includes Alcohol, Opioid, and other substance use disorders.
- **Initiation Events**
  One of the following substances use disorder encounters with a diagnosis of alcohol abuse, opioid abuse or other drug abuse diagnosis that occur within 14 days (about 2 weeks) of the substance use disorder episode date.

✓ Acute or Non-acute Inpatient Substance Use Disorder admissions - the discharge date is considered the initiation event date.

✓ Outpatient behavioral health outpatient visits

✓ Intensive outpatient encounters or partial hospitalizations

✓ Opioid treatment services – weekly or monthly

✓ Non-residential substance abuse treatment facility visits

- ✓ Community mental health center visits
- ✓ Telehealth visits
- ✓ E-visit or virtual check-ins
- ✓ An alcohol use disorder medication treatment dispensing event or medication administration event – for alcohol use disorder SUD episodes.
- ✓ An opioid use disorder medication treatment dispensing event or medication administration event for opioid use disorder SUD episodes.

· **Engagement Events**
At least two of the following encounters in 34-day period after initiation episode with a substance use disorder diagnosis (alcohol abuse, opioid abuse and dependence, or other drug abuse and dependence).

- ✓ Acute or nonacute inpatient substance use disorder admission
- ✓ Intensive outpatient or partial hospitalizations.
- ✓ Non-residential substance abuse treatment facility visits
- ✓ Outpatient Substance Use Disorder Visits
- ✓ Community mental health center visits
- ✓ Telehealth visits
- ✓ Telephone visits
- ✓ E-visit or virtual check-ins (with two-way communication)
- ✓ Weekly or monthly substance use disorder treatment services.
- ✓ Medication treatment events - Long-acting substance use disorder medication administration events.

· An alcohol use disorder medication treatment dispensing event or medication administration event.

| Alcohol Use Disorder Treatment Medications | |
|---|---|
| Aldehyde dehydrogenase inhibitor | Disulfiram - oral |
| Antagonist | Naltrexone - oral or injectable |
| Other | Acamprosate – oral, delayed-release tablet |

- Opioids use disorder medication treatment dispensing event or medication administration event.

| Opioid Use Disorder Treatment Medications | |
|---|---|
| Antagonist | Naltrexone - oral or injectable |
| Partial Agonists | Buprenorphine - sublingual tablet, Injection, or implant<br>Buprenorphine/naloxone - sublingual tablet, buccal film, or sublingual film |

**Two engagement visit encounters on the same date of service meet criteria but must be with different providers.*

***An engagement encounter when a provider prescribes medication that is dispensed on the same date meets criteria for two engagement visits.*

****Methadone is not included in the medications for engagement*

## QUALIFYING EVENT/ELIGIBLE ENCOUNTER

A new substance uses disorder episode.

## REQUIRED EXCLUSIONS

- Members treated for a substance use disorder in the past 194 days.
- Members who had an inpatient stay with a discharge date after November 27th of the MY.
- Members who used hospice during the MY.
- Members who died during the MY.

# (IMA-E) Immunizations for Adolescents

*Product Lines:* ***Medicaid***, ***Marketplace***

The percentage of adolescent members 13 years of age during the MY and had the following vaccines on or before their 13th birthday:

| VACCINE | # OF DOSES | MINIMUM AGE |
|---|---|---|
| **Meningococcal Conjugate (MCV4)**<br>MenACWY, Menveo, Menactra, MCV, MCV4P, Menomune, MPSV4, MenQuadfi | 1 | 10 years |
| Tetanus, Diphtheria Toxoids and Acellular Pertussis (Tdap)<br>Adacel, Boostrix, Tdap/Td | 1 | 10 years |
| **Human Papillomavirus Vaccine Series (HPV)**<br>Gardasil/HPV4, Gardasil 9/HPV9, Cervarix/HPV2<br>*2 HPV vaccines meet criteria if administered at least 146 days apart. | 2 or 3 | 9 years |

**Combo 2 includes all vaccines, Meningococcal, Tdap, and HPV series.*
***Combo 1 includes only Meningococcal and Tdap vaccines.*

## ELIGIBLE POPULATION

Members who turned 13 years of age during MY.

## TIMELINE/LOOKBACK PERIOD

Member's 9th birthday - 13th birthday.

## TIPS

- DTaP is administered to infants and does not met criteria for the Tdap vaccine.
- Documentation may be taken from any section of the medical record.
- Documentation must include the following:
  - Name of vaccine and date administered or
  - Certificate of immunization with names of vaccines and dates administered.
- The following documentation does not meet criteria:
  - "UTD"," Up to date on immunizations," "None needed," "Ordered," "Recommended."
- Parent refusal does not exclude members from the measure.

## QUALIFYING EVENT/DIAGNOSIS

None

## OPTIONAL EXCLUSIONS

- Anaphylaxis to any of the vaccines anytime in the member's history through the 13th birthday excludes member from that vaccine. Must be documented in the record including the date of occurrence.
- Encephalitis due to the Tetanus, Diphtheria, or Pertussis vaccine anytime in the member's history through the 13th birthday excludes member from the Tdap vaccine. Must be documented in the record including the date of occurrence.

## REQUIRED EXCLUSIONS

- Members who used hospice care during the MY.
- Members who died during measurement year.

# (KED) Kidney Health Evaluation for Patients with Diabetes

*Product Lines:* ***Medicaid***, ***Marketplace***, ***Medicare***

The percentage of members 18 – 85 years of age with Diabetes (Type 1 and 2) who received a kidney health evaluation defined by both:

- An Estimated Glomerular Filtration Rate (eGFR) **AND**
- A Urine Albumin-Creatinine Ratio (uACR) during the MY.

  Either of the following:
  - A uACR (Urine Albumin Creatinine Ratio)

    or
  - Both a quantitative urine albumin test and urine creatinine test, 4 days or less apart.

## ELIGIBLE POPULATION

Members 18 – 85 years of age during the MY. Three age stratifications and the total are reported:

- 18 - 64 years
- 65 years - 75 years
- 76 - 85 years
- Total

## TIMELINE/LOOKBACK PERIOD

January 1, MY - December 31, MY

## TIPS

- An eGFR and uACR can be on the same or different dates of service during the MY.
- A Quantitative Urine Albumin test and a Urine Creatinine Lab test with different dates of service meet criteria for uACR if four days or less apart.

## ACCEPTABLE DOCUMENTATION

- ✓ eGFR and uACR test results can be taken from any section of the medical record and from any type of visit.
- ✓ Documentation in member's medical record that the test was done in the doctor's office with date and result.
- ✓ Members reported results in the medical history portion of the progress notes from a PCP or appropriate specialist meet criteria if date and results are present.
- ✓ Diabetic flowsheets with test date and result

## UNACCEPTABLE DOCUMENTATION

- ✓ Home test results or dipsticks
- ✓ Documentation in the medical record without exact date or result. ("most recent eGFR," "last visit uACR," "eGFR withing normal range")
- ✓ Results on a fax coversheet.

## QUALIFYING EVENT/DIAGNOSIS

Members identified as having diabetes by either:

- Claims/encounter data - with at least **two** diagnoses of diabetes on different dates of service during the MY or PY.

  ***or***

- Pharmacy claims data + Claims/encounter data - dispensed insulin or hypoglycemics/antihyperglycemics **and** at least one diagnosis of diabetes during the MY or PY.

## REQUIRED EXCLUSIONS

- Members with a diagnosis of ESRD anytime during their history through December 31, MY.
- Members who had dialysis anytime during their history through December 31, MY.
- Members 66 years of age or older during the MY who were either:
  - Enrolled in an Institutional SNP (I-SNP) during the MY or
  - Living long-term in an institution during the MY.
- Members 66 – 80 years of age during the MY who meet the criteria for both frailty and advanced illness.
- Members 81 years of age or older during the MY with at least two indications of frailty during the MY.
- Members who received palliative care during the MY.
- Members who used hospice during the MY.
- Members who died during the MY.

# (LBP) Use of Imaging Studies for Low Back Pain

*Product Lines:* ***Medicaid, Marketplace, Medicare***

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

## ELIGIBLE POPULATION

Members 18 – 75 years of age with a principal diagnosis of uncomplicated lower back pain. Two age stratifications and the total are reported:

- 18 - 64 years
- 65 - 75 years
- Total

## TIMELINE/LOOKBACK PERIOD

January 1, MY – December 3, MY

## TIPS

- IESD – Index Episode Start Date
- Supplemental data can only be used for required exclusions.
- An eligible encounter includes any outpatient, ED, telephone, e-visit, virtual check-in, physical therapy, osteopathic, or chiropractic visit with uncomplicated low back pain as principal diagnosis.
- The member must have no claims with uncomplicated low back pain in the 180 days prior.

## QUALIFYING EVENT/ELIGIBLE ENCOUNTER

The earliest date of service for an eligible encounter with low back pain is the principal diagnosis.

## REQUIRED EXCLUSIONS

| | TIMEFRAME | |
|---|---|---|
| **Exclusion Reason** | **Days prior to IESD through** | **Number of Days after IESD** |
| Cancer –Malignant or other Neoplasms | Anytime during their history | 28 days after IESD |
| Recent trauma | 90 days prior to IESD | 28 days after IESD |
| Fragility fracture | 90 days prior to IESD | 28 days after IESD |
| IV Drug abuse | 365 days prior to IESD | 28 days after IESD |
| Neurologic impairment | 365 days prior to IESD | 28 days after IESD |
| Spinal infection | 365 days prior to IESD | 28 days after IESD |
| Use of corticosteroids 90 consecutive days or more | 365 days prior to IESD | The day of IESD |
| HIV | Anytime during their history | 28 days after IESD |
| Major Organ transplant | Anytime during their history | 28 days after IESD |
| Osteoporosis/ Osteoporosis therapy | Anytime during their history | 28 days after IESD |
| Lumbar surgery | Anytime during their history | 28 days after IESD |
| Spondylopathy | Anytime during their history | 28 days after IESD |

- Members 66 years and older with both frailty and advanced illness during the MY.
- Frailty-Two or more indications of frailty on two separate dates of service during the MY meets frailty criteria.
- Advanced illness-two or more indications of advanced illness on separate dates of service OR dispensed dementia medication during the MY or the PY meet advanced illness criteria.
- Members who received palliative care during the MY.
- Members who used hospice during the MY.
- Members who died during the MY.

# (LSC) Lead Screening in Children

*Product Lines:* ***Medicaid***

The percentage of members who had at least one lead capillary or venous blood test on or before their 2nd birthday.

## ELIGIBLE POPULATION

Members who turned 13 years of age during MY.

## TIMELINE/LOOKBACK PERIOD

Member's 9th birthday - 13th birthday.

## TIPS

- Documentation may be taken from any section of the medical record but must include:
  - The date the test was performed.
  - Result or finding.
- Parent refusal does not exclude the member from measure.

| DOCUMENTATION |
| --- |
| **MEETS CRITERIA** |

- ✓ A copy of the lab with the result.
- ✓ Results documented in the notes of the member's record. Any of the following notes meets criteria:
  - A lead screening number value, "Negative," "Positive," "Normal," "Abnormal," "WNL,' "Low," "None Noted."
- ✓ Parent/Caregiver reported results meet criteria if they include a date and result.

| **DOES NOT MEET CRITERIA** |
| --- |

- ✓ Continuity of Care documents
- ✓ Documentation on a fax cover sheet.

## REQUIRED EXCLUSIONS

- Members who used Hospice or anytime during measurement period.
- Members who died anytime during the measurement period.

# (OED) Oral Evaluation, Dental Services

*Product Lines:* ***Medicaid***

The percentage of members under 21 years of age who received a comprehensive or periodic oral evaluation with a dental provider during the MY.

## ELIGIBLE POPULATION

Members who were under 21 years of age before December 31, MY. Four age stratifications and the total are reported.

- 0 - 2 years
- 3 - 5 years
- 6 - 14 years
- 15 - 20 years

## TIMELINE/LOOKBACK PERIOD

January 1, MY - December 31, MY.

## TIPS

- Educate parents/guardians on the importance of dental health.
- Member outreach events, postcards, phone calls, text messages, emails, etc.
- Assist parents/members with finding a dental provider and scheduling appointments.
- ADV (Annual Dental Visit) retired. OED was introduced in MY23.

## QUALIFYING EVENT/DIAGNOSIS

None

## REQUIRED EXCLUSIONS

- Members who used hospice during the MY.
- Members who died during the MY.

# (OMW) Osteoporosis Management in Women Who Had a Fracture

*Product Lines:* ***Medicare***

The percentage of women 67 – 85 years of age who suffered a fracture and had either a bone mineral density (BMD) test or prescription for a drug to treat osteoporosis in the six months (180 days) after the fracture.

## ELIGIBLE POPULATION

Women 67 – 85 years of age during the MY.

## INTAKE PERIOD

July 1, PY - June 30, MY.

## TIPS

- Ask members about any fractures that are treated by another provider/healthcare facility.
- *Fractures of the face, skull, fingers, or toes are not included.
- IESD – Index Episode Start Date. The earliest episode date that meets the measure criteria.
- Episode Date – The date of service for the encounter.
  - Outpatient, observation, or ED visit - the date of service.
  - Inpatient stays - the date of discharge.
  - Direct transfers - the discharge date from the last admission.
- Appropriate testing or treatment for osteoporosis includes any of the following on or during the 180 days following the IESD:
  - A Bone Mineral Density Test
  - A Claim/Encounter for Osteoporosis Therapy
  - A prescription dispensed to treat osteoporosis.

| OSTEOPOROSIS MEDICATIONS | | |
|---|---|---|
| **Bisphosphonates** | • Alendronate<br>• Alendronate-Cholecalciferol | • Ibandronate<br>• Risedronate<br>• Zoledronic acid |
| **Other agents** | • Abaloparatide<br>• Denosumab<br>• Raloxifene | • Romosozumab<br>• Teriparatide |

## QUALIFYING EVENT/DIAGNOSIS

A claim/encounter with a diagnosis of fracture.

## REQUIRED EXCLUSIONS

- Women who had a BMD test during the 24 months prior to the fracture.
- Women who had osteoporosis therapy or dispensed a prescription to treat osteoporosis during the 12 months prior to the fracture.
- Women 67+ years of age or older during the MY who were either enrolled in an Institutional SNP (I-SNP) or living long-term in an institution during the intake period through the end of the MY.
- Women 67 – 80 years of age during the MY who meet the criteria for both frailty and advanced illness.
- Women 81 years of age and older during the MY who meet the criteria for frailly during the intake period through the end of the MY.
- Women receiving palliative care during the MY.
- Women who used hospice during the MY
- Women who died during the MY.

# (OSW) Osteoporosis Screening in Older Women

*Product Lines:* ***Medicare***

The percentage of women 65 – 75 years of age who received osteoporosis screening.

## ELIGIBLE POPULATION

Women 65 – 75 years of age during the MY.

## TIMELINE/LOOKBACK PERIOD

The member's 65th birthday - December 31, MY

## TIPS

- Assist with scheduling the DEXA scan.
- Education on the importance of osteoporosis screening and risks of osteoporosis.

## QUALIFYING EVENT/DIAGNOSIS

None

## REQUIRED EXCLUSIONS

- Women who have claim/encounter for osteoporosis therapy or had a dispensed prescription to treat osteoporosis anytime in their history through December 31st of PY.
- Women who had a dispensed prescription to treat osteoporosis anytime on or between January 1st, 3 years prior through December 31st of the PY.
- Women 66 years of age and older with both frailty and advanced illness.
- Women who received palliative care during the MY.
- Women who used hospice during the MY.
- Women who died during the MY.

# (PPC) Prenatal and Postpartum Care

*Product Lines:* ***Medicaid, Marketplace***

The percentage of deliveries of live births on or between October 8th of the prior year through October 7th of the MY.

Two facets are assessed:

- **Timeliness of Prenatal Care** – The percentage of deliveries that received a prenatal care visit during 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 7 – 84 days after delivery.

## ELIGIBLE POPULATION

The number of live birth deliveries.

## TIMELINE/LOOKBACK PERIOD

October 8, PY – October 7, MY.

## TIPS

- Educate pregnant members about healthy baby programs and/or assist them with enrollment.
- Schedule postpartum visits prior to discharge after delivery.
- If a member has more than one live birth delivery in a 180 day period, only the first delivery is used.
- If more than one live birth delivery occurs more than 180 days apart, between October 8th of PY and October 7th of MY, both can be used. Deliveries should be identified chronologically.
- Visits that occurred before the member was enrolled meet criteria.
- Deliveries from any setting meet criteria.

## ACCEPTABLE PRENATAL DOCUMENTATION

- ✓ A prenatal visit with the appropriate provider type during the first trimester, 280 – 176 days prior to delivery or Estimated Delivery Date (EDD), or within 42 days of enrollment in the organization. LMP may not be used to calculate the first trimester.
- ✓ Appropriate providers for PPC include a PCP, OB/GYN (or Nurse Practitioner, Physician's Assistant, or Nurse Midwife in the OB/GYN practice).
- ✓ Synchronous telehealth or telehealth visits with documentation of LMP, EDD, gestational age, or complete obstetrical history
- ✓ Documentation of a member seeing a Midwife at a birthing center meets criteria.
- ✓ ED visits and inpatient visits by an OB/GYN with reference to pregnancy., physical obstetrical exam, or evidence that a prenatal care procedure was performed.
- ✓ Evidence of one of the following must be present in the record:
  - A reference to pregnancy
    - Standardized prenatal flow sheet.
    - LMP (Month/Year), EDD, or gestational age
    - Positive pregnancy test result
    - Gravity or Parity
    - A complete obstetrical history
    - A prenatal risk assessment and counseling/education
  - A basic physical obstetrical exam including at least one of the following:
    - Fetal heart tone, FHT. ("present," a numeric rate, "doppler," "Dop," "WNL")
    - The pelvic exam with obstetrical with obstetrical findings - uterus size, effacement, etc.
    - Fundus height – Qualitative or quantitative, specific to fundus measurement (S=D, S<D, or S>D).
  - The following meet criteria but must be combined with an office visit with an appropriate practitioner.
    - Obstetrical panel – must include all: hematocrit, differential WBC count, platelet count, hepatitis B surface antigen, rubella antibody, syphilis test, RBC antibody screen, RH and ABO typing.
    - TORCH antibody panel
    - Rubella antibody test/titer with an Rh incompatibility (ABO/Rh) blood typing
    - Ultrasound of a pregnant uterus linked to an office visit.

## ACCEPTABLE POSTPARTUM DOCUMENTATION

- ✓ Office visits, urgent care, telehealth, telephone, e-visits, and virtual check-ins with the appropriate PCP or OB/GYN provider 7 – 84 days after delivery.
- ✓ Postpartum care from in an acute inpatient setting does not meet criteria.
- ✓ One of the following must be present in the record:
  - Documented reason for visit is Postpartum care – Preprinted Postpartum form, checklist, or notation of "PP care," "PP check," "6-week check", etc.
  - A Pelvic exam, a Pap Test, or IUD insertion.
  - Evaluation of the following (all four must be present):
    - Weight
    - Blood Pressure
    - Breasts/Breastfeeding
    - Abdomen
  - Perineal or cesarean incision check
  - Depression, tobacco use, substance use disorder or pre-existing mental health disorder screenings.
  - Glucose screening (if member had gestational diabetes)
  - Discussion about any of the following topics:
    - Infant care or breastfeeding
    - Sleep/fatigue
    - Resumption of physical activity
    - Attainment of healthy weight
    - Resumption of intercourse, birth spacing, or family planning

### QUALIFYING EVENT/DIAGNOSIS

Live birth deliveries, October 8th of PY through October 7th of MY.

### REQUIRED EXCLUSIONS

- A delivery that did not result in a live birth.
- Members who used hospice during the MY.
- Members who died during the MY

# (TFC) Topical Fluoride for Children

*Product Lines:* ***Medicaid***

The percentage of members 1 – 4 years of age who received at least two fluoride varnish applications during the MY.

## ELIGIBLE POPULATION

Members who were 1 - 4 years of age during the MY. Two age stratifications and total are reported.

- 1 - 2 years
- 3 - 4 years
- Total

## TIMELINE/LOOKBACK PERIOD

January 1, MY - December 31, MY.

## TIPS

- Educate parent/guardian the importance of dental health.
- Assist parents/members with finding a dental provider and scheduling appointments.
- Member outreach events, postcards, phone calls, text messages, emails, etc.
- TFC was introduced in MY23.

## QUALIFYING EVENT/DIAGNOSIS

- No event/diagnosis. The member's age qualifies them for this measure.

## REQUIRED EXCLUSIONS

- Members who used hospice during the MY.
- Members who died during the MY.

# (TRC) Transitions of Care

*Product Lines:* ***Medicare***

The percentage of inpatient discharges for members 18 years of age or older who had each of the following:

- **Notification of Inpatient Admission.** Documentation of receipt of notification of inpatient admission
  - On the day of admission through two days after the admission (3 days total).
- **Receipt of Discharge Information.** Documentation of receipt of discharge information.
  - On the day of discharge through two days after the discharge (3 days total).
- **Patient engagement after Inpatient Discharge**. Documentation of patient engagement (office visit, home visit, telehealth).
  - The day after discharge through 30 days after discharge (30 days total).
- **Medication Reconciliation Post-Discharge**. Documentation of medication reconciliation.
  - On the date of discharge through 30 days after discharge (31 days total).

## ELIGIBLE POPULATION

Members 18 years of age or older during the MY. Two age stratifications and total are reported:

- 18 - 64 years
- 65 years and older
- Total

## TIMELINE/LOOKBACK PERIOD

January 1, MY - December 31, MY

## TIPS

- If the member is readmitted or has a direct transfer to an acute or nonacute inpatient care setting on the date of discharge through 30 days after discharge, use the admit date from the first admission and the discharge date from the last discharge.
- Schedule follow-up appointments prior to the member's discharge from hospital.
- Ongoing Care Provider (OCP). A provider who is responsible for the member's care after discharge.

## ACCEPTABLE DOCUMENTATION

### NOTIFICATION OF INPATIENT ADMISSION

✓ Inpatient providers, emergency department staff, or specialist communication documented in the MR about the admission to the member's PCP or OCP.
Any of the following meet criteria:
- Phone call
- Health Information Exchange System
- Email
- Communication from the member's health plan
- Fax
- PCP/OCP admitted member to hospital
- EMR

✓ Communication prior to or during the admission that indicate the PCP/OCP had knowledge of member's admission are exceptions:
- The PCP or OCP placed orders for test/treatments any time during the patient's stay.
- The PCP/OCP performed pre-admission exam or received information about the admission prior to the admission.

✓ Observation days prior to admission dates are not counted.
✓ The PCP or OCP sending the member to the ER does not meet criteria as they should be notified of inpatient admission from the ER.
✓ The member or member's family notifying the PCP/OCP does not meet criteria.

### RECEIPT OF DISCHARGE INFORMATION

✓ Discharge information must include all the following information:
- The inpatient provider is responsible for the member's care during the inpatient stay.
- Procedures or treatment provided during the inpatient stay.
- Diagnosis at discharge.
- Current Medication List
- Testing Results, documentation of pending tests or no tests pending.
- Discharge Instructions

**If the PCP/OCP is the discharging provider, the information must be in the medical record within 3 days of discharge.*

## PATIENT ENGAGEMENT AFTER INPATIENT DISCHARGE

✓ Documentation of patient engagement within 30 days after discharge (not including the day of discharge) must include any of the following:
- An outpatient visit, office visit, or home visit.
- Telephone visit or synchronous telehealth visit where real-time interaction occurred between the member and provider using audio and video communication.
- An e-visit or virtual check-in (asynchronous telehealth visit with 2-way interaction between provider and member).
- Transitional care management services.

*Communication with a caregiver meets criteria if member is unable to communicate.*

## MEDICATION RECONCILIATION POST-DISCHARGE

✓ Documentation of the current medications (prescription, over the counter, herbal, supplements, etc.) with notation of any of the following:
- The provider reconciled the current and discharged medications.
- A notation referencing the discharge medications such as “no changes in medications since discharge," "same medications at discharge," "discontinue all discharge medications,” or “no medications were prescribed at discharge,” etc.
- The discharge medications were reviewed or both lists were reviewed on the same date of service.
- Evidence the member was seen for post-discharge hospital follow-up with medication reconciliation or review.
- Medication reconciliation performed by a prescribing practitioner, clinical pharmacist, physician assistant, or registered nurse meet criteria.

*The medication list may contain the medication name only or medication name with dosage and/or frequency.*
*The member does not need to be present for medication reconciliation.*

### QUALIFYING EVENT/DIAGNOSIS

An acute or non-acute inpatient discharge on or between January 1, MY - December 1, MY.

### REQUIRED EXCLUSIONS

- Members who remain in an acute or nonacute facility on or after 12/1/MY.
- Members who used hospice serviced during the MY.
- Members who died during the MY.

# (URI) Appropriate Treatment for Upper Respiratory Infection

*Product Lines:* ***Medicaid***, ***Marketplace***, ***Medicare***

The percentage of episodes for members 3 months of age or older who had a diagnosis of upper respiratory infection, and an antibiotic was not dispensed.

## ELIGIBLE POPULATION

Members 3 months of age or older as of the episode date. Three age stratifications and the total are rated.

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

## TIMELINE/LOOKBACK PERIOD

July 1, PY - June 30, MY

## TIPS

- A higher rate indicates appropriate URI treatment.
- The URI measure is calculated per episode; therefore, a member can have more than one episode during the intake period. If a member has more than one eligible episode in a 31-day period, the first episode is used.
- Exclude the following URI episode dates:
  - Result in an inpatient stay.
  - An antibiotic prescription (new or refill) was dispensed during the 30 days prior to or was active on the episode date.
  - A claim/encounter with a diagnosis for a co-morbid condition during the 12 months prior through the episode date.
  - A claim/encounter with a diagnosis of pharyngitis or other competing diagnosis on or during the three days following the episode date.
- Educate members on the difference between viral and bacterial infections and risks of antibiotic overuse.
- Educate members on managing symptoms of a URI (increase fluid intake, throat lozenges, over the counter pain relievers and cold medicine, saline nasal drops, decongestants, antihistamines, humidifiers, etc.

### QUALIFYING EVENT/ELIGIBLE ENCOUNTER

An outpatient, telephone, ED visit, e-visit, or virtual check-in during the intake period with a diagnosis of URI.

### REQUIRED EXCLUSIONS

- Members who used hospice during the MY.
- Members who died during the MY.

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

*Product Lines:* ***Medicaid***, ***Marketplace***

The percentage of members between the age of birth and 30 months who had the appropriate number of well-child visits with a PCP. Two rates reported:

- Birth to 15 months – 6 or more well-child visits.
- 15 months to 30 months – 2 or more well-child visits.

### ELIGIBLE POPULATION

Members who turned 15 months during the MY.
Members who turned 30 months during the MY.

### TIMELINE/LOOKBACK PERIOD

Birth - 30 months of age.

## (WCV) Child and Adolescent Well-Care Visits

*Product Lines:* ***Medicaid***, ***Marketplace***

The percentage of members 3 to 21 years old had at least one well-care visit with a PCP or OB/GYN during the MY.

### ELIGIBLE POPULATION

Members who are 3 to 21 years old. The total plus three separate age stratifications are reported:

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

### TIMELINE/LOOKBACK PERIOD

January 1, MY – December 31, MY

# W30 and WCV

*Product Lines:* ***Medicaid***, ***Marketplace***

## TIPS

- The PCP does not have to be the PCP assigned to the member to meet criteria.
- A Comprehensive visit can be completed during a visit for an acute or chronic condition. (ex: visit for medication refill, visit for skin rash, etc.)
- **Best Practices:**
  - Schedule future appointments before parent, caregiver, or patient leaves the office.
  - Send appointment reminders – Postcards, email, text, or phone calls, and have them print their names and addresses on the postcards.
  - Educate parents, caregivers, or patients about the importance of well-child visits.

## QUALIFYING EVENT/DIAGNOSIS

None

## REQUIRED EXCLUSIONS

- Members who used hospice care anytime during the MY.
- Members who died during the MY.
- Telehealth visits no longer meet the criteria for these measures.

# (WCC) Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents

*Product Lines:* ***Medicaid***, ***Marketplace***

The percentage of members 3-17 years of age who had an outpatient visit with a PCP or OB/GYN and evidence of the following during the MY.

- BMI Percentile (including height and weight)
- Counseling for Nutrition
- Counseling for Physical Activity or referral for physical activity

## ELIGIBLE POPULATION

Members who turned 3 - 17 years of age during MY.

## TIMELINE/LOOKBACK PERIOD

January 1, MY - December 31, MY.

## TIPS

Documentation from any type of visit/encounter meets criteria (ED visit, outpatient and inpatient encounters, school-based clinics, specialists, telehealth visit, e-visit, or virtual check-in).

## DOCUMENTATION - MEETS CRITERIA

### BMI PERCENTILE

- ✓ BMI percentile, height, and weight documented as a value in the medical record.
- ✓ BMI percentile, height, and weight plotted on an age-growth chart.
- ✓ Documentation by any provider type (Dietitian, RN, LPN, Medical Assistant…)
- ✓ BMI Percentile documented as ">99%" or "<1%" (indicating 100% or 0%)
- ✓ Member reported values recorded by a PCP or specialist who is providing care for the condition assessed.

### COUNSELING FOR NUTRITION

- ✓ Documentation that the child's current eating habits or nutritional behaviors were discussed.
  - Ex: "well-balanced diet," "eats adequate fruits and vegetables"
- ✓ A checklist with nutrition marked.
- ✓ Educational materials for nutrition provided during a face-to-face visit.
- ✓ Anticipatory guidance for nutrition
- ✓ Nutrition, weight, eating disorders, or obesity counseling.
- ✓ Referral for nutrition education
- ✓ Referral to WIC

### COUNSELING FOR PHYSICAL ACTIVITY

- ✓ Documentation that the child's current physical activity routine, habits, or behaviors was discussed.
  - Ex: "gets adequate amount of exercise, participates in sports," "does not get adequate amount of exercise."
- ✓ A checklist with physical activity discussion marked.
- ✓ Educational materials for physical activity or exercise provided during a face-to-face visit.
- ✓ Anticipatory guidance specific to physical activity
- ✓ Physical Activity or exercise counseling or referral
- ✓ Weight or obesity counseling

## DOCUMENTATION - DOES NOT MEETS CRITERIA

### BMI PERCENTILE

- ✓ BMI value alone, without the percentile
- ✓ BMI percentile without height and weight
- ✓ Documentation from a fax cover sheet.
- ✓ Documentation from Continuity of Care Documents
- ✓ A BMI percentile value documented as "approximate" or "estimated."
- ✓ BMI percentile range (ex: 70-75%)
- ✓ BMI percentile documented as a threshold (>75% or <25%) *unless >99% or <1%
- ✓ Member reported values that were not recorded by a PCP or specialist providing care related to the condition assessed

### COUNSELING FOR NUTRITION

- ✓ Documentation about the child's appetite
  - Ex: "has poor appetite," appears well-nourished)
- ✓ Documentation about a diet related to an acute or chronic condition or illness.
  - Ex: BRAT diet for diarrhea
  - Loss of appetite due to medication side effects.

### COUNSELING FOR PHYSICAL ACTIVITY

- ✓ Physical activity discussion pertaining to an acute or chronic condition or injury.
  - Ex: "cleared for gym class," "may return to PE," "walking with a limp"
- ✓ Documentation of developmental milestones
  - Ex: "able to ride bike without training wheels," "can jump on one foot"
- ✓ Documentation about safety alone
  - Ex: "wears helmet," "wears lifejacket"
- ✓ Documentation about screen-time alone
  - Ex: "plays video games 2 hours a day"

## REQUIRED EXCLUSIONS

- Members with a diagnosis of pregnancy during the MY.
- Members who used hospice anytime during the MY.
- Members who died anytime during the MY.

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