Health Insurance Exchange

2027 Quality Rating System Measure Technical Specifications

March 2026

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Technical Assistance and Contact Information

The following links and contact information should be used to obtain additional details and technical assistance related to the Quality Rating System (QRS) measure set for 2027 (Measurement Year 2026).

Website Links

- Centers for Medicare & Medicaid Services (CMS) Health Insurance Marketplace Quality Initiatives website: https://www.cms.gov/marketplace/about/health-insurance-marketplace-quality-initiatives

- National Committee for Quality Assurance (NCQA) Healthcare Effectiveness Data and Information Set (HEDIS®)[1] Compliance Audit™ website: https://www.ncqa.org/programs/data-and-information-technology/hit-and-data-certification/hedis-compliance-audit-certification/

Contact Information

- For questions regarding the QRS clinical measure specifications, please contact the appropriate measure steward:
  1. NCQA for the HEDIS measures: via the Policy Clarification Support (PCS) system available at https://my.ncqa.org/
  2. Pharmacy Quality Alliance (PQA) for the PQA measures: https://www.pqaalliance.org/QRS

- For questions regarding the general guidelines for data collection, please contact NCQA via the PCS system available at https://my.ncqa.org/

- For questions regarding QRS survey measures, the Qualified Health Plan (QHP) Enrollee Survey, or QRS requirements, please contact the Marketplace Service Desk (MSD) via email at CMS_FEPS@cms.hhs.gov or via phone at 1-855-CMS-1515 (1-855-267-1515). Reference the "Marketplace Quality Initiatives (MQI)-QRS."

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

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1. Introduction

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Introduction

Document Purpose

This document includes the measure specifications and guidelines for data collection for the 2027 Quality Rating System (QRS) measure set. QHP issuers will need to reference this document to collect and submit QRS measure data to the Centers for Medicare & Medicaid Services (CMS) in accordance with the QRS 2027 requirements. The document specifically details the following:

- *QRS measure set*. This section includes a list of the QRS measures and a brief background on the QRS measure set. The QRS measure set comprises clinical quality measures, including the NCQA Healthcare Effectiveness Data and Information Set (HEDIS) measures and PQA measures. The measure set also includes survey measures based on questions from the Qualified Health Plan Enrollee Experience Survey (QHP Enrollee Survey).

- *QRS clinical measure technical specifications*. This section includes measure specifications and data collection guidelines for NCQA's HEDIS measures and the PQA measures in the QRS measure set. For the PQA measures, QHP issuers should refer to NCQA's "General Guidelines for Data Collection and Reporting" (see Section 3.1 for guidance related to data collection protocols, with the exception of a few guidelines specific to the PQA measures as noted in Section 3.2).

- *QRS survey measure technical specifications*. This section includes descriptions for the survey measures in the QRS measure set that will be collected as part of the QHP Enrollee Survey.

CMS anticipates updating this document on an annual basis to reflect any changes to the measure set, including changes to the measure specifications or data collection guidelines. This document includes the measure specifications for all potential measures in the 2027 QRS measure set (i.e., any measures proposed for addition and removal in the *Draft 2026 Call Letter for the QRS and QHP Enrollee Survey*).[2]

In the fall of 2026, CMS intends to publish the *Quality Rating System and Qualified Health Plan Enrollee Experience Survey: Technical Guidance for 2027* (2027 QRS and QHP Enrollee Survey Technical Guidance), reflecting applicable finalized changes announced in the *Final 2026 QRS and QHP Enrollee Survey Call Letter*. The 2027 QRS and QHP Enrollee Survey Technical Guidance will announce which measures eligible QHP issuers are required to collect and submit to CMS for the 2027 QRS ratings year.

Background

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

[2] The Draft 2026 Call Letter for the QRS and QHP Enrollee Survey is available at: https://www.cms.gov/files/document/draft-2026-call-letter-qrs-qhp-enrollee-survey-february-2026.pdf
[3] 45 CFR § 156.200(b)(5)(h); § 156.1120; and § 156.1125.
[4] The QHP Enrollee Survey includes a core question set that will be used to assess enrollees' experience with health care services. Specific questions are grouped to form survey measures that will be used in the QRS.

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2. QRS Measure Set

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QRS Measure Set

The QRS measure set consists of measures that address areas of clinical quality management; enrollee experience; and plan efficiency, affordability, and management. Exhibit 1 includes the list of all potential QRS measures for 2027 as proposed in the *Draft 2026 Call Letter for the QRS and QHP Enrollee Survey*. Measures denoted with a strikethrough (–) are under consideration for retirement or removal from the QRS measure set. If these measures are removed as proposed, they will not be collected for the 2027 ratings year. Measures denoted with an asterisk (*) are under consideration for addition to the QRS measure set. If these measures are finalized as proposed, they will be required for 2027 QRS data collection but will not be included in 2027 QRS scoring. The measures collected using the ECDS reporting method are noted with a euro sign (€). CMS will communicate final changes to the 2027 QRS measure set in the *Final 2026 Call Letter for the QRS and QHP Enrollee Survey*, which CMS anticipates publishing in late spring 2026.

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

Some measures have multiple indicators (or rates). QHP issuers are required to collect and submit validated data for every indicator associated with a measure.

Exhibit 1. Proposed 2027 QRS Measures

Measure Title	Measure Steward	Consensus-Based Entity (CBE) ID[6]
QRS Clinical Measures		
Adult Immunization Status (AIS-E)€	NCQA	3620
Appropriate Treatment for Upper Respiratory Infection	NCQA	0069
~~Asthma Medication Ratio~~	~~NCQA~~	~~1800~~
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis	NCQA	0058
Blood Pressure Control for Patients with Hypertension (BPC-E)€	NCQA	N/A
Breast Cancer Screening (BCS-E)€	NCQA	2372
Cervical Cancer Screening (CCS-E)€	NCQA	0032
Child and Adolescent Well-Care Visits	NCQA	N/A
~~Childhood Immunization Status (Combination 10) (CIS-E)~~€	~~NCQA~~	~~0038~~
Chlamydia Screening in Women	NCQA	0033
Colorectal Cancer Screening (COL-E)€	NCQA	0034
Controlling High Blood Pressure	NCQA	0018
Depression Screening and Follow-Up for Adolescents and Adults (DSF-E)	NCQA	0418
Enrollment by Product Line[7]	NCQA	N/A
Eye Exam for Patient with Diabetes	NCQA	0055
Glycemic Status Assessment for Patients With Diabetes: Glycemic Status >9.0%	NCQA	0575

[5] CAHPS is a registered trademark of the Agency for Healthcare Research and Quality. The surveys are available at https://www.ahrq.gov/cahps/surveys-guidance/index.html.
[6] Definitions of CBE-endorsed measures can be found on the Partnership for Quality Measurement website at https://p4qm.org/.
[7] The *Enrollment by Product Line* measure is listed as a QRS clinical measure for the purposes of this document; however, CMS is collecting data for this descriptive information measure separately from other measures to support measure validation and other processes. *Enrollment by Product Line* measure data will not be used in QRS scoring.

2. QRS Measure Set

Measure Title	Measure Steward	Consensus-Based Entity (CBE) ID[6]
Follow-Up After Acute and Urgent Care Visits for Asthma (AAF-E)*€	NCQA	N/A
Follow-Up After Hospitalization for Mental Illness (7-Day Follow-Up and 30- Day Follow-Up)	NCQA	0576
~~Immunizations for Adolescents (Combination 2) (IMA-E)€~~	~~NCQA~~	~~1407~~
Initiation and Engagement of Substance Use Disorder Treatment	NCQA	0004
Kidney Health Evaluation for Patients with Diabetes	NCQA	N/A
Oral Evaluation, Dental Services	DQA & NCQA[8]	2517
Plan All-Cause Readmissions	NCQA	1768
Prenatal and Postpartum Care	NCQA	1517
Proportion of Days Covered: Diabetes All Class	PQA	0541
Proportion of Days Covered: Renin Angiotensin System Antagonists	PQA	0541
Proportion of Days Covered: Statins	PQA	0541
Tobacco Use Screening and Cessation Intervention (TSC-E)*€	NCQA	N/A
Use of Imaging Studies for Low Back Pain	NCQA	0052
Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents	NCQA	0024
Well-Child Visits in the First 30 Months of Life	NCQA	1392
QRS Survey Measures		
Access to Care	Agency for Healthcare Research and Quality (AHRQ), CMS	0006
Access to Information	AHRQ, CMS	0007
Care Coordination	AHRQ, CMS	0006
Enrollee Experience with Cost	AHRQ, CMS	N/A
~~Medical Assistance with Smoking and Tobacco Use Cessation~~	~~NCQA~~	~~0027~~
Plan Administration	AHRQ, CMS[9]	0006
Rating of All Health Care	AHRQ	0006
Rating of Health Plan	AHRQ	0006
Rating of Personal Doctor	AHRQ	0006
Rating of Specialist	AHRQ	0006

[8] This measure has been adapted by NCQA, with permission, from a measure owned by the American Dental Association (ADA) on behalf of the Dental Quality Alliance (DQA). The ADA (on behalf of the DQA) is the steward for the CBE-endorsed measure ID 2517.

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

3. QRS Clinical Measure Specifications

3.1 NCQA Measure Specifications

3.2 PQA Measure Specifications

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HEDIS® for QRS
Measurement Year 2026 (MY 2026)

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

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Overview

HEDIS MY 2026

The Healthcare Effectiveness Data and Information Set (HEDIS) is one of the most widely used sets of health care performance measures in the United States. HEDIS tracks how well health care organizations deliver and support the use of essential health services for their enrolled populations.

How HEDIS Is Developed

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

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

This publication contains specifications for Measurement Year 2026 (MY 2026). MY 2026 refers to the 2026 calendar year data that is reported on June 15, 2027 (2027 ratings year).

Please note that this publication includes the specifications for measures and/or measure rates that are proposed for inclusion or removal in the 2027 QRS measure set in the *Draft 2026 Call Letter for the Quality Rating System (QRS) and Qualified Health Plan (QHP) Enrollee Experience Survey* (Draft 2026 Call Letter). Refer to the *Final 2026 Call Letter for the QRS and QHP Enrollee Experience Survey* (Final 2026 Call Letter), anticipated June/July 2026, for finalized changes.

The *Quality Rating System and Qualified Health Plan Enrollee Experience Survey: Technical Guidance for 2027* (2027 QRS and QHP Enrollee Survey Technical Guidance) will announce which measures eligible QHP issuers are required to collect and submit to CMS for the 2027 ratings year.

Proposed new measures	• Follow-Up After Acute and Urgent Care Visits for Asthma (AAF-E) • Tobacco Use Screening and Cessation Intervention (TSC-E)
Proposed removed measures	• Childhood Immunization Status (CIS-E) • Immunizations for Adolescents (IMA-E) Please note that retired measures proposed for removal are not included in this publication: • Asthma Medication Ratio (AMR) • Medical Assistance With Smoking and Tobacco Use Cessation (MSC)
Revised measures	For specific revisions, refer to each measure's *Summary of Changes* for a complete summary.

Overall changes

- Updated the formatting of all HEDIS measures (with the exception of the *Enrollment by Product Line* measure) to align with the FHIR® standard. These changes are intended to enable future interoperability of human-readable technical specifications, and do not modify the intent or calculation of a measure.
  - Added measurement period, copyright and disclaimer notice, clinical recommendation statement/rationale and characteristic sections.
  - Updated terminology (replaced "measurement year" with "measurement period"; "members" with "persons"; "eligible population" with "initial population"; "required exclusions" with "denominator exclusions").
  - Reformatted the initial population section. Attribution now describes health plan enrollment criteria.
  - Removed medication list tables, where applicable. This information can be found in the Medication List Directory (MLD). The medication list tables remain only in measures where the information in the tables is required for measure calculation.
  - For measures using the hybrid methodology, replaced "denominator identified via administrative specifications" with "administrative denominator."
- Updated the data element tables to align with changes to the measure format.
- Removed Source System of Record (SSoR) reporting from all ECDS reported measures.
- Removed the domain-specific guidelines for Effectiveness of Care Measures, Access/Availability of Care Measures, Risk Adjusted Utilization and ECDS measures. Moved the applicable guidelines to the measure narratives.
- Added, removed and edited glossary terms in Appendix 1. Separated provider type requirements from general glossary terms.

Technical specification updates—HEDIS MY 2026

NCQA will freeze the HEDIS specifications for MY 2026 with the *QRS Measure Technical Specifications* release (March 2026).

The Centers for Medicare & Medicaid Services (CMS) publishes guidance for Qualified Health Plans (QHP) in the Exchanges to specify requirements for participating in the Quality Rating System (QRS), including the clinical and survey measures that must be reported. The *2027 QRS and QHP Enrollee Survey Technical Guidance* will be posted to the CMS Marketplace Quality Initiatives (MQI) website in the fall of 2026.

Additionally, CMS publishes an **updated** version of the *QRS Measure Technical Specifications*, which includes guidance on the finalized data submission requirements for the QRS measure set. Specifically, CMS includes callout boxes summarizing the final decision regarding measures and/or measure rates proposed for addition and those proposed for removal in the Draft Call Letter and finalized via the Final Call Letter. CMS anticipates releasing an updated version of the *QRS Measure Technical Specifications* when refinements to the QRS measures and/or measure rates are addressed via the QRS and QHP Enrollee Survey Call Letter process and finalized via the Final Call Letter. The updated *2027 QRS Measure Technical Specifications for MY 2026* will be posted to the CMS Marketplace Quality Initiatives (MQI) website in the fall of 2026.

HEDIS MY 2026 for Quality Rating System Reporting Resources Bundle

The HEDIS MY 2026 for Quality Rating System Reporting Resources Bundle will be available for free in the NCQA Store and includes the following:

- *Quality Rating System HEDIS Value Set Directory*— HEDIS MY 2026 (anticipated release by March 31, 2026)
- *Quality Rating System Random Number (RAND) Table*— HEDIS MY 2026 (anticipated release by October 31, 2026)
- *Medication List Directory*—HEDIS MY 2026 (anticipated release by March 31, 2026)
- *Risk Adjustment Tables*— HEDIS MY 2026 (anticipated release by March 31, 2026)

Referring to HEDIS Measures and Rates

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

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

Organizations that need help determining the correct naming convention for HEDIS measures or rates can contact NCQA through My NCQA for guidance.

If You Have Questions About the Specifications

Policy Clarification Support

NCQA provides policy support to help customers navigate HEDIS specifications with confidence. Customers can submit questions about policy interpretation through My NCQA to receive guidance directly from NCQA staff.

FAQs and Policy Updates

The FAQs and Policy Updates clarify HEDIS for QRS uses and specifications to help promote consistent interpretation. Updates are posted to the NCQA website on the 15th of each month.

Reporting Hotline for Fraud and Misconduct

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

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

How to Report

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

Reporting Data Errors to NCQA

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

Organizations must immediately report any error in a measure rate or in its component (in any previous submission, regardless of timing) that is >5% higher or lower than what was reported originally. These should be reported to NCQA via My NCQA by selecting the Product/Program Type as "HEDIS Audit" and the General Content Area as "Data Errors." The report to NCQA must include:

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

Auditors must document all findings for the year in question and the current year's corrections. Organizations are not required to submit corrected rates for additional impacted data years unless requested by NCQA. Findings must be included in the work papers, and must be noted in detail in the organization's Final Audit Report.

General Guidelines for Data Collection and Reporting

General Guidelines for Data Collection and Reporting

These MY 2026 HEDIS for QRS General Guidelines for the *2027 Quality Rating System Measure Technical Specifications* are unique to the issuers offering plans on the Exchanges and participating in the CMS Quality Rating System (QRS).[1,2]

SUMMARY OF CHANGES TO HEDIS MY 2026 FOR QRS

- Updated *General Guideline: The NCQA HEDIS Compliance Audit™* to provide additional information.
- Deleted *General Guideline: Date Specificity;* requirements are included in each applicable measure.
- Added *General Guideline: Which Services Count* to the *Data Collection Methods and Data Sources* section.
- Updated *General Guideline: Race and Ethnicity Stratifications* to align with the March 2024 updates to the Office of Management and Budget Standards for Maintaining, Collecting, and Presenting Federal Data on Race and Ethnicity and US Core Version 6.1.0 Model Definition.
- Added text to *Data refresh for the systematic sample* in *General Guideline: Obtaining Information for the Systematic Sample.*
- Deleted *General Guideline: Measures That Use Medication Lists;* requirements are included in each applicable measure.
- Deleted *General Guideline: Anchor Dates;* requirements are included in *General Guideline: Continuous Enrollment*.
- Updated *General Guideline: Data Collection Methods* to include information regarding the electronic method of reporting.
- Deleted *General Guideline: SNOMED Codes*.

HEDIS FOR QRS SPECIFIC GUIDANCE

- HEDIS for QRS does not require race and ethnicity stratification reporting.

MY 2026 HEDIS for QRS Data Collection

General Guideline: Exchange Product-Line Reporting

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

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

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

General Guideline: Reporting Units (Product)

Organizations must collect audited HEDIS for QRS measure data for each product (EPO, HMO, POS, PPO) offered through an Exchange in 2027 that had more than 500 enrollees as of July 1 in the prior year (July 1, 2026) and continues to have more than 500 enrollees as of January 1 of the ratings year (January 1, 2027). Reporting units that are decertified or discontinued before June 15 of the ratings year (June 15, 2027) are exempt from QRS reporting requirements.

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

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

Combining products into one reporting unit is not allowed for HEDIS for QRS reporting.

Definitions

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

HMO Health maintenance organization. An organized health care system that is accountable for both the financing and delivery of a broad range of comprehensive health services to an enrolled population. An HMO is accountable for assessing access and ensuring quality and appropriate care.

Practitioners affiliated with the health care system render health care services. In this type of organization, members must obtain all services from affiliated practitioners and must usually comply with a predefined authorization system to receive reimbursement.

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

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

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

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

General Guideline: Minimum Enrollment Threshold

Organizations are required to submit data for each product offered through an Exchange in 2027 that had more than 500 enrollees as of July 1, 2026, and continues to have more than 500 enrollees as of January 1, 2027.

General Guideline: Individual and Small Business Health Options Program (SHOP) Members

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

The NCQA HEDIS Compliance Audit™

The HEDIS Compliance Audit is required for all HEDIS for QRS measures.

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

All Licensed Organizations and Certified HEDIS Compliance Auditors use the methodology and requirements described in *Volume 5, HEDIS Compliance Audit: Standards, Policies and Procedures*.

All Licensed Organizations and Certified HEDIS Compliance Auditors are required to remain independent, and they must avoid conflicts of interest, including perceived conflicts of interest. They are prohibited from providing technical assistance or advisory services to organizations that they audit. Noncompliance may result in revocation of licensure and certification status.

General Guideline: Audit Preparation

Contract with an audit firm

The organization requests an application for a HEDIS Audit from an NCQA Licensed Organization and is responsible for determining fees and entering into contracts. The first activity in audit preparation is contract execution. An organization contacts NCQA Licensed Organizations for bids and selects a firm to conduct the HEDIS audit.

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

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

HEDIS Roadmap

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

Preliminary rate review

All organizations are required to provide auditors with initial rate information. Preliminary rates are used to assess data completeness and accuracy early in the audit. Significant rate variations must be recorded, discussed, and sufficiently substantiated or corrected, if needed.

Supplemental data validation All supplemental data sources must be reviewed and approved annually. Each source is reviewed separately and includes a review of data capture, data file formats, quality control processes, impact of the source on reported rates and primary source verification to ensure the integrity of the data, as needed.

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

HEDIS Audit Timeline Organizations must follow the HEDIS Audit Timeline, which will be posted on the NCQA website on March 31, 2026, and is published in *Volume 5, HEDIS Compliance Audit: Standards, Policies and Procedures.*

General Guideline: Reporting

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

For Performance Measures

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

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

General Guideline: Marketing

Release of HEDIS Audit results must be in accordance with NCQA's *Guidelines for Advertising and Marketing,* posted on the NCQA website. Organizations may release the entire Final Audit Report without prior authorization from NCQA, but must obtain written authorization from NCQA before releasing abridged, summarized or quoted information from the Final Audit Report.

Organizations that refer to the HEDIS Audit or any HEDIS data audited by a Certified HEDIS Compliance Auditor must adhere to the Guidelines.

Membership Changes

General Guideline: Members Who Switch Organizations

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

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

General Guideline: Members Who Switch Organizations as a Result of a Merger or Acquisition

Measures with a continuous enrollment period	Members who switch organizations because of a merger that occurred during the measurement year may be counted as continuously enrolled.
Measures without a continuous enrollment period	The surviving organization may include members from the non-surviving entity in the initial population, starting on the official date of the merger or acquisition. For example, if the merger or acquisition occurred on March 1 of the measurement year, the surviving organization excludes members acquired from the non-surviving entity from the initial population for January and February.

This guideline must be used consistently across all measures.

General Guideline: Members Who Switch Products/Product Lines

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

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

Required Enrollment Periods and Benefits

General Guideline: Continuous Enrollment

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

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

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

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

General Guideline: Continuous Enrollment Over Multiple Years

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

General Guideline: Required Benefits

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

cover a specific medication class, the member has a pharmacy benefit and is included in the applicable measures requiring this benefit, similarly if the member has partial coverage of mental health services (either by service or diagnosis), they are included as having a mental health benefit). Organizations must assess benefits first at the organization level and then at the individual member level using continuous enrollment data.

…at the organization level	Organizations report HEDIS measures requiring a specific benefit provided to members directly or through a contractor. Organizations are not required to report HEDIS measures specifying a benefit that it does not offer. Before reporting a measure specifying a benefit, the organization must be able to determine if a member has the required benefit. If the organization does not offer the benefit, the plan does not report the measure and receives an NB (No Benefit) audit designation. No member assessment is necessary.
…at the member level	Members who do not have a specified benefit are not counted in the measure. For example, exclude members without a pharmacy benefit from the Appropriate Treatment for Upper Respiratory Infection (URI) measure.
Exhausted benefits *(optional)*	*For measures without a continuous enrollment criterion,* include only services or procedures that occurred while the member had a benefit. For a member whose benefit is lost or exhausted during the time specified in the measure, include services or procedures that occurred while the member had the benefit. *For measures with a continuous enrollment criterion*, the required benefits must be active for the period of continuous enrollment, accounting for any allowable gap. Exclude a member if the period when the benefit is exhausted exceeds any allowable gap. For example, the Initiation and Engagement of Substance Use Disorder Treatment (IET) measure requires a pharmacy benefit during the 194 days prior to the SUD episode date through 47 days after the SUD episode date (242 days total). Exclude a member whose pharmacy benefit is exhausted 30 days after the SUD episode, as this measure does not allow any gaps in enrollment.
Carved-out benefits *(optional)*	Some organizations can obtain the necessary information from a carved-out entity and may include these members in their measures. For example, an employer contracts directly with a pharmacy benefit manager (PBM), which shares pharmacy information with the organization. The employer's members may be included in the measure.

This guideline must be used consistently across all measures.

General Guideline: Accessing Medical Records Prior to Enrollment

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

HEDIS Data Submission and Reporting to NCQA

General Guideline: HEDIS Reporting Date

For HEDIS MY 2026, all organizations reporting audited data to NCQA through the IDSS must submit data on or before **June 15, 2027.**

Data Collection Methods and Data Sources

General Guideline: Data Collection Methods

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

- Administrative Method.
- Hybrid Method.
- Survey Method.
- Electronic Clinical Data Systems (ECDS) Method.

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

Administrative Method	Transaction data or other administrative data are used to identify the initial population, denominator exclusions, denominator and numerator. The reported rate is based on all members who meet the denominator criteria and who are found through administrative data to have received the service required for the numerator.
Hybrid Method	Organizations look for numerator compliance in both administrative and medical record data. The hybrid denominator consists of a systematic sample of members drawn from the measure's administrative denominator.[3] Organizations review administrative data to determine if members in the systematic sample received the service and review medical record data for members who do not meet the numerator criteria through administrative data. The reported rate is based on members in the sample who received the service required for the numerator.
Survey Method	Requires organizations to collect data through the Qualified Health Plan Enrollee Experience Survey (QHP Enrollee Survey). Specifications for survey measures are included in Section 4.1 QRS Survey Measure Specifications and the *Qualified Health Plan Enrollee Experience Survey: Technical Specifications*, which are available on the CMS QHP Enrollee Survey page of the CMS Marketplace Quality Initiatives (MQI).
ECDS Method	Measures reported using ECDS are specified for the electronic method of data collection. Data sets for ECDS reporting must contain data that have been structured to be able to be queried by a HEDIS digital quality measure (dQM). Each electronic data source used for HEDIS ECDS reporting must have:

[3] For hybrid reported measures, the administrative denominator is not a reported data element, but equals the initial population minus exclusions.

- Policies and procedures for establishing and maintaining database management systems.
- Standard layout requirements.
- An automated process for extraction, transformation and loading of all data elements to the master file.

The proof-of-service and validation requirements are outlined in *General Guideline: Supplemental Data.*

Administrative and non-administrative data may be used to identify the initial population.

To qualify for HEDIS ECDS reporting, data must use standard layouts, meet the measure's technical specification requirements and be accessible by the care team upon request. Organizations meet this requirement if they can provide the requested information (e.g., phone, secure email, direct feed, provider portal, file request) to providers. Organizations should have documented processes for tracking these requests, to be reviewed as part of the HEDIS audit. Practitioners or practitioner groups that are accountable for clinical services provided to individuals must not be prevented from accessing data used by an organization for quality measure reporting.

Organizations may use several data sources to provide complete information about the quality of health services. Data systems that may be eligible for HEDIS ECDS reporting include, but are not limited to, member eligibility files, EHRs, personal health records (PHR), clinical registries, health information exchanges (HIE), administrative claims systems, electronic laboratory reports (ELR), electronic pharmacy systems, immunization information systems (IIS) and disease/case management registries.

The data in these systems come in a variety of formats. The format type determines how the source is audited. Self-reported services are acceptable if the information is recorded, dated and maintained in the legal health record. The self-reported data must follow *General Guideline: Self-Reported Services and Biometric Values.*

Note

- *For administrative and hybrid methods, supplemental data are considered an administrative data source; however, for all non-survey measures, numerator events identified using supplemental data are reported separately from numerator events identified by administrative (claims/ encounter) and medical record data, as indicated in the applicable Data Elements for Reporting tables.*
- *For administrative and hybrid methods, any data found in a supplemental data source are considered a supplemental data hit if the person would not be compliant for the measure/indicator without the data source. If supplemental data are not used, report zero in the "Numerator events by supplemental data" element. For all other measures, numerator events identified using supplemental data are reported in the "Numerator events by administrative data" element. Refer to General Guideline*: Supplemental Data.

General Guideline: Supplemental Data

Supplemental data uses

Organizations may find information about services in administrative data, medical records and other data sources. When evidence to support the measure is found in multiple data sources, a hierarchy is applied. Supplemental

data are considered last as long as the specifications are followed as written (e.g., if the organization uses a combination of data sources to identify the Glycemic Status >9.0% indicator in the Glycemic Status Assessment for Patients With Diabetes measure, the most recent test must be used, regardless of data source).

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

Supplemental data may help determine:

- Numerators that are labeled as *numerators* in the specification.
- Persons in hospice and persons who have died.
- Exclusions that are labeled as *denominator exclusions* in the specification.

Supplemental data* may not *be used for:

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

Supplemental Data Definitions

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

Standard supplemental data

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

Audit requirements. Standard supplemental data are not required to be accompanied by proof-of-service documents and the audit does not require primary source verification, unless requested by the auditor.

Note: *Prior years' validated historic hybrid medical record result files are loaded as administrative data.*

Nonstandard supplemental data

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

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

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

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

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

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

- *Surveys.* Organizations and providers may not use information obtained from surveys or other documents completed by the individual, except for data collected for Language Description of Membership and Race/ Ethnicity Description of Membership.
- *Phone calls.* Recorded phone calls to collect information about services rendered are not proof of service.

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

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

Audit requirements. The auditor confirms that the data meet all requirements. Primary source verification is required (e.g., go back to each unique EHR) to validate the CCDs' accuracy. This level of validation is required for at least the first year, or the first submission by the EHR, but may continue in subsequent years until the auditor is certain the data are accurate, reliable and unchanged.

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

- Receive completed Roadmap documentation from the reporting entity using the data. The Roadmap must explain how data from the validated DAV entity are transferred in an outbound file to the organization, and what is done to the data. No documentation is required from the DAV validated entity unless the entity processes the validated CCD.

  - If the validated CCD is processed in any way after receipt, the auditor may (but is not required to) perform secondary source validation (SSV): examine processed data back to the validated and conformed CCD files. SSV does not include PSV back to the original source on any of these data sources. PSV is not to be performed.

    Note: *This applies only to CCDs.*
  - If the reporting entity receives validated data formatted using FHIR standards from the DAV entity, the conformed data formatted using FHIR standards cannot be processed in any way. Processing the data formatted using FHIR standards to another format compromises the DAV status.
- Receive the final validation report of validated data cases and clusters, and the date when they were validated.
- Refer to NCQA's Data Aggregator Validation to ensure that the NCQA validated entity is approved to share validated data. Organizations with a "Validated Data Stream" evaluation product with a validated status and expiration date may share data and contribute to reducing audit burden. Organizations with a "Certified Data Partner" evaluation product may not share data.

Data from ingestion sites or clusters that failed validation may not be shared as standard supplemental data. These data are considered nonstandard supplemental data, and must be audited accordingly.

Required Data Elements

Standard supplemental data

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

Nonstandard supplemental data

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

- Payment status when applicable.
- Evidence that tests or services were performed, not just ordered.
  - When data are abstracted from medical record sources to be used as supplemental data, codes alone (without additional documentation of the service provided) do not meet criteria for proof of service. If a provider performs a service, it is expected that there is additional documentation in the medical record or in the primary source document. Auditors must validate, through primary source verification, all elements required by the measure specification.
- Evidence of provider accountability from the practitioner or practitioner group (signed contracts with accountability tied to passwords, signatures or TIN/NPI data). For home visits, if clinical services are rendered, there must be evidence of accountability by the practitioner, and at a minimum include the date, name and signature on each in-home form. Documentation of the practitioner's TIN/NPI is not required; however, documentation of TIN/NPI with date, name and signature is preferred.

- More than a simple yes or no attestation on provider forms. Forms must have all necessary data elements and be signed by the rendering practitioner.
- All data elements for a measure must be captured for self-reported services (date and place of service, procedure, prescription, test result or finding, practitioner type). When using supplemental data derived from medical records to meet administrative specifications, documentation must be clinically synonymous with the codes included in the measure's value sets. Refer to *General Guideline: Self-Reported Services and Biometric Values*.

All supplemental data

All proof-of-service documents must show that services were rendered by the deadline established for the measure.

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

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

Supplemental Data Timeline

Supplemental data may be collected during the measurement year and into the beginning of the reporting year. Supplemental data collection and use must adhere to all applicable deadlines in the Audit Timeline posted on NCQA's website on March 31, 2026.

Identifying and Validating Supplemental Data

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

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

- Completed HEDIS Roadmap documentation.
- Impact of supplemental data source by measure (e.g., lists of numerator-positive hits from the supplemental data, by measure; year-to-year comparisons of percentage increases associated with supplemental data; proportion of numerator compliance from supplemental data).
- Primary source verification where required or requested by the auditor.

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

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

General Guideline: Which Services Count?

Each measure has its own requirements for using transactional data and administrative claims to report measure components. Information on which services count are located in the measure's *Guidance* section.

If a measure requires that all paid, suspended, pending and denied claims be used for reporting, report all services, whether or not the organization paid for them. For example, report services paid for by a third party, such as a community center, or services for which payment was denied because they were not authorized.

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

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

Count the service as denied if:

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

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

General Guideline: Obtaining Information for the Systematic Sample

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

MRR abstractors count a service if the legal health record contains the date of the service and evidence that the service occurred. All services must be rendered and documented in the medical record by the deadline established in the measure.

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

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

Data refresh for the systematic sample

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

The InitialPopulation, NumeratorByAdminDenom and Exclusions data elements should be locked after the sample is pulled; the MRSS is fixed, and these administrative data elements must not change during an administrative data refresh.

Exclusions found through administrative data in a data refresh must be reported in the "ExclusionValidDataErrors" data element. Members identified as valid data errors must be reported in the InitialPopulation data element, but are removed from the sample.

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

Manually updating the sample

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

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

Automated updates to the sample

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

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

General Guideline: Race and Ethnicity Stratifications

This guideline provides instructions on how organizations categorize Exchange members by the race and ethnicity stratification (RES) when it is included in a measure.

Reporting categories

NCQA requires reporting race and ethnicity as defined by the Office of Management and Budget (OMB) 1997 and 2024 Standards for Maintaining, Collecting, and Presenting Federal Data on Race and Ethnicity, and best practices identified in the March 2024 updates.[4,5]

Race and ethnicity values must be rolled up into the OMB categories specified in this guideline. NCQA supports efforts to collect data that are more detailed than the minimum OMB reporting categories. If more detailed race and ethnicity data are collected, data must be aggregated and reported in the

[4] Office of Management and Budget Revisions to the Standards for the Classification of Federal Data on Race and Ethnicity. https://www.govinfo.gov/content/pkg/FR-2024-03-29/pdf/2024-06469.pdf

[5] OMB Statistical Policy Directive No. 15 on Race and Ethnicity Data Standards: Categories and Definitions: https://spd15revision.gov/content/spd15revision/en/2024-spd15/categories-definitions.html

categories provided. For health plans using the CMS classification scheme for race and ethnicity, refer to Table RES-A-4 for a crosswalk to HEDIS reporting. Report member race and ethnicity separately. If a combined race/ethnicity category question is used to collect data, data must be disaggregated, and race and ethnicity categories must be reported separately. When using the combined race/ethnicity data format for collection, refer to Table RES-B-4 for a crosswalk of reporting categories.

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

- "Race & Ethnicity – CDC" (CDCREC) is used to report race and ethnicity categories.
- "Asked But No Answer" and "Unknown" use the HL7 version 3 NullFlavor code system.

Determining race reporting category

For the Exchange product line, report members in only one of the ten race stratifications listed below and the total.

- *American Indian or Alaska Native*: Identification with any of the original peoples of North, Central and South America. Examples of these groups include, but are not limited to, people who identify as "American Indian" or "Alaska Native" and includes groups such as Navajo Nation, Blackfeet Tribe of the Blackfeet Indian Reservation of Montana, Native Village of Barrow Inupiat Traditional Government, Nome Eskimo Community, Aztec and Maya.
- *Asian*: Identification with one or more nationalities or ethnic groups originating in any of the original peoples of Central, East, Southeast or South Asia. Examples of these groups include, but are not limited to, Chinese, Asian Indian, Filipino, Vietnamese, Korean, Japanese, Pakistani, Cambodian, Hmong, Thai, Bengali and Mien.
- *Black or African American*: Identification with one or more nationalities or ethnic groups originating in any of the Black racial groups of Africa. Examples of these groups include, but are not limited to, African American, Jamaican, Haitian, Nigerian, Ethiopian, Somali, Ghanaian, South African, Barbadian, Kenyan, Liberian and Bahamian.
- *Middle Eastern or North African*: Identification with one or more nationalities or ethnic groups originating in the Middle East or North Africa. Examples of these groups include, but are not limited to, Lebanese, Iranian, Egyptian, Syrian, Iraqi and Israeli.
- *Native Hawaiian or Pacific Islander*: Identification with one or more nationalities or ethnic groups originating in Hawaii, Guam, Samoa, or other Pacific Islands. Examples of these groups include, but are not limited to, Native Hawaiian, Samoan, Chamorro, Tongan, Fijian, Marshallese, Palauan, Tahitian, Chuukese, Pohnpeian, Saipanese and Yapese.
- *White*: Identification with one or more nationalities or ethnic groups originating in Europe. Examples of these groups include, but are not limited to, English, German, Irish, Italian, Polish, Scottish, French, Slavic and Cajun.

- *Other Race*: People whose race information has been collected but does not fit into any of the specified race categories.
- *Two or More Races*: People with any combination of races, including "Other Race."
- *Asked But No Answer:* People who the organization asked to identify race but who declined to provide a response.
- *Unknown:* People for whom the organization did not obtain race information and for whom the organization did not receive a declined response ("Asked But No Answer").
- *Total:* Total of all categories above.

Determining ethnicity reporting category

For the Exchange product line, report members in only one of the four ethnicity stratifications listed below and the total.

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

Data source

Approved data sources include data collected directly from members and data obtained through imputation methods. In cases where a plan has a race or ethnicity value but no data source, the plan must report using the "Unknown" data source category. In cases where the race or ethnicity value and the source are missing, plans must record this as no data. NCQA strongly encourages plans to report directly collected data when available and emphasizes the importance of improving completeness of directly collected member race and ethnicity data. Additionally, NCQA strongly encourages plans to track the source of their race and ethnicity data in order to facilitate valid disparities assessments.

Supplemental data may be used as a data source for the race and ethnicity stratification.

Direct data

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

Directly collected data include any source for which the member self-identified race or ethnicity. This includes member self-reported data collected directly from members under the full control of the health plan (i.e., no data were obtained through an intermediary), as well as third-party data collected directly from a member by another entity (e.g., the state, CMS, Health Information

Exchanges [HIE] or clinical feeds). Direct sources may include, but are not limited to:

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

Note: *The "Asked But No Answer" category is only reported using direct data.*

Imputed data Plans may choose to report race and ethnicity data supplemented by imputed methods. Imputed assignment of race and ethnicity values include using an alternate data source (e.g., nationally representative data obtained from databases like the American Community Survey) to assign a race or ethnicity value to a member based on their primary location of residence. Some commonly used imputed methods combine geographic data with additional imputation methods such as surname analysis.
NCQA reiterates that directly collected race and ethnicity is considered the gold standard and is highly preferred to imputed race and ethnicity. For plans choosing to use imputed methods to report the HEDIS race and ethnicity stratification, NCQA emphasizes the following:

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

Unknown data When the reported value for race or for ethnicity is known, but the source is unknown (i.e., cases where an organization has a race or ethnicity value on file from a legacy system but does not know the source).

No data When both the race or ethnicity value and the source are missing.

Note: *The "Unknown" category is only reported using the "No Data Source" category because unknown values cannot be attributed to a particular data source.*

Sampling For measures collected using the Hybrid Method with the race and ethnicity stratification, follow the guidelines for sampling outlined in *Guidelines for*

Calculation and *Sampling Guidelines for the Hybrid Method.* The race and ethnicity stratifications are applied to the denominator after hybrid sampling.

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

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

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

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

Race/Ethnicity Combined Category (examples)[6]	HEDIS/OMB Race	HEDIS/OMB Ethnicity
American Indian/Alaska Native	American Indian or Alaska Native	Not Hispanic or Latino
Asian	Asian	Not Hispanic or Latino
Black	Black	Not Hispanic or Latino
Middle Eastern or North African	Middle Eastern or North African	Not Hispanic or Latino
Native Hawaiian or Pacific Islander	Native Hawaiian or Pacific Islander	Not Hispanic or Latino
White	White	Not Hispanic or Latino
Hispanic/Latino	Other Race	Hispanic or Latino
Hispanic/Latino/Black	Black	Hispanic or Latino
Hispanic/Latino/White	White	Hispanic or Latino
Other	Other Race	Unknown
Multiple races marked	Two or More Races	Unknown
Unknown	Unknown	Unknown

[6] Does not reflect the full set of possible combinations but provides examples of how categories should be handled when a combined data collection question is used.

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

HEDIS/OMB Race	CDCREC OMB Category: Direct Reference Code*	CDCREC Detailed Category: Value Set
American Indian or Alaska Native	1002-5	American Indian or Alaska Native Detailed Race Value Set
Asian	2028-9	Asian Detailed Race Value Set
Black	2054-5	Black or African American Detailed Race Value Set
Middle Eastern or North African	NA	Middle Eastern or North African Detailed Race Value Set
Native Hawaiian or Pacific Islander	2076-8	Native Hawaiian or Pacific Islander Detailed Race Value Set
White	2106-3	White Detailed Race Value Set
Other Race	2131-1	NA
Two or More Races	NA***	NA
Asked But No Answer	ASKU**	NA
Unknown	UNK**	NA

*Codes to identify race and ethnicity are from the CDC Race and Ethnicity code system developed by the U.S. Centers for Disease Control and Prevention (CDC). They resemble, but are not, LOINC codes.

**HL7 v3 Code System NullFlavor.

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

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

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

*Codes to identify race and ethnicity are from the CDC Race and Ethnicity code system developed by the U.S. Centers for Disease Control and Prevention (CDC). They resemble, but are not, LOINC codes.

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

Note

- *Race and ethnicity are social constructs, not biological; stratifying HEDIS measures by race and ethnicity is intended to further understanding of racial and ethnic disparities in care and to hold health plans accountable to address such disparities, with the goal of achieving equitable health care and outcomes. Data are not to be used to further bias in health care or to suggest that race and ethnicity are biological determinants of health.*
- *When multiple sources of data are used for race and ethnicity, there may be disagreements in the data collected. When this happens, data sources should be prioritized based on evaluation of anticipated accuracy. This includes use of specific categories over nonspecific categories, most*

frequent or consistently reported category and selection of data with clear provenance (source, method of collection) over data without clear provenance. Known data sources should be prioritized over unknown data sources, and data collected directly by the organization should be prioritized over all other data sources.

- *Race and ethnicity data may come from different categories of data source (direct, imputed, unknown, no data). In such cases, use the data source that applies to the data element (race, ethnicity). If the same data element is received from two different data sources, prioritize data sources based on the second bullet above.*

General Guideline: Date of Service for Laboratory Tests

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

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

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

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

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

- If a sample is collected on December 28 of the measurement year and the result is documented on January 2 of the year after the measurement year, the dates are within 7 days and can be considered the same test. The result is present and the collection date is eligible for use, making the person numerator compliant.
- If a sample is collected on December 28 of the measurement year and the result is documented on January 15 of the year after the measurement year, the dates are not within 7 days and cannot be considered the same test. There is no result for the lead test collected on December 28 and the person is not numerator compliant.
- If a test had a collection date of December 1 and a reported date of December 8, these dates are not more than 7 days apart and can be considered the same test.
- If a test had a collection date of December 1 and a reported date of December 9, these dates are more than 7 days apart and cannot be considered the same test.

General Guideline: Collecting Data for Measures With Multiple Numerator Events

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

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

For only the measures listed above, all events must be at least 14 days apart.

For example, the organization may count two influenza vaccines identified through administrative data if the dates of service are at least 14 days apart; if the service date for the first vaccine was February 1, then the service date for the second vaccine must be on or after February 15.

General Guideline: Self-Collected Samples

Test results from self-collected samples processed by a laboratory or provider's office may be used for reporting.

General Guideline: Self-Reported Services and Biometric Values

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

HEDIS Coding Conventions

General Guideline: Using Claims to Identify Events in Conjunction With Diagnoses or other Events

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

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

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

General Guideline: Visits That Result in an Inpatient Stay

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

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

General Guideline: Principal vs. Secondary Diagnosis

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

Some measures require a specific principal diagnosis for eligibility; other measures allow any diagnosis (principal or secondary). For example, the Follow-Up After Hospitalization for Mental Illness (FUH) measure specifies in the Event/Diagnosis criteria that only an acute inpatient discharge with a principal diagnosis of mental illness is eligible. If a person's claim lists the principal diagnosis as "diabetes," but mental illness is listed as a secondary diagnosis on the same claim form and there are no diagnosis for intentional self-harm, the member is not included in the Follow-Up After Hospitalization for Mental Illness (FUH) measure.

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

General Guideline: Code Modifiers

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

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

General Guideline: Uniform Bill Code Specificity

HEDIS reporting requires the four-digit version of Uniform Bill (UB) type of bill codes. Organizations whose data includes three-digit versions of the codes must convert the codes to four-digit codes by adding a leading zero.

General Guideline: Mapping Proprietary or Other Codes

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

- *State-specific codes.* The organization must provide the auditor with evidence that the codes are required by the state.
- *NDC codes.* An NDC code that is not in a medication list can be mapped if its generic name (or brand name), strength/dose and route match those of a code in the medication list. NDC codes that identify immunizations can be mapped to codes in value sets that identify immunizations.
- *RxNorm codes*. An RxNorm code that is not in the medication list can be mapped if its generic name (or brand name), strength/dose and route match those of a code in the medication list.
- *ICD*-9 *codes:* ICD-9 codes can be mapped to ICD-10 codes only for concepts with a time frame that looks back "any time during the person's history."

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

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

General Guideline: Retiring Codes

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

HEDIS Specification Tables

General Guideline: Table Names

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

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

Reporting tables Data element tables begin with the measure's three-character abbreviation and the Exchange product line is assigned a number of 4; for example:

- CBP-4 (Exchange).

If more than one table will be reported, the table is assigned an uppercase letter. For example, the tables for the Controlling High Blood Pressure measure are CBP-A-4, CBP-B-4 and CBP-C-4.

General Guideline: Reporting Tables

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

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

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

Coding

Example Data Elements for Reporting Table

Metric	Stratifications 1	Stratifications 2	Data Element	Reporting Instructions	A
Metric1	Level1	Level1	DataElement1	Instruction1	✓
Metric2	Level2	Level2	DataElement2	Instruction2	✓
	Total	Level3	DataElement3	Instruction3	
		Total	DataElement4	Instruction4	
			DataElement5	Instruction5	✓
			DataElement6	Instruction6	
			Rate	Calculation / (Units)	✓

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

Example:

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

Shading

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

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

Reported by the organization
Calculated by IDSS
Data not used

Guidelines for Calculations and Sampling

Guidelines for Calculations and Sampling

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

SUMMARY OF CHANGES TO HEDIS MY 2026 FOR QRS

- Updated the steps in *How to Use the Administrative Method* to align with changes to the measure templates.
- Replaced references to "eligible population" with "denominator" in the *Guidelines for the Hybrid Method*.
- Updated the *Guidelines for the Hybrid Method* to remove guidance for membership-dependent denominators.
- In *Determining the required sample size,* clarified that the sample is drawn from the administrative denominator.
- Renamed "eligible member (EM)" to "administrative denominator member (ADM)."
- Removed the oversample requests to NCQA requirement in the Systematic Sampling Methodology.

How to Use the Administrative Method

Step 1 Identify the initial population.

Step 2 Identify denominator exclusions.

Step 3 Subtract denominator exclusions from the initial population to identify the final denominator.

Step 4 Search administrative systems to identify numerator events for all members in the denominator.

Step 5 Calculate the rate.

Guidelines for the Hybrid Method

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

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

- *Claims-dependent denominator.* Defined by membership and claims data (e.g., members who were diagnosed with hypertension, for Controlling High Blood Pressure).

Drawing the sample prior to the reporting year

Organizations are strongly encouraged to draw samples no earlier than January 2027 for the 2026 measurement year. This increases the accuracy and completeness of the denominator from which the sample is drawn.

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

Claim-dependent denominators

The denominator for the following measures is determined through claims data. Organizations may draw the sample for these measures as early as December 1 of the measurement year:

- Controlling High Blood Pressure.
- Glycemic Status Assessment for Patients With Diabetes.
- Prenatal and Postpartum Care.
- Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents.

Determining the required sample size

Using the Hybrid Method to collect and report a measure requires a sample to be drawn from the administrative denominator. Use Table 1 to determine the appropriate sample size for measures.

- For hybrid measures reported in the prior year, use the last column of Table 1 to determine whether the prior year's audited result can be used to reduce the current year's sample size.
- For measures with stratifications, use the total rate when reducing sample sizes.
- For measures with multiple indicators and stratifications, use the lowest total rate across indicators when reducing sample sizes.

Use Table 2 if the prior year's rate is used to determine the current year's sample. The organization may also use the product line-specific rate derived from administrative data for the current measurement year and Table 2 to reduce the required sample size. The required sample size decreases as the organization's rate improves.

For example, the organization calculates a 77% administrative rate for the Exchange product line for a new measure and decides to implement the Hybrid Method. Instead of using a sample size of 411, the organization reduces the sample size for this measure for its Exchange product line by using the 77% administrative rate and Table 2. According to Table 2, the minimum required sample size is 296. The sample size can be reduced even when the original administrative denominator[7] member (ADM) population is less than 411.

Organization responsibility for chart review

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

After the systematic sample is generated and chart pursuit has started, the sample may be reduced on rare occasions, such as after a natural disaster.

[7] For hybrid reported measures, the administrative denominator is not a reported data element. It equals the initial population minus exclusions.

Removing uninvestigated members from the sample in this situation is an alternative sampling method, and the organization must submit a request for approval to PCS via My NCQA that includes the reason for not completing chart review, and the auditor's approval showing that the members to be removed are distributed systematically across the larger sample and the hybrid results from the reduced sample are reportable.

Statistical assumptions for sample size

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

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

Table 1: Sample Size Information for Hybrid Measures

Measure	Exchange	Prior Year's Rate May Be Used to Reduce MY 2026 Sample Size[1]
Controlling High Blood Pressure	411	Y[3]
Glycemic Status Assessment for Patients With Diabetes	411	Y[3]
Prenatal and Postpartum Care	411	Y[2,3]
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents	411	Y[2,3]

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

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

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

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

Table 2: Sample Sizes When Data Are Available Being Measured

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

Note

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

Systematic Sampling Methodology

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

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

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

To use a larger MRSS, an organization must provide written rationale to NCQA through PCS via My NCQA.

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

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

Step 4

- If ADM ≤MRSS, all ADMs are included in the sample. The MRSS must be reported as the ADM.
- If ADM >MRSS + all oversample records, go to step 5.
- If MRSS <ADM ≤MRSS + all oversample records, proceed to step 8.

Step 5 Sort the list of ADMs in alphabetical order (by applicable measurement year) by last name, first name, date of birth and event (if applicable). If the organization reports on combined products, it must alphabetize the combined ADM population.

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

For example, for HEDIS MY 2026, sort the list of ADMs from A to Z. For HEDIS MY 2027, sort the list from Z to A.

Note: *Sort order applies to all components. For HEDIS MY 2026, sort all fields by ascending order (i.e., last name ascending, first name ascending, date of birth ascending, event ascending).*

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

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

N = ADM/(MRSS + all oversample records)

where ADM = the administrative denominator (step 1) and MRSS = the minimum required sample size (step 2).

Step 7 Calculate START = (RAND × N). Before choosing members, determine the member to start with (START). It is important that the sample be selected from a single pass through the member list. START can have many values and still allow only one pass.
Use the Random Number (RAND) table for the appropriate measurement year that lists a value between 0 and 1 for each measure where the Hybrid Method is applicable. Refer to this table to determine the RAND to be used when determining START. The RAND for each measure is used to calculate the starting point from which to draw the final sample.

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

$$START = (RAND \times N)$$

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

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

$$i^{th} \text{ member} = START + [(i-1) \times ADM/(MRSS + \text{all oversample records})]$$

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

For i = 2,3,4, …, MRSS where ADM = administrative denominator (step 1). MRSS = the minimum required sample size (step 2).

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

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

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

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

Oversampling methodology

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

To adjust for this, divide the sample size by the percentage of charts expected to be inappropriate for review. Suppose 10% of charts are expected to be inappropriate for the measure.

To determine the oversample, multiply the MRSS by the oversample percentage and round up to the nearest whole number.

411 x 0.10 = 41.1
(rounded up to 42 = oversample).

The recommended methodology for substitution is:

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

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

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

Example 1

The ADM for the Exchange product line for Prenatal and Postpartum Care is 9,000. Reduce the minimum required sample size using the Exchange rate from the prior year's HEDIS submission, which was 77%. Based on experience, estimate a 5% oversample rate. Follow the systematic sampling methodology.

Step 1 ADM = 9,000.

Step 2 From Table 2, the MRSS is 296.

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

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

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

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

Step 7 For this example, assume that RAND = 0.66, so START = 0.66 x 28 = 18.48.

- Rounding using the .5 rule, START = 18.
- The 18th sorted member is chosen *first.*
- The 2nd member chosen is the 18 + [(2-1) x (9,000/311)] = 18 + 29 = 47th sorted member, after rounding the term [(2-1) x (9,000/311)] to 29, using the .5 rule.
- The 3rd member chosen is the 18 + [(3-1) x (9,000/311)] = 18 + 58 = 76th sorted member.
- The 296th member (the last one in the primary list) is the 18 + [(296-1) x (9,000/311)] = 18 + 8,537 = 8,555th sorted member.
- The last member in the oversample* is the 18 + [(311-1) x (9,000/311)] = 18 + 8,971 = 8,989th sorted member.

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

Example 2

The ADM for Controlling High Blood Pressure is 389. This measure was not collected last year, nor will the administrative rate from this year be used to reduce the sample size. Follow the systematic sampling methodology.

Step 1 ADM = 389.

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

Step 3 *Skip this step.*

Step 4 Include all 389 members in your primary list.

Example 3

The ADM for Weight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents is 436. The sample size will not be adjusted using this year's administrative rate. Based on experience with this population, about 10% of the members from the primary sample will have to be excluded. Follow the systematic sampling methodology.

Step 1 ADM = 436.

Step 2 From Table 1, the MRSS is 411.

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

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

Step 5 *Skip this step.*

Step 6 *Skip this step.*

Step 7 *Skip this step.*

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

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

Example 4

The ADM for Glycemic Status Assessment for Patients With Diabetes is 400. Reduce the minimum required sample size using the rate from the prior year's HEDIS submission, which was 62%. Based on experience, estimate a 5% oversample rate. Follow the systematic sampling methodology.

Step 1 ADM = 400.

Step 2 From Table 2, the MRSS is 388.

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

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

Step 5 *Skip this step.*

Step 6 *Skip this step.*

Step 7 *Skip this step.*

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

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

Complex Probability Sampling

Organization responsibility

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

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

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

Substituting Medical Records

Acceptable circumstances for substitution

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

1. Errors in sampling data

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

- A member selected for the Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents sample is found to be 22 years old.
- A member in the sample for any measure has a notation entered by the deadline established for the measure, explaining the reason for the erroneous inclusion and stating the member does not have the condition.

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

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

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

References

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

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

MY 2026 HEDIS for QRS Measure Technical Specifications

(Alphabetical Order)

Appropriate Treatment for Upper Respiratory Infection (URI)

Measure title	Appropriate Treatment for Upper Respiratory Infection	**Measure ID**	URI
Description	The percentage of episodes for persons 3 months of age and older with a diagnosis of upper respiratory infection (URI) that did not result in an antibiotic dispensing event.		
Measurement period	January 1–December 31.		
Copyright and disclaimer notice	Refer to the complete copyright and disclaimer information at the front of the NCQA Measure Specifications. NCQA website: www.ncqa.org. Submit policy clarification support questions via My NCQA (https://my.ncqa.org).		
Clinical recommendation statement/ rationale	The common cold (or URI) is a frequent reason for patients visiting the doctor's office. Though existing clinical guidelines do not support the use of antibiotics for the common cold, physicians often prescribe them for this ailment. Clinical practice guidelines do not recommend antibiotics for a majority of URIs because of the viral etiology of these infections, including the common cold. A performance measure of antibiotic use for URI sheds light on the prevalence of inappropriate antibiotic prescribing in clinical practice and raises awareness of the importance of reducing inappropriate antibiotic use to combat antibiotic resistance in the community.		
Citations	Sur, D.K.C., & M.L. Plesa. 2022. "Antibiotic Use in Acute Upper Respiratory Tract Infections." *Am Fam Physician* 106(6):628–36. Kimberlin, D.W., R. Banerjee, E.D. Barnett, et al. 2024. "Principles of Appropriate Use of Antimicrobial Therapy for Upper Respiratory Tract Infections." In: D.W. Kimberlin, R. Banerjee, E.D. Barnett, R. Lynfield, M.H. Sawyer, eds. *Red Book: 2024–2027 Report of the Committee on Infectious Diseases*. 33rd ed. Committee on Infectious Diseases, American Academy of Pediatrics.		
Characteristics			
Scoring	Proportion.		
Type	Process.		
Product line	Exchange.		
Stratifications	Age as of the episode date. • 3 months–17 years. • 18–64 years. • 65 years and older.		
Risk adjustment	None.		

Improvement notation	Increased score indicates improvement.
Guidance	**Data collection methodology:** Administrative. Refer to *General Guideline: Data Collection Methods* for additional information. **Date specificity:** Dates must be specific enough to determine the event occurred in the period being measured. **Which services count?** • Include all paid, suspended, pending and denied claims to identify the initial population and denominator exclusions. • Do not include denied claims when identifying numerator events; only include claims the organization paid for or expects to pay for (i.e., claims incurred but not paid). **Supplemental data exceptions:** Supplemental data may not be used for this measure, except for denominator exclusions. **Other guidance:** • Reported as an inverted rate [1–(numerator/denominator)]. A higher rate indicates appropriate treatment (i.e., the proportion of episodes that did not result in an antibiotic dispensing event). • The measure is based on episodes; therefore, it is possible for the denominator to include multiple events for the same person.
Definitions	
Episode date	The date of service for any outpatient, telephone or ED visit, e-visit or virtual check-in during the intake period with a diagnosis of URI.
Intake period	July 1 of the year prior to the measurement period to June 30 of the measurement period. The intake period captures eligible episodes of treatment.
Negative comorbid condition history	A period of 365 days prior to and including the episode date when the person had no claims/encounters with a diagnosis for a comorbid condition (366 days total).
Negative competing diagnosis	The episode date and 3 days following the episode date when the person had no claims/encounters with a competing diagnosis.
Negative medication history	To qualify for negative medication history, the following criteria must be met: • A period of 30 days prior to the episode date when the person had no pharmacy claims for either new or refill prescriptions for a listed antibiotic drug. • No prescriptions dispensed more than 30 days prior to the episode date that are active on the episode date. A prescription is considered active if the “days supply” indicated on the date when the person was dispensed the prescription is the number of days or more between that date and the relevant service date. The 30-day look-back period for pharmacy data includes the 30 days prior to the intake period.

Initial population	*Measure item count:* Episode. *Attribution basis:* Enrollment. • *Benefits:* Medical and pharmacy. • *Continuous enrollment:* 30 days prior to the episode date through 3 days after the episode date (34 total days). • *Allowable gap:* None. *Ages:* 3 months of age or older as of the episode date. *Event:* **Episodes of upper respiratory infection diagnosis.** **Step 1.** Identify all persons who had an outpatient visit, ED visit telephone visit, e-visit or virtual check-in (Outpatient, ED and Telehealth Value Set) during the intake period, with a diagnosis of URI (URI Value Set). **Step 2.** Determine all URI episode dates. For each person identified in step 1, determine all outpatient, telephone or ED visits, e-visits and virtual check-ins with a URI diagnosis. Exclude visits that result in an inpatient stay (Inpatient Stay Value Set). **Step 3.** Test for negative comorbid condition history. Remove episode dates where the person had a claim/encounter with any diagnosis for a comorbid condition (Comorbid Conditions Value Set*) during the 365 days prior to or on the episode date. **Step 4.** Test for negative medication history. Remove episode dates where a new or refill prescription for an antibiotic medication (AAB Antibiotic Medications List) was dispensed 30 days prior to the episode date or was active on the episode date. **Step 5.** Test for negative competing diagnosis. Remove episode dates where the person had a claim/encounter with a competing diagnosis (Pharyngitis Value Set*; Competing Diagnosis Value Set*) on or three days after the episode date. **Step 6.** Calculate continuous enrollment. **Step 7.** Deduplicate eligible episodes. If a person has more than one eligible episode in a 31-day period, include only the first eligible episode. For example, if a person has an eligible episode on January 1, include the January 1 visit and do not include eligible episodes that occur on or between January 2 and January 31; then, if applicable, include the next eligible episode that occurs on or after February 1. Identify visits chronologically, including only one per 31-day period. **Coding Guidance** *Do not include laboratory claims (claims with POS code 81).

<table>
<tr><td>Denominator exclusions</td><td>Persons with a date of death.
Death in the measurement period, identified using data sources determined by the organization. Method and data sources are subject to review during the HEDIS audit.

Persons in hospice or using hospice services.
Persons who use hospice services (Hospice Encounter Value Set; Hospice Intervention Value Set) or elect to use a hospice benefit any time during the measurement period. Organizations that use the Monthly Membership Detail Data File to identify these persons must use only the run date of the file.</td></tr>
<tr><td>Denominator</td><td>The initial population minus denominator exclusions.</td></tr>
<tr><td>Numerator</td><td>Antibiotic medication was dispensed.
Dispensed prescription for an antibiotic medication (AAB Antibiotic Medications List) on or 3 days after the episode date.</td></tr>
<tr><td>Summary of changes</td><td>• No changes to this measure.</td></tr>
<tr><td>Data element tables</td><td>Organizations that submit HEDIS data to NCQA must provide the following data elements.

Table URI-4: Data Elements for Appropriate Treatment for Upper Respiratory Infection
<table>
<tr><th>Metric</th><th>Age</th><th>Data Element</th><th>Reporting Instructions</th></tr>
<tr><td rowspan="6">AppropriateURITreatment</td><td rowspan="6">3m-17</td><td>Benefit</td><td>Metadata</td></tr>
<tr><td rowspan="5">18-64</td><td>InitialPopulation</td><td>For each Stratification</td></tr>
<tr><td rowspan="4">65+</td><td>Exclusions</td><td>For each Stratification</td></tr>
<tr><td>Total</td><td>Denominator</td><td>For each Stratification</td></tr>
<tr><td>NumeratorByAdmin</td><td>For each Stratification</td></tr>
<tr><td>Rate</td><td>(Percent)</td></tr>
</table></td></tr>
</table>

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

Measure title	Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis	**Measure ID**	AAB
Description	The percentage of episodes for persons 3 months of age and older with a diagnosis of acute bronchitis/bronchiolitis that did not result in an antibiotic dispensing event.		
Measurement period	January 1–December 31.		
Copyright and disclaimer notice	Refer to the complete copyright and disclaimer information at the front of the NCQA Measure Specifications. NCQA website: www.ncqa.org. Submit policy clarification support questions via My NCQA (https://my.ncqa.org).		
Clinical recommendation statement/ rationale	Antibiotics are not indicated in clinical guidelines for treating patients with acute bronchitis who do not have a comorbidity or other infection for which antibiotics may be appropriate. Inappropriate antibiotic treatment of patients with acute bronchitis is of clinical concern, especially since misuse and overuse of antibiotics lead to antibiotic drug resistance. Acute bronchitis ranks among the top 10 most common outpatient illnesses in the U.S. While most acute bronchitis cases (more than 90%) have a nonbacterial cause, inappropriate antibiotic prescriptions are still common, occurring between 58%–72% of the time.		
Citations	Baillie, E.J., G. Merlo, P. Magin, et al. 2033. "Antibiotic Prescribing for Upper Respiratory Tract Infections and Acute Bronchitis: A Longitudinal Analysis of General Practitioner Trainees." *Fam Pract* 39(6):1063–9. doi:10.1093/fampra/cmac052. Bronchiolitis—Clinical Practice Guideline. American Academy of Family Physicians. Updated 2019. Accessed April 7, 2025. https://www.aafp.org/family-physician/patient-care/clinical-recommendations/all-clinical-recommendations/bronchiolitis.html Singh, A., A. Avula, E. Zahn. 2024. *Acute Bronchitis.* StatPearls Publishing. Snyder, R.L., L.M. King, A.L. Hersh, K.E. Fleming-Dutra. 2020. "Unnecessary Antibiotic Prescribing in Pediatric Ambulatory Care Visits for Bronchitis and Bronchiolitis in the United States, 2006–2015." *Infect Control Hosp Epidemiol* 42(5):612–15. doi:10.1017/ice.2020.1231.		
Characteristics			
Scoring **Type**	Proportion. Process.		

Product line	Exchange.
Stratifications	Age as of the episode date. • 3 months–17 years. • 18–64 years. • 65 years and older.
Risk adjustment	None.
Improvement notation	Increased score indicates improvement.
Guidance	**Data collection methodology:** Administrative. Refer to *General Guideline: Data Collection Methods* for additional information. **Date specificity:** Dates must be specific enough to determine the event occurred in the period being measured. **Which services count?** • Include all paid, suspended, pending and denied claims to identify the initial population and denominator exclusions. • Do not include denied claims when identifying numerator events; only include claims the organization paid for or expects to pay for (i.e., claims incurred but not paid). **Supplemental data exceptions:** Supplemental data may not be used for this measure, except for denominator exclusions. **Other guidance:** • Reported as an inverted rate [1–(numerator/denominator)]. A higher rate indicates appropriate acute bronchitis/bronchiolitis treatment (i.e., the proportion for episodes that did not result in an antibiotic dispensing event). • The measure is based on episodes; therefore, it is possible for the denominator to include multiple events for the same person.
Definitions	
Episode date	The date of service for any outpatient, telephone or ED visit, e-visit or virtual check-in during the intake period with a diagnosis of acute bronchitis/ bronchiolitis.
Intake period	July 1 of the year prior to the measurement period to June 30 of the measurement period. The intake period captures eligible episodes of treatment.
Negative comorbid condition history	A period of 365 days prior to and including the episode date when the person had no claims/encounters with any diagnosis for a comorbid condition (366 total days).
Negative competing diagnosis	The episode date and 3 days following the episode date when the person had no claims/encounters with any competing diagnosis.

Negative medication dispensed history	To qualify for negative medication history, the following criteria must be met: • A period of 30 days prior to the episode date when the person had no pharmacy claims for either new or refill prescriptions for a listed antibiotic drug. • No prescriptions dispensed more than 30 days prior to the episode date that are active on the episode date. A prescription is considered active if the "days supply" indicated on the date when the person was dispensed the prescription is the number of days or more between that date and the relevant service date. The 30-day look-back period for pharmacy data includes the 30 days prior to the intake period.
Initial population	*Measure item count:* Episode. *Attribution basis:* Enrollment. • *Benefits:* Medical and pharmacy. • *Continuous enrollment:* 30 days prior to the episode date through 3 days after the episode date (34 days total). • *Allowable gap:* None. *Ages:* 3 months of age or older as of the episode date. *Event:* **Episodes of acute bronchitis/bronchiolitis diagnosis.** **Step 1.** Identify all persons who had an outpatient, ED, telephone or e-visit or virtual check-in visit (Outpatient, ED and Telehealth Value Set) during the intake period with a diagnosis of acute bronchitis/bronchiolitis (Acute Bronchitis Value Set). **Step 2.** For each person identified in step 1, determine all acute bronchitis/ bronchiolitis episode dates. Exclude visits that result in an inpatient stay (Inpatient Stay Value Set). **Step 3.** Test for negative comorbid condition history. Remove episode dates where the person had a claim/encounter with any diagnosis for a comorbid condition (Comorbid Conditions Value Set*) during the 365 days prior to or on the episode date (366 days total). **Step 4.** Test for negative medication history. Remove episode dates where a new or refill prescription for an antibiotic medication (AAB Antibiotic Medications List) was dispensed 30 days prior to the episode date or was active on the episode date. **Step 5.** Test for negative competing diagnoses. Remove episode dates where the person had a claim/encounter with a competing diagnosis (Pharyngitis Value Set*, Competing Diagnosis Value Set*) on or 3 days after the episode date. **Step 6.** Calculate continuous enrollment. **Step 7.** Deduplicate eligible episodes. Identify visits chronologically, including only one per 31-day period. If a person has more than one eligible episode in a 31-day period, include only the first eligible episode.

<table>
<tr><td></td><td>

- *For example,* if a person has an eligible episode on January 1, include the January 1 visit and do not include eligible episodes that occur on or between January 2 and January 31. Then, if applicable, include the next eligible episode that occurs on or after February 1.

Coding Guidance
*Do not include laboratory claims (claims with POS code 81).
</td></tr>
<tr><td>Denominator exclusions</td><td>

Persons with a date of death.
Death in the measurement period, identified using data sources determined by the organization. Method and data sources are subject to review during the HEDIS audit.

Persons in hospice or using hospice services.
Persons who use hospice services (Hospice Encounter Value Set; Hospice Intervention Value Set) or elect to use a hospice benefit any time during the measurement period. Organizations that use the Monthly Membership Detail Data File to identify these persons must use only the run date of the file.
</td></tr>
<tr><td>Denominator</td><td>The initial population minus denominator exclusions.</td></tr>
<tr><td>Numerator</td><td>

Antibiotic medication was dispensed.
Dispensed prescription for an antibiotic medication (AAB Antibiotic Medications List) on or 3 days after the episode date.
</td></tr>
<tr><td>Summary of changes</td><td>

- No changes to this measure.
</td></tr>
<tr><td>Data element tables</td><td>

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

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

Metric	Age	Data Element	Reporting Instructions
AvoidanceAntibioticTreatment	3m-17	Benefit	Metadata
	18-64	InitialPopulation	For each Stratification
	65+	Exclusions	For each Stratification
	Total	Denominator	For each Stratification
		NumeratorByAdmin	For each Stratification
		Rate	(Percent)
</td></tr>
</table>

Child and Adolescent Well-Care Visits (WCV)

Measure title	Child and Adolescent Well-Care Visits	**Measure ID**	WCV
Description	The percentage of persons 3–21 years of age who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement period.		
Measurement period	January 1–December 31.		
Copyright and disclaimer notice	Refer to the complete copyright and disclaimer information at the front of the NCQA Measure Specifications. NCQA website: www.ncqa.org. Submit policy clarification support questions via My NCQA (https://my.ncqa.org).		
Clinical recommendation statement/ rationale	This measure is based on the American Academy of Pediatrics Bright Futures guidelines for Health Supervision of Infants, Children and Adolescents. Bright Futures recommends one or more well care visits from age 3–21.		
Citations	Bright Futures & American Academy of Pediatrics. “Periodicity Schedule — Recommendations for Preventive Pediatric Health Care.” 2025. https://downloads.aap.org/AAP/PDF/periodicity_schedule.pdf		
Characteristics			
Scoring	Proportion.		
Type	Process.		
Product line	Exchange.		
Stratifications	Age as of the last day of the measurement period. • 3–11 years. • 12–17 years. • 18–21 years. Race. (Refer to *General Guideline: Race and Ethnicity Stratification*.) • American Indian or Alaska Native. • Asian. • Black or African American. • Middle Eastern or North African. • Native Hawaiian or Pacific Islander. • White. • Other Race.		

	• Two or More Races. • Asked But No Answer. • Unknown. Ethnicity. (Refer to *General Guideline: Race and Ethnicity Stratification*.) • Hispanic or Latino. • Not Hispanic or Latino. • Asked But No Answer. • Unknown.
Risk adjustment	None.
Improvement notation	Increased score indicates improvement.
Guidance	**Data collection methodology:** Administrative. Refer to *General Guideline: Data Collection Methods* for additional information. **Date specificity:** Dates must be specific enough to determine the event occurred in the period being measured. **Which services count?** When using claims, include all paid, suspended, pending and denied claims. **Other guidance:** • Refer to Appendix 1 for the definition of *PCP* and *OB/GYN and other prenatal care practitioner.* • The well-care visit must occur with a PCP or an OB/GYN practitioner, but the practitioner does not have to be the practitioner assigned to the child/ adolescent.
Definitions	
Initial population	*Measure item count:* Person. *Attribution basis:* Enrollment. • *Benefits:* Medical. • *Continuous enrollment:* The measurement period. • *Allowable gap:* No more than one gap of ≤45 days during the measurement period. No gaps on the last day of the measurement period. *Ages:* 3–21 years of age as of the last day of the measurement period. *Event:* None.
Denominator exclusions	**Persons with a date of death.** Death in the measurement period, identified using data sources determined by the organization. Method and data sources are subject to review during the HEDIS audit.

	Persons in hospice or using hospice services. Persons who use hospice services (Hospice Encounter Value Set; Hospice Intervention Value Set) or elect to use a hospice benefit any time during the measurement period. Organizations that use the Monthly Membership Detail Data File to identify these persons must use only the run date of the file.
Denominator	The initial population minus denominator exclusions.
Numerator	**Persons who had one or more well-care visits during the measurement period with a PCP or OB/GYN practitioner.** Either of the following meet criteria: • A well-care visit (Well Care Visit Value Set). • An encounter for well-care (Encounter for Well Care Value Set*). Do not include telehealth visits (visits billed with a code that indicates telehealth: Telehealth POS Value Set; Virtual Encounters Value Set). **Coding Guidance** *Do not include laboratory claims (claims with POS code 81).
Summary of changes	• Updated the race and ethnicity stratification categories and Data Elements for Reporting table to align with OMB SPD 15 2024 and US Core Version 6.1.0 Model Definition.
HEDIS for QRS-specific guidance	• HEDIS for QRS does not require race and ethnicity stratification reporting.
Data element tables	Organizations that submit HEDIS data to NCQA must provide the following data elements. ***Table WCV-A-4: Data Elements for Child and Adolescent Well-Care Visits***

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

Table WCV-B-4: Data Elements for Child and Adolescent Well-Care Visits: Stratifications by Race

Metric	Race	Data Element	Reporting Instructions
ChildAdolescentWellVisits	AmericanIndianOrAlaskaNative	Denominator	For each Stratification
	Asian	Numerator	For each Stratification
	BlackOrAfricanAmerican	Rate	(Percent)
	MiddleEasternOrNorthAfrican		
	NativeHawaiianOrPacificIslander		
	White		
	OtherRace		
	TwoOrMoreRaces		
	AskedButNoAnswer		
	Unknown		

Table WCV-C-4: Data Elements for Child and Adolescent Well-Care Visits: Stratifications by Ethnicity

Metric	Ethnicity	Data Element	Reporting Instructions
ChildAdolescentWellVisits	HispanicOrLatino	Denominator	For each Stratification
	NotHispanicOrLatino	Numerator	For each Stratification
	AskedButNoAnswer	Rate	(Percent)
	Unknown		

Chlamydia Screening (CHL)

Measure title	Chlamydia Screening	**Measure ID**	CHL
Description	The percentage of persons 16–24 years of age who were recommended for routine chlamydia screening, were identified as sexually active and had at least one test for chlamydia during the measurement period.		
Measurement period	January 1–December 31.		
Copyright and disclaimer notice	Refer to the complete copyright and disclaimer information at the front of the NCQA Measure Specifications. NCQA website: www.ncqa.org. Submit policy clarification support questions via My NCQA (https://my.ncqa.org).		
Clinical recommendation statement/ rationale	The U.S. Preventive Services Task Force recommends screening for chlamydia in all sexually active women 24 years or younger and in women 25 years or older who are at increased risk for infection. (B recommendation)		
Citations	U.S. Preventive Services Task Force. September 14, 2021. "Screening for Chlamydia and Gonorrhea: US Preventive Services Task Force Recommendation Statement," *JAMA* 326, no. 10: 949–56, https://doi.org/10.1001/jama.2021.14081 Centers for Disease Control and Prevention. 2019. "Sexually Transmitted Disease Surveillance 2018." Atlanta: U.S. Department of Health and Human Services. https://doi.org/10.15620/cdc.79370 Thompson, J. March 2021. "Medical Care of Trans and Gender Diverse Adults" (Boston: Fenway Health). E. Coleman et al. August 19, 2022. "Standards of Care for the Health of Transgender and Gender Diverse People, Version 8." *International Journal of Transgender Health* 23, no. sup1: S1–259. https://doi.org/10.1080/26895269.2022.2100644		
Characteristics			
Scoring	Proportion.		
Type	Process.		
Product line	Exchange.		
Stratifications	Age as of the last day of the measurement period. • 16–20 years. • 21–24 years.		
Risk adjustment	None.		

Improvement notation	Increased score indicates improvement.
Guidance	**Data collection methodology:** Administrative. Refer to *General Guideline: Data Collection Methods* for additional information. **Date specificity:** Dates must be specific enough to determine the event occurred in the period being measured. **Which services count?** When using claims, include all paid, suspended, pending and denied claims. **Supplemental data exceptions:** Do not include supplemental data when identifying the initial population, except when identifying the gender/sex criteria (persons recommended for routine chlamydia screening).
Initial population	*Measure item count:* Person. *Attribution basis:* Enrollment. • *Benefits:* Medical. • *Continuous enrollment:* The measurement period. • *Allowable gap:* No more than one gap of ≤45 days during the measurement period. No gaps on the last day of the measurement period. *Ages:* 16–24 years of age as of the last day of the measurement period. *Gender/sex criteria (persons recommended for routine chlamydia screening):* • Administrative Gender of Female (AdministrativeGender code Female) any time in the person's history. • Sex assigned at birth (LOINC code 76689-9) of Female (Female Value Set) any time in the person's history. • Sex Parameter for Clinical Use of Female (SexParameterForClinicalUse code female-typical) during the measurement period. *Event:* **Persons recommended for routine chlamydia screening.** **Step 1.** Identify persons who were recommended for routine chlamydia screening and are sexually active. Either of the following meets criteria: • *Claim/encounter data*. Persons with a claim or encounter indicating sexual activity (Diagnoses Indicating Sexual Activity Value Set*, Procedures Indicating Sexual Activity Value Set, Pregnancy Tests Value Set) during the measurement period. • *Pharmacy data*. Persons with at least one contraceptive medication dispensing event (Contraceptive Medications List) during the measurement period. **Step 2.** For persons identified in step 1 based on Pregnancy Tests Value Set alone, remove persons with either of the following: • A pregnancy test (Pregnancy Tests Value Set) during the measurement period and a prescription for isotretinoin (Retinoid Medications List) on the date of the pregnancy test through 6 days after the pregnancy test.

<table>
<tr><td></td><td>

- A pregnancy test (Pregnancy Tests Value Set) during the measurement period and an x-ray (Diagnostic Radiology Value Set) on the date of the pregnancy test through 6 days after the pregnancy test.

Coding Guidance
*Do not include laboratory claims (claims with POS code 81).
</td></tr>
<tr><td>Denominator exclusions</td><td>

Persons with a date of death.
Death in the measurement period, identified using data sources determined by the organization. Method and data sources are subject to review during the HEDIS audit.

Persons in hospice or using hospice services.
Persons who use hospice services (Hospice Encounter Value Set; Hospice Intervention Value Set) or elect to use a hospice benefit any time during the measurement period. Organizations that use the Monthly Membership Detail Data File to identify these persons must use only the run date of the file.

Persons with a sex assigned at birth of male.
Sex Assigned at Birth (LOINC code 76689-9) Male (Male Value Set) any time in the person's history through the last day of the measurement period.
</td></tr>
<tr><td>Denominator</td><td>The initial population minus denominator exclusions.</td></tr>
<tr><td>Numerator</td><td>

Persons with a chlamydia test.
At least one chlamydia test (Chlamydia Tests Value Set) during the measurement period.
</td></tr>
<tr><td>Summary of changes</td><td>

- No changes to this measure.
</td></tr>
<tr><td>Data element tables</td><td>

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

Table CHL-4: Data Elements for Chlamydia Screening

Metric	Age	Data Element	Reporting Instructions
ChlamydiaScreening	16-20	InitialPopulation	For each Stratification
	21-24	Exclusions	For each Stratification
	Total	Denominator	For each Stratification
		NumeratorByAdmin	For each Stratification
		NumeratorBySupplemental	For each Stratification
		Rate	(Percent)
</td></tr>
</table>

Controlling High Blood Pressure (CBP)

Measure title	Controlling High Blood Pressure	**Measure ID**	CBP
Description	The percentage of persons 18–85 years of age who had a diagnosis of hypertension (HTN) and whose blood pressure (BP) was adequately controlled (<140/90 mm Hg) during the measurement period.		
Measurement period	January 1–December 31.		
Copyright and disclaimer notice	Refer to the complete copyright and disclaimer information at the front of the NCQA Measure Specifications. NCQA website: www.ncqa.org. Submit policy clarification support questions via My NCQA (https://my.ncqa.org).		
Clinical recommendation statement/ rationale	The American Academy of Family Physicians (AAFP) strongly recommends clinicians treat adults who have hypertension to a standard blood pressure target (<140/90 mm Hg) to reduce the risk of all-cause and cardiovascular mortality. The Joint National Committee recommends that pharmacologic treatment be initiated in the general population <60 years, to lower systolic BP ≥140 mm Hg (and treat to a goal of systolic BP <140 mm Hg) and to lower diastolic BP ≥90 mm Hg (and treat to a goal of diastolic BP <90 mm Hg).		
Citations	Coles, S., L. Fisher, K. Lin, C. Lyon, A. Vosooney, and M. Bird. "Blood Pressure Targets in Adults With Hypertension: A Clinical Practice Guideline From the AAFP." November 14, 2022. James, P.A., S. Oparil, B.L. Carter, W.C. Cushman, C. Dennison-Himmelfarb, J. Handler, D.T. Lackland, et al. "2014 Evidence-Based Guideline for the Management of High Blood Pressure in Adults: Report From the Panel Members Appointed to the Eighth Joint National Committee (JNC 8)." *JAMA* 311, no. 5 (February 5, 2014): 507–20. https://doi.org/10.1001/jama.2013.284427		
Characteristics			
Scoring	Proportion.		
Type	Outcome.		
Product line	Exchange.		

Stratifications	Race. (Refer to *General Guideline: Race and Ethnicity Stratification*.) • American Indian or Alaska Native. • Asian. • Black or African American. • Middle Eastern or North African. • Native Hawaiian or Pacific Islander. • White. • Other Race. • Two or More Races. • Asked But No Answer. • Unknown. Ethnicity. (Refer to *General Guideline: Race and Ethnicity Stratification.*) • Hispanic or Latino. • Not Hispanic or Latino. • Asked But No Answer. • Unknown.
Risk adjustment	None.
Improvement notation	Increased score indicates improvement.
Guidance	**Data collection methodology:** Administrative and hybrid. Refer to *General Guideline: Data Collection Methods* for additional information. **Date specificity:** Dates must be specific enough to determine the event occurred in the period being measured. **Which services count?** When using claims, include all paid, suspended, pending and denied claims.
Definitions	
Adequate control	Both a representative systolic BP <140 mm Hg and a representative diastolic BP of <90 mm Hg.
Representative BP	The most recent BP reading during the measurement period on or after the second diagnosis of hypertension. If multiple BP measurements occur on the same date, or are noted in the chart on the same date, use the lowest systolic and lowest diastolic BP reading. If no BP is recorded during the measurement period, assume the BP is "not controlled."
Initial population	*Measure item count:* Person. *Attribution basis:* Enrollment. • *Benefits:* Medical. • *Continuous enrollment:* The measurement period.

	• *Allowable gap:* No more than one gap of ≤45 days during the measurement period. No gaps on the last day of the measurement period. *Ages:* 18–85 years of age as of the last day of the measurement period. *Event:* **Persons with a diagnosis of hypertension.** **Step 1.** Identify persons who had at least two outpatient visits, telephone visits, e-visits or virtual check-ins (Outpatient and Telehealth Without UBREV Value Set) on different dates of service with a diagnosis of hypertension (Essential Hypertension Value Set) on or between January 1 of the year prior to the measurement period and June 30 of the measurement period. **Step 2.** Remove persons who had a nonacute inpatient admission during the measurement period. To identify nonacute inpatient admissions: 1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set). 2. Confirm the stay was for nonacute care based on the presence of a nonacute code (Nonacute Inpatient Stay Value Set) on the claim. 3. Identify the admission date for the stay.
Denominator exclusions	**Persons with a date of death.** Death in the measurement period, identified using data sources determined by the organization. Method and data sources are subject to review during the HEDIS audit. **Persons in hospice or using hospice services.** Persons who use hospice services (Hospice Encounter Value Set; Hospice Intervention Value Set) or elect to use a hospice benefit any time during the measurement period. Organizations that use the Monthly Membership Detail Data File to identify these persons must use only the run date of the file. **Persons receiving palliative care.** Persons receiving palliative care (Palliative Care Assessment Value Set, Palliative Care Encounter Value Set, Palliative Care Intervention Value Set) or who had an encounter for palliative care (ICD-10-CM code Z51.5*) any time during the measurement period. **Persons 66–80 years of age by the last day of the measurement period, with both frailty and advanced illness.** 1. **Frailty.** At least two indications of frailty (Frailty Device Value Set; Frailty Diagnosis Value Set*; Frailty Encounter Value Set; Frailty Symptom Value Set*) with different dates of service during the measurement period. 2. **Advanced Illness.** Either of the following during the measurement period or the year prior to the measurement period: – Advanced illness (Advanced Illness Value Set*) on at least two different dates of service. – Dispensed dementia medication (Dementia Medications List).

	Persons 81 years of age and older as of the last day of the measurement period, with frailty. Persons with at least two indications of frailty (Frailty Device Value Set; Frailty Diagnosis Value Set*; Frailty Encounter Value Set; Frailty Symptom Value Set*) with different dates of service during the measurement period. **End-stage renal disease (ESRD).** Persons with any of the following during their history on or prior to the last day of the measurement period: • Diagnosis that indicates end-stage renal disease (ESRD) (ESRD Diagnosis Value Set*; History of Nephrectomy or Kidney Transplant Value Set*). • Procedure that indicates ESRD: dialysis (Dialysis Procedure Value Set), nephrectomy (Total Nephrectomy Value Set; Partial Nephrectomy Value Set) or kidney transplant (Kidney Transplant Value Set). **Diagnosis of pregnancy.** Persons with a diagnosis of pregnancy (Pregnancy Value Set*) any time during the measurement period. **Coding Guidance** *Do not include laboratory claims (claims with POS code 81).
Denominator	***ADMINISTRATIVE*** The initial population minus denominator exclusions. ***HYBRID*** A systematic sample drawn from the administrative denominator. The organization may reduce the sample size using the current year's administrative rate or the prior year's audited, product line-specific rate. Refer to the *Guidelines for Calculations and Sampling* for information on reducing the sample size.
Numerator	***ADMINISTRATIVE*** **Both a systolic and diastolic reading <140/90 mm Hg.** Identify the most recent BP reading (Systolic Blood Pressure Value Set; Diastolic Blood Pressure Value Set) taken during the measurement period. Do not include CPT Category II codes (Systolic and Diastolic Result Value Set) with a modifier (CPT CAT II Modifier Value Set). Do not include BPs taken in an acute inpatient setting (Acute Inpatient Value Set; Acute Inpatient POS Value Set) or during an ED visit (ED Value Set; POS code 23). The BP reading must occur *on or after* the date of the second diagnosis of hypertension (identified using the initial population criteria). If there are multiple BPs on the same date of service, use the lowest systolic and lowest diastolic BP on that date as the representative BP. • *Compliant*: BP is <140/90 mm Hg. • *Non-compliant*: BP is ≥140/90 mm Hg; no BP reading during the measurement period; or if the reading is incomplete (e.g., the systolic or diastolic level is missing).

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

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

HYBRID

Administrative: Refer to the administrative specifications to identify positive numerator hits from administrative data.

Identifying the medical record.

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

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

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

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

Medical record: Identify the most recent BP reading noted during the measurement period. The BP reading must occur on or after the date when the second diagnosis of hypertension (identified using the event criteria) occurred.

Do not include BP readings:

- Taken during an acute inpatient stay or an ED visit.
- Taken on the same day as a diagnostic test or diagnostic or therapeutic procedure that requires a change in diet or change in medication on or 1 day before the day of the test or procedure, with the exception of fasting blood tests.
- Taken by the person using a non-digital device such as with a manual blood pressure cuff and a stethoscope.

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

	BP readings taken by the person and documented in the medical record are eligible for use in reporting (provided the BP does not meet any exclusion criteria). There is no requirement that there be evidence the BP was collected by a PCP or specialist. The person is not compliant if the BP reading is ≥140/90 mm Hg or is missing, or if there is no BP reading during the measurement period or if the reading is incomplete (e.g., the systolic or diastolic level is missing). Ranges and thresholds do not meet criteria for this measure. A distinct numeric result for both the systolic and diastolic BP reading is required for numerator compliance. A BP documented as an "average BP" (e.g., "average BP: 139/ 70") is eligible for use. ***Note*** • *When identifying the most recent BP reading, all eligible BP readings in the appropriate medical record should be considered, regardless of practitioner type and setting (excluding acute inpatient and ED visit settings).* • *An EMR can be used to identify the most recent BP reading if it meets the criteria for appropriate medical record.* • *When excluding BP readings from the numerator, identify diagnostic or therapeutic procedures that require a medication regimen, a change in diet or a change in medication; for example (this list is for reference only and is not exhaustive):* – *A colonoscopy requires a change in diet (NPO on the day of the procedure) and a medication change (a medication is taken to prep the colon).* – *Dialysis, infusions and chemotherapy (including oral chemotherapy) are all therapeutic procedures that require a medication regimen.* – *A nebulizer treatment with albuterol is considered a therapeutic procedure that requires a medication regimen (the albuterol).* – *A person forgetting to take regular medications on the day of the procedure is not considered a required change in medication; the BP reading is eligible.* • *BP readings taken on the same day the person receives a common low-intensity or preventive procedure are eligible for use; for example, the following procedures are considered common low-intensity or preventive (this list is for reference only and is not exhaustive):* – *Vaccinations.* – *Injections (e.g., allergy, vitamin B-12, insulin, steroid, Toradol, Depo-Provera, testosterone, lidocaine).* – *TB test.* – *IUD insertion.* – *Eye exam with dilating agents.* – *Wart or mole removal.*
Summary of changes	• Updated the race and ethnicity stratification categories and Data Elements for Reporting table to align with OMB SPD 15 2024 and US Core Version 6.1.0 Model Definition.
HEDIS for QRS-specific guidance	• HEDIS for QRS does not require race and ethnicity stratification reporting.

Data element tables

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

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

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

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

Metric	Race	Data Element	Reporting Instructions	A
ControlHighBP	AmericanIndianOrAlaskaNative	CollectionMethod	Repeat per Stratification	✓
	Asian	Denominator	For each Stratification	✓
	BlackOrAfricanAmerican	Numerator	For each Stratification	✓
	MiddleEasternOrNorthAfrican	Rate	(Percent)	✓
	NativeHawaiianOrPacificIslander			
	White			
	OtherRace			
	TwoOrMoreRaces			
	AskedButNoAnswer			
	Unknown			

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

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

Enrollment by Product Line (ENP)

SUMMARY OF CHANGES TO HEDIS MY 2026

- No changes to this measure.

Description

The total number of members enrolled in the product line, stratified by age.

Calculations

Product lines Report the following table, stratified by age:

- Table ENP-4 Exchange.

Member months Report all member months for the measurement year. IDSS will convert these to member years. Member months are a member's "contribution" to the total yearly membership.

Step 1 Determine member months using a specified day of each month (e.g., the 15th or the last day of the month), to be determined according to the organization's administrative processes. The day selected must be consistent from member to member, month to month and from year to year. For example, if the organization tallies membership on the 15th of the month, a member who is enrolled in the organization on January 15 contributes 1 member month in January.

Retroactive enrollment. The organization may include any months in which members were enrolled retrospectively and for which the organization received a retroactive capitation payment.

Step 2 Use the member's age on the specified day of each month to determine the age group to which member months will be contributed. For example, if an organization tallies membership on the 15th of each month, a member who turns 25 on April 3 and is enrolled for the entire year contributes 3 member months (January, February, March) to the 20–24 age category and 9 member months to the 25–29 age category.

Table ENP-4: Data Elements for Enrollment by Product Line

Metric	Age	Data Element	Reporting Instructions
Enrollment	LessThan1	MemberMonths	For each Stratification
	1-4	Rate	(Member Years)
	5-9		
	10-14		
	15-17		
	18-19		
	20-24		
	25-29		
	30-34		
	35-39		
	40-44		
	45-49		
	50-54		
	55-59		
	60-64		
	65-69		
	70-74		
	75-79		
	80-84		
	85-89		
	90+		
	Unknown		
	Total		

Eye Exam for Patients With Diabetes (EED)

Measure title	Eye Exam for Patients With Diabetes	**Measure ID**	EED
Description	The percentage of persons 18–75 years of age with diabetes (type 1 or type 2) who had a retinal eye exam.		
Measurement period	January 1–December 31.		
Copyright and disclaimer notice	Refer to the complete copyright and disclaimer information at the front of the NCQA Measure Specifications. NCQA website: www.ncqa.org. Submit policy clarification support questions via My NCQA (https://my.ncqa.org).		
Clinical recommendation statement/ rationale	American Diabetes Association (2025) • Adults with type 1 diabetes should have an initial dilated and comprehensive eye examination by an ophthalmologist or optometrist within 5 years after the onset of diabetes. Level of evidence: B • Patients with type 2 diabetes should have an initial dilated and comprehensive eye examination by an ophthalmologist or optometrist at the time of the diabetes diagnosis. Level of evidence: B • If there is no evidence of retinopathy for one or more annual eye exams and glycemic indicators are within the goal range, then screening every 1–2 years may be considered. If any level of diabetic retinopathy is present, subsequent dilated retinal examinations should be repeated at least annually by an ophthalmologist or optometrist. If retinopathy is progressing or sight-threatening, then examinations will be required more frequently. Level of evidence: B • Programs that use retinal photography with remote reading or the use of U.S. Food and Drug Administration–approved artificial intelligence algorithms to improve access to diabetic retinopathy screening are appropriate screening strategies for diabetic retinopathy. Such programs need to provide pathways for timely referral for a comprehensive eye examination when indicated. Level of evidence: B		
Citations	American Diabetes Association Professional Practice Committee. 2025. 12. "Retinopathy, Neuropathy, and Foot Care: Standards of Care in Diabetes—2025." *Diabetes Care* 48(Suppl. 1):S252–65.		
Characteristics			
Scoring	Proportion.		
Type	Process.		
Product line	Exchange.		

Stratifications	Race. (Refer to *General Guideline: Race and Ethnicity Stratification.*) • American Indian or Alaska Native. • Asian. • Black or African American. • Middle Eastern or North African. • Native Hawaiian or Pacific Islander. • White. • Other Race. • Two or More Races. • Asked But No Answer. • Unknown. Ethnicity. (Refer to *General Guideline: Race and Ethnicity Stratification.*) • Hispanic or Latino. • Not Hispanic or Latino. • Asked But No Answer. • Unknown.
Risk adjustment	None.
Improvement notation	Increased score indicates improvement.
Guidance	**Data collection methodology:** Administrative. Refer to *General Guideline: Data Collection Methods* for additional information. **Date specificity:** Dates must be specific enough to determine the event occurred in the period being measured. **Which services count?** When using claims, include all paid, suspended, pending and denied claims.
Initial population	*Measure item count:* Person. *Attribution basis:* Enrollment. • *Benefits:* Medical. • *Continuous enrollment:* The measurement period. • *Allowable gap:* No more than one gap of ≤45 days during the measurement period. No gaps on the last day of the measurement period. *Ages:* 18–75 years of age as of the last day of the measurement period. *Event:* **Identify persons with a diagnosis of diabetes.** Either of the following meets criteria: • *Claim/encounter data.* At least two diagnoses of diabetes (Diabetes Value Set*) on different dates of service during the measurement period or the year prior to the measurement period.

	• *Pharmacy data.* At least one diagnosis of diabetes (Diabetes Value Set*) ***and*** at least one diabetes medication dispensing event of insulin or a hypoglycemic/antihyperglycemic medication (Diabetes Medications List) during the measurement period or the year prior to the measurement period. **Coding Guidance** *Do not include laboratory claims (claims with POS code 81).
Denominator exclusions	**Persons with a date of death.** Death in the measurement period, identified using data sources determined by the organization. Method and data sources are subject to review during the HEDIS audit. **Persons in hospice or using hospice services.** Persons who use hospice services (Hospice Encounter Value Set; Hospice Intervention Value Set) or elect to use a hospice benefit any time during the measurement period. Organizations that use the Monthly Membership Detail Data File to identify these persons must use only the run date of the file. **Persons receiving palliative care.** Persons receiving palliative care (Palliative Care Assessment Value Set; Palliative Care Encounter Value Set; Palliative Care Intervention Value Set) or who had an encounter for palliative care (ICD-10-CM code Z51.5*) any time during the measurement period. **Persons 66 years of age or older by the last day of the measurement period, with both frailty and advanced illness.** 1. **Frailty.** At least two indications of frailty (Frailty Device Value Set; Frailty Diagnosis Value Set*; Frailty Encounter Value Set; Frailty Symptom Value Set*) with different dates of service during the measurement period. 2. **Advanced illness.** Either of the following during the measurement period or the year prior to the measurement period: – Advanced illness (Advanced Illness Value Set*) on at least two different dates of service. – Dispensed dementia medication (Dementia Medications List). **Persons with bilateral absence of eyes or eye enucleation.** • Bilateral absence of eyes (SNOMED CT code 15665641000119103) any time during the person's history through the last day of the measurement period. • Bilateral eye enucleation any time during the person's history through the last day of the measurement period: – Unilateral eye enucleation (Unilateral Eye Enucleation Value Set) with a bilateral modifier (CPT Modifier code 50). – Two unilateral eye enucleations (Unilateral Eye Enucleation Value Set) with service dates 14 days or more apart. – Left unilateral eye enucleation (ICD-10-PCS code 08T1XZZ) and right unilateral eye enucleation (ICD-10-PCS code 08T0XZZ) on the same or different dates of service.

	– A unilateral eye enucleation (Unilateral Eye Enucleation Value Set) and a left unilateral eye enucleation (ICD-10-PCS code 08T1XZZ) with service dates 14 days or more apart. – A unilateral eye enucleation (Unilateral Eye Enucleation Value Set) and a right unilateral eye enucleation (ICD-10-PCS code 08T0XZZ) with service dates 14 days or more apart. **Coding Guidance** *Do not include laboratory claims (claims with POS code 81).
Denominator	The initial population minus denominator exclusions.
Numerator	**Retinal eye exam.** Screening or monitoring for diabetic retinal disease. This includes persons with diabetes who had one of the following: • A retinal or dilated eye exam by an eye care professional (optometrist or ophthalmologist) in the measurement period. • A negative retinal or dilated eye exam (negative for retinopathy) by an eye care professional in the year prior to the measurement period. Any of the following meet criteria: • Any code in the Retinal Eye Exams Value Set billed by an eye care professional (optometrist or ophthalmologist) during the measurement period. • Any code in the Retinal Eye Exams Value Set billed by an eye care professional (optometrist or ophthalmologist) during the year prior to the measurement period, with a diagnosis of diabetes without complications (Diabetes Mellitus Without Complications Value Set). • Any code in the Eye Exam With Evidence of Retinopathy Value Set†, Eye Exam Without Evidence of Retinopathy Value Set† billed by any provider type during the measurement period. • Retinal imaging with interpretation and reporting by a qualified reading center (Retinal Imaging Value Set) billed by any provider type during the measurement period. • Autonomous eye exam billed by any provider type during the measurement period. Either of the following meets criteria: – CPT code 92229. – LOINC code 105914-6 ***with*** a result (Autonomous Eye Exam Result or Finding Value Set). • Any code in the Eye Exam Without Evidence of Retinopathy Value Set† billed by any provider type during the year prior to the measurement period. • Diabetic retinal screening negative in prior year (CPT-CAT-II code 3072F†) billed by any provider type during the measurement period. • Any combination that indicates findings from a retinal exam for diabetic retinopathy performed in **both** the **left and right eye** by any provider, or a combination that indicates one eye is enucleated and the other was examined.

<table>
<tr><td></td><td>
– Left eye:
▪ Retinal exam finding: Any level of retinopathy (LOINC code 71490-7 with Diabetic Retinopathy Severity Level Value Set) during the measurement period.
▪ Retinal exam finding: No retinopathy (LOINC code 71490-7 with LOINC code LA18643-9) in the year prior to the measurement period.
▪ Enucleation: ICD-10-PCS code 08T1XZZ any time during the person’s history through the last day of the measurement period.
– Right eye:
▪ Retinal exam finding: Any level of retinopathy (LOINC code 71491-5 with Diabetic Retinopathy Severity Level Value Set) during the measurement period.
▪ Retinal exam finding: No retinopathy (LOINC code 71491-5 with LOINC code LA18643-9) in the year prior to the measurement period.
▪ Enucleation: ICD-10-PCS code 08T0XZZ any time during the person’s history through the last day of the measurement period.

Coding Guidance
†Do not include codes with a modifier (CPT CAT II Modifier Value Set).
</td></tr>
<tr><td>Summary of changes</td><td>• Updated the race and ethnicity stratification categories and Data Elements for Reporting table to align with OMB SPD 15 2024 and US Core Version 6.1.0 Model Definition.</td></tr>
<tr><td>HEDIS for QRS-specific guidance</td><td>• HEDIS for QRS does not require race and ethnicity stratification reporting.</td></tr>
<tr><td>Data element tables</td><td>Organizations that submit HEDIS data to NCQA must provide the following data elements.

Table EED-A-4: Data Elements for Eye Exam for Patients With Diabetes
<table>
<tr><th>Metric</th><th>Data Element</th><th>Reporting Instructions</th></tr>
<tr><td>EyeExams</td><td>InitialPopulation</td><td>Report once</td></tr>
<tr><td></td><td>Exclusions</td><td>Report once</td></tr>
<tr><td></td><td>Denominator</td><td>Report once</td></tr>
<tr><td></td><td>NumeratorByAdmin</td><td>Report once</td></tr>
<tr><td></td><td>NumeratorBySupplemental</td><td>Report once</td></tr>
<tr><td></td><td>Rate</td><td>(Percent)</td></tr>
</table>
</td></tr>
</table>

Table EED-B-4: Data Elements for Eye Exam for Patients With Diabetes: Stratifications by Race

Metric	Race	Data Element	Reporting Instructions
EyeExams	AmericanIndianOrAlaskaNative	Denominator	For each Stratification
	Asian	Numerator	For each Stratification
	BlackOrAfricanAmerican	Rate	(Percent)
	MiddleEasternOrNorthAfrican		
	NativeHawaiianOrPacificIslander		
	White		
	OtherRace		
	TwoOrMoreRaces		
	AskedButNoAnswer		
	Unknown		

Table EED-C-4: Data Elements for Eye Exam for Patients With Diabetes: Stratifications by Ethnicity

Metric	Ethnicity	Data Element	Reporting Instructions
EyeExams	HispanicOrLatino	Denominator	For each Stratification
	NotHispanicOrLatino	Numerator	For each Stratification
	AskedButNoAnswer	Rate	(Percent)
	Unknown		

Follow-Up After Hospitalization for Mental Illness (FUH)

Measure title	Follow-Up After Hospitalization for Mental Illness	**Measure ID**	FUH
Description	The percentage of discharges for persons 6 years of age and older who were hospitalized for a principal diagnosis of mental illness, or any diagnosis of intentional self-harm, and had a mental health follow-up service. Two rates are reported: 1. The percentage of discharges for which the person received follow-up within 30 days after discharge. 2. The percentage of discharges for which the person received follow-up within 7 days after discharge.		
Measurement period	January 1–December 31.		
Copyright and disclaimer notice	Refer to the complete copyright and disclaimer information at the front of the NCQA Measure Specifications. NCQA website: www.ncqa.org. Submit policy clarification support questions via My NCQA (https://my.ncqa.org).		
Clinical recommendation statement/ rationale	Ensuring coordination of care for individuals leaving the inpatient setting is critical. Individuals discharged from these settings may face health risks, including potential medication non-compliance, social isolation, substance use, suicidal ideation or self-harm, as well as financial or practical challenges, such as stable housing. Follow-up services can act as a critical link between the inpatient setting and transition into the community, ensuring coordination of care and ongoing support. During follow-up, providers have the opportunity to evaluate progress, address emerging symptoms and concerns, and adjust the treatment plan as needed. Early interventions and proactive management of potential challenges can reduce risk of readmission and promote sustained well-being. Additionally, studies have shown that timely follow-up after psychiatric hospitalization can increase the likelihood of adherence to medication and outpatient treatment, and reduce risk of suicide.		
Citations	Fontanella, C.A., L.A. Warner, J.D. Steelesmith, G. Brock, J.A. Bridge, & J.V. Campo. 2020. “Association of Timely Outpatient Mental Health Services for Youths after Psychiatric Hospitalization with Risk of Death by Suicide.” *JAMA Network Open* 3(8), E2012887. Chung, D.T. C.J. Ryan, D. Hadzi-Pavlovic, S.P. Singh, C. Stanton, & M.M. Large. 2017. “Suicide Rates After Discharge From Psychiatric Facilities: A Systematic Review and Meta-Analysis.” *JAMA Psychiatry* 74(7), 694–702. Fontanella, C.A., J.A. Bridge, S.C. Marcus, & Campo, J.V. 2011. “Factors Associated with Antidepressant Adherence for Medicaid-Enrolled Children and Adolescents. *Annals of Pharmacotherapy* 45(7-8), 898–909.		

	Beadles, C.A., A.R. Ellis, J.C. Lichstein, J.F. Farley, C.T. Jackson, J.P. Morrissey, & M.E. Domino. 2015. "First Outpatient Follow-Up After Psychiatric Hospitalization: Does One Size Fit All?" *Psychiatric Services* 66(4), 364–72. https://doi.org/10.1176/appi.ps.201400081
Characteristics	
Scoring	Proportion.
Type	Process.
Product line	Exchange.
Stratifications	Age as of the date of discharge. • 6–17 years. • 18–64 years. • 65 years and older. Race. (Refer to *General Guideline: Race and Ethnicity Stratification.*) • American Indian or Alaska Native. • Asian. • Black or African American. • Middle Eastern or North African. • Native Hawaiian or Pacific Islander. • White. • Other Race. • Two or More Races. • Asked But No Answer. • Unknown. Ethnicity. (Refer to *General Guideline: Race and Ethnicity Stratification.*) • Hispanic or Latino. • Not Hispanic or Latino. • Asked But No Answer. • Unknown.
Risk adjustment	None.
Improvement notation	Increased score indicates improvement.
Guidance	**Data collection methodology:** Administrative. Refer to the *General Guideline: Data Collection Methods* for additional information. **Date specificity:** Dates must be specific enough to determine the event occurred in the period being measured.

	Which services count? • When using claims, include all paid, suspended, pending and denied claims. • Organizations may have different methods for billing intensive outpatient visits and partial hospitalizations. Some may be comparable to outpatient billing, with separate claims for each date of service; others may be comparable to inpatient billing, with an admission date, a discharge date and units of service. Organizations whose billing methods are comparable to inpatient billing may count each unit of service as an individual visit. The unit of service must have occurred during the required period for the rate (e.g., within 30 days after discharge or within 7 days after discharge). **Other guidance:** • Refer to Appendix 1 for the definition of *mental health provider.* Organizations must develop their own methods to identify mental health providers. Methods are subject to review by the HEDIS auditor. • The measure is based on episodes; therefore, it is possible for the denominator to include multiple events for the same person.
Initial population	*Measure item count:* Episode. *Attribution basis:* Enrollment. • *Benefits:* Medical and mental health (inpatient and outpatient). • *Continuous enrollment:* Date of discharge through 30 days after discharge. • *Allowable gap:* None. *Ages:* 6 years of age and older as of the date of discharge. *Event:* **Hospitalization for mental illness.** An acute inpatient discharge with a principal diagnosis of mental illness (Mental Illness Value Set), or any diagnosis of intentional self-harm (Intentional Self Harm Value Set), on the discharge claim on or between January 1 and December 1 of the measurement period. To identify acute inpatient discharges: 1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set). 2. Exclude nonacute inpatient stays (Nonacute Inpatient Stay Value Set). 3. Identify the discharge date for the stay. ***Acute readmission or direct transfer.*** Identify readmissions and direct transfers to an acute inpatient care setting during the 30-day follow-up period: 1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set). 2. Exclude nonacute inpatient stays (Nonacute Inpatient Stay Value Set). 3. Identify the admission date for the stay (the admission date must occur during the 30-day follow-up period). 4. Identify the discharge date for the stay. Exclude both the initial discharge and the readmission/direct transfer discharge if the last discharge occurs after December 1 of the measurement period.

	If the readmission/direct transfer to the acute inpatient care setting was for a principal diagnosis of mental health disorder, or any diagnosis of intentional self-harm (Mental Health Diagnosis Value Set; Intentional Self Harm Value Set), count only the last discharge (use only the discharge claim). If the readmission/direct transfer to the acute inpatient care setting was for any other principal diagnosis, and intentional self-harm was not on the claim in any diagnosis position, exclude both the original and the readmission/direct transfer discharge (use only the discharge claim). ***Nonacute readmission or direct transfer.*** Exclude discharges followed by readmission or direct transfer to a nonacute inpatient care setting (except for psychiatric residential treatment) within the 30-day follow-up period, regardless of the diagnosis for the readmission. To identify readmissions and direct transfers to a nonacute inpatient care setting: 1. Identify all acute and nonacute inpatient stays except for residential psychiatric treatment (Inpatient Stay Except Psychiatric Residential Value Set). 2. Confirm the stay was for nonacute care based on the presence of a nonacute code (Nonacute Inpatient Stay Value Set) on the claim. 3. Identify the admission date for the stay. These discharges are excluded from the measure because rehospitalization or direct transfer may prevent an outpatient follow-up visit from taking place.
Denominator exclusions	**Persons with a date of death.** Death in the measurement period, identified using data sources determined by the organization. Method and data sources are subject to review during the HEDIS audit. **Persons in hospice or using hospice services.** Persons who use hospice services (Hospice Encounter Value Set; Hospice Intervention Value Set) or elect to use a hospice benefit any time during the measurement period. Organizations that use the Monthly Membership Detail Data File to identify these persons must use only the run date of the file.
Denominator	The initial population minus denominator exclusions.
Numerator	**Numerator 1: 30-day follow-up.** A follow-up visit with a mental health provider, or with any practitioner for any diagnosis of a mental health disorder, within 30 days after discharge. Do not include visits that occur on the date of discharge. **Numerator 2: 7-day follow-up.** A follow-up visit with a mental health provider, or with any practitioner for any diagnosis of a mental health disorder, within 7 days after discharge. Do not include visits that occur on the date of discharge. For both indicators, any of the following meet criteria for a follow-up visit: • An outpatient visit (Visit Setting Unspecified Value Set) ***with*** (Outpatient POS Value Set) ***with*** a mental health provider.

	• An outpatient visit (Visit Setting Unspecified Value Set) ***with*** (Outpatient POS Value Set) ***with*** any diagnosis of mental health disorder (Mental Health Diagnosis Value Set). • An outpatient visit (BH Outpatient Value Set) ***with*** a mental health provider. • An outpatient visit (BH Outpatient Value Set) ***with*** any diagnosis of mental health disorder (Mental Health Diagnosis Value Set). • An intensive outpatient encounter or partial hospitalization (Visit Setting Unspecified Value Set ***with*** POS code 52). • An intensive outpatient encounter or partial hospitalization (Partial Hospitalization or Intensive Outpatient Value Set). • A community mental health center visit (Visit Setting Unspecified Value Set; BH Outpatient Value Set; Transitional Care Management Services Value Set) ***with*** POS code 53. • Electroconvulsive therapy (Electroconvulsive Therapy Value Set) ***with*** (Outpatient POS Value Set; POS code 24; POS code 52; POS code 53). • A telehealth visit (Visit Setting Unspecified Value Set) ***with*** (Telehealth POS Value Set) ***with*** a mental health provider. • A telehealth visit (Visit Setting Unspecified Value Set) ***with*** (Telehealth POS Value Set) ***with*** any diagnosis of mental health disorder (Mental Health Diagnosis Value Set). • Transitional care management services (Transitional Care Management Services Value Set) ***with*** a mental health provider. • Transitional care management services (Transitional Care Management Services Value Set) ***with*** any diagnosis of mental health disorder (Mental Health Diagnosis Value Set). • A visit in a behavioral healthcare setting (Behavioral Healthcare Setting Value Set). • A telephone visit (Telephone Visits Value Set) ***with*** a mental health provider. • A telephone visit (Telephone Visits Value Set) ***with*** any diagnosis of mental health disorder (Mental Health Diagnosis Value Set). • Psychiatric collaborative care management (Psychiatric Collaborative Care Management Value Set). • Peer support services (Peer Support Services Value Set) ***with*** any diagnosis of mental health disorder (Mental Health Diagnosis Value Set). • Psychiatric residential treatment (Residential Behavioral Health Treatment Value Set). • Psychiatric residential treatment (Visit Setting Unspecified Value Set ***with*** POS code 56).
Summary of changes	• Updated the race and ethnicity stratification categories and Data Elements for Reporting table to align with OMB SPD 15 2024 and US Core Version 6.1.0 Model Definition.

HEDIS for QRS-specific guidance

- HEDIS for QRS does not require race and ethnicity stratification reporting.

Data element tables

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

Table FUH-A-4: Data Elements for Follow-Up After Hospitalization for Mental Illness

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

Table FUH-B-4: Data Elements for Follow-Up After Hospitalization for Mental Illness: Stratifications by Race

Metric	Race	Data Element	Reporting Instructions
FollowUp30Day	AmericanIndianOrAlaskaNative	Denominator	For each Stratification, repeat per Metric
FollowUp7Day	Asian	Numerator	For each Metric and Stratification
	BlackOrAfricanAmerican	Rate	(Percent)
	MiddleEasternOrNorthAfrican		
	NativeHawaiianOrPacificIslander		
	White		
	OtherRace		
	TwoOrMoreRaces		
	AskedButNoAnswer		
	Unknown		

Table FUH-C-4: Data Elements for Follow-Up After Hospitalization for Mental Illness: Stratifications by Ethnicity

Metric	Ethnicity	Data Element	Reporting Instructions
FollowUp30Day	HispanicOrLatino	Denominator	For each Stratification, repeat per Metric
FollowUp7Day	NotHispanicOrLatino	Numerator	For each Metric and Stratification
	AskedButNoAnswer	Rate	(Percent)
	Unknown		

Glycemic Status Assessment for Patients With Diabetes (GSD)

Measure title	Glycemic Status Assessment for Patients With Diabetes	**Measure ID**	GSD
Description	The percentage of persons 18–75 years of age with diabetes (type 1 or type 2) whose most recent glycemic status (hemoglobin A1c [HbA1c] or glucose management indicator [GMI]) was at the following levels during the measurement period: • Glycemic Status >9.0%.		
Measurement period	January 1–December 31.		
Copyright and disclaimer notice	Refer to the complete copyright and disclaimer information at the front of the NCQA Measure Specifications. NCQA website: www.ncqa.org. Submit policy clarification support questions via My NCQA (https://my.ncqa.org).		
Clinical recommendation statement/ rationale	American Diabetes Association (2025) • Assess glycemic status by A1C (Level of evidence: A) and/or continuous glucose monitoring (CGM) metrics such as time in range, time above range, and time below range (Level of evidence: B). Fructosamine or CGM can be used for glycemic monitoring when an alternative to A1C is required. Level of evidence: B • Assess glycemic status at least two times a year, and more frequently (e.g., every 3 months) for individuals not meeting glycemic goals or with recent treatment changes, frequent or severe hypoglycemia or hyperglycemia, or changes in health status, or during periods of rapid growth and development in youth. Level of evidence: E • An A1C goal of <7% (<53 mmol/mol) is appropriate for many nonpregnant adults without severe hypoglycemia or frequent hypoglycemia affecting health or quality of life. Level of evidence: A • Based on health care professional judgment and the preference of the person with diabetes, achievement of lower A1C levels than the goal of 7% (53 mmol/mol) may be acceptable and even beneficial if it can be achieved safely without frequent or severe hypoglycemia or other adverse effects of treatment. Level of evidence: B • Less stringent glycemic goals may be appropriate for individuals with limited life expectancy or where the harms of treatment are greater than the benefits. Level of evidence: B		
Citations	American Diabetes Association Professional Practice Committee. 2025. “6. Glycemic Goals and Hypoglycemia: Standards of Care in Diabetes—2025.” *Diabetes Care* 48(Suppl. 1):S128–45.		

Characteristics	
Scoring	Proportion.
Type	Outcome.
Product line	Exchange.
Stratifications	Race. (Refer to *General Guideline: Race and Ethnicity Stratification*.) • American Indian or Alaska Native. • Asian. • Black or African American. • Middle Eastern or North African. • Native Hawaiian or Pacific Islander. • White. • Other Race. • Two or More Races. • Asked But No Answer. • Unknown. Ethnicity. (Refer to *General Guideline: Race and Ethnicity Stratification*.) • Hispanic or Latino. • Not Hispanic or Latino. • Asked But No Answer. • Unknown.
Risk adjustment	None.
Improvement notation	Decreased score indicates improvement.
Guidance	**Data collection methodology:** Administrative and hybrid. Refer to *General Guideline: Data Collection Methods* for additional information. Organizations must use the same data collection method (Administrative or Hybrid) to report these indicators. **Date specificity:** Dates must be specific enough to determine the event occurred in the period being measured. **Which services count?** When using claims, include all paid, suspended, pending and denied claims. **Other guidance:** If a combination of administrative, supplemental or hybrid data are used, the most recent glycemic status assessment must be used, regardless of data source.
Initial population	*Measure item count:* Person. *Attribution basis:* Enrollment. • *Benefits:* Medical.

	• *Continuous enrollment:* The measurement period. • *Allowable gap:* No more than one gap of ≤45 days during the measurement period. No gaps on the last day of the measurement period. *Ages:* 18–75 years of age as of the last day of the measurement period. *Event:* **Identify persons with a diagnosis of diabetes.** Either of the following meets criteria: • *Claim/encounter data.* At least two diagnoses of diabetes (Diabetes Value Set*) on different dates of service during the measurement period or the year prior to the measurement period. • *Pharmacy data.* At least one diagnosis of diabetes (Diabetes Value Set*) ***and*** at least one diabetes medication dispensing event of insulin or a hypoglycemic/antihyperglycemic medication (Diabetes Medications List) during the measurement period or the year prior to the measurement period. **Coding Guidance** *Do not include laboratory claims (claims with POS code 81).
Denominator exclusions	**Persons with a date of death.** Death in the measurement period, identified using data sources determined by the organization. Method and data sources are subject to review during the HEDIS audit. **Persons in hospice or using hospice services.** Persons who use hospice services (Hospice Encounter Value Set; Hospice Intervention Value Set) or elect to use a hospice benefit any time during the measurement period. Organizations that use the Monthly Membership Detail Data File to identify these persons must use only the run date of the file. **Persons receiving palliative care.** Persons receiving palliative care (Palliative Care Assessment Value Set; Palliative Care Encounter Value Set; Palliative Care Intervention Value Set) or who had an encounter for palliative care (ICD-10-CM code Z51.5*) any time during the measurement period. **Persons 66 years of age or older by the last day of the measurement period, with both frailty and advanced illness.** 1. **Frailty.** At least two indications of frailty (Frailty Device Value Set; Frailty Diagnosis Value Set*; Frailty Encounter Value Set; Frailty Symptom Value Set*) with different dates of service during the measurement period. 2. **Advanced illness.** Either of the following during the measurement period or the year prior to the measurement period: – Advanced illness (Advanced Illness Value Set*) on at least two different dates of service. – Dispensed dementia medication (Dementia Medications List). **Coding Guidance** *Do not include laboratory claims (claims with POS code 81).

Denominator	***ADMINISTRATIVE*** The initial population minus denominator exclusions. ***HYBRID*** A systematic sample drawn from the administrative denominator. Organizations may reduce the sample size based on the current year's administrative rate or the prior year's audited, product line-specific rate. Refer to the *Guidelines for Calculations and Sampling* for information on reducing sample size.
Numerator	***ADMINISTRATIVE*** **Glycemic status >9%.** Identify the most recent glycemic status assessment (HbA1c or GMI) (HbA1c Lab Test Value Set; HbA1c Test Result or Finding Value Set*†; LOINC code 97506-0) during the measurement period. If there are multiple glycemic status assessments on the same date, use the lowest result. • *Compliant*: Most recent glycemic status assessment with a result of >9.0% or is missing a result, or if a glycemic status assessment was not done during the measurement period. • *Not compliant*: Most recent glycemic status assessment during the measurement period is ≤9.0%. If the most recent glycemic status assessment was an HbA1c test identified based on a CPT Category II code (HbA1c Test Result or Finding Value Set), use the following to determine compliance: • *Compliant:* CPT Category II code 3046F. • *Not compliant:* HbA1c Level Less Than or Equal To 9.0 Value Set. **Coding Guidance** *Do not include laboratory claims (claims with POS code 81). †Do not include CPT Category II codes with a modifier (CPT CAT II Modifier Value Set). ***HYBRID*** *Administrative:* Refer to the administrative specifications to identify positive numerator hits from administrative data. **Glycemic status >9.0%.** The result of the *most recent* glycemic status assessment (HbA1c or GMI) (performed during the measurement period) is >9.0% or is missing, or was not done during the measurement period, as documented through laboratory data or medical record review. *Medical record:* Documentation in the medical record must include a note indicating the date when the glycemic status assessment was performed, and the result. The person is numerator compliant if the result of the most recent glycemic status assessment during the measurement period is >9.0% or is missing, or if a glycemic status assessment was not done during the measurement period.

	When identifying the most recent glycemic status assessment (HbA1c or GMI), GMI values must include documentation of the continuous glucose monitoring data date range used to derive the value. Use the terminal date in the range to assign assessment date. If multiple glycemic status assessments were recorded for a single date, use the lowest result. GMI results collected by the person and documented in their medical record are eligible for use in reporting (if the GMI does not meet any exclusion criteria). There is no requirement for evidence the GMI was collected by a PCP or specialist. The person is not numerator compliant if the most recent glycemic status during the measurement year is ≤9.0%. Ranges and thresholds do not meet criteria for this indicator. A distinct numeric result is required for numerator compliance. “Unknown” is not considered a result/finding.
Summary of changes	• Updated the race and ethnicity stratification categories and Data Elements for Reporting table to align with OMB SPD 15 2024 and US Core Version 6.1.0 Model Definition.
HEDIS for QRS-specific guidance	• HEDIS for QRS reports only the Glycemic Status >9.0% indicator. • HEDIS for QRS does not require race and ethnicity stratification reporting.

Data element tables

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

Table GSD-A-4: Data Elements for Glycemic Status Assessment for Patients With Diabetes

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

Table GSD-B-4: Data Elements for Glycemic Status Assessment for Patients With Diabetes: Stratifications by Race

Metric
GreaterThan9

Race	Data Element	Reporting Instructions	A
AmericanIndianOrAlaskaNative	CollectionMethod	Repeat per Metric and Stratification	✓
Asian	Denominator	For each Stratification, repeat per Metric	✓
BlackOrAfricanAmerican	Numerator	For each Metric and Stratification	✓
MiddleEasternOrNorthAfrican	Rate	(Percent)	✓
NativeHawaiianOrPacificIslander			
White			
OtherRace			
TwoOrMoreRaces			
AskedButNoAnswer			
Unknown			

Table GSD-C-4: Data Elements for Glycemic Status Assessment for Patients With Diabetes: Stratifications by Ethnicity

Metric
GreaterThan9

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

Repeat the InitalPopulation, Exclusions and Denominator values for metrics using the Administrative Method.

Initiation and Engagement of Substance Use Disorder Treatment (IET)

Measure title	Initiation and Engagement of Substance Use Disorder Treatment	**Measure ID**	IET
Description	The percentage of new substance use disorder (SUD) episodes that result in treatment initiation and engagement. Two rates are reported: • *Initiation of SUD Treatment.* The percentage of new SUD episodes that result in treatment initiation through an inpatient SUD admission, outpatient visit, intensive outpatient encounter, partial hospitalization, telehealth visit or medication treatment within 14 days. • *Engagement of SUD Treatment.* The percentage of new SUD episodes that have evidence of treatment engagement within 34 days of initiation.		
Measurement period	January 1–December 31.		
Copyright and disclaimer notice	Refer to the complete copyright and disclaimer information at the front of the NCQA Measure Specifications. NCQA website: www.ncqa.org. Submit policy clarification support questions via My NCQA (https://my.ncqa.org).		
Clinical recommendation statement/ rationale	Evidence-based treatment for SUD involves both psychosocial supports and medication (Department of Veteran Affairs, 2015, Kampman et al. 2020, Michigan Quality Improvement Consortium 2015, Reus et al. 2018). Individuals who receive timely follow-up care may be more likely to complete treatment or receive more days of treatment than those who leave care prematurely (Proctor & Herschman, 2014). Benefits of SUD treatment typically extend beyond reduction of substance misuse to reduced crime, reduced risk of infectious diseases and improved patient function (Pew, 2016). Early treatment engagement is a critical step between accessing care and completing a full course of treatment. Individuals who engage in early SUD treatment have been found to have decreased odds of negative outcomes, including mortality (Paddock et al. 2017; Watkins et al. 2016).		
Citations	Department of Veteran Affairs, Department of Defense. 2015. *VA/DoD Clinical Practice Guideline for the Management of Substance Use Disorders.* Washington DC: Department of Veterans Affairs, Department of Defense. Kampman, K., K. Freedman. 2020. “American Society of Addiction Medicine (ASAM) National Practice Guideline for the Treatment of Opioid Use Disorder: 2020 Focused Update.” *Journal of Addiction Medicine* 14, no. 2S: 1–91, https://doi.org/10.1097/ADM.0000000000000633 Michigan Quality Improvement Consortium. August 2015. *Screening, Diagnosis and Referral for Substance Use Disorders.* Southfield (MI): Michigan Quality Improvement Consortium. 1 p.		

	Paddock, S.M., K.A. Hepner, T. Hudson, et al. 2017. "Association Between Process-Based Quality Indicators and Mortality for Patients with Substance Use Disorders." *J Stud Alcohol Drugs* 78:588–96. Pew. 2016. *Medication-Assisted Treatment Improves Outcomes for Patient with Opioid Use Disorder*. https://www.pewtrusts.org/en/research-and-analysis/fact-sheets/2016/11/medication-assisted-treatment-improves-outcomes-for-patients-with-opioid-use-disorder#1-background Proctor, S.L., P.L. Herschman. 2014. "The Continuing Care Model of Substance Use Treatment: What Works, and When Is "Enough," "Enough?" *Psychiatry Journal*, vol. 2014, Article ID 692423. https://doi.org/10.1155/2014/692423 Reus, V., et al. 2018. "Practice Guideline for the Pharmacological Treatment of Patients with Alcohol Use Disorder." *American Journal of Psychiatry* 175(1), 86–90. doi:10.1176/appi.ajp.2017.1750101
Characteristics	
Scoring	Proportion.
Type	Process.
Product line	Exchange.
Stratifications	Age as of the SUD episode date. • 13–17 years. • 18–64 years. • 65+ years. SUD diagnosis cohort. • Alcohol use disorder. • Opioid use disorder. • Other substance use disorder. Race. (Refer to *General Guideline: Race and Ethnicity Stratification.*) • American Indian or Alaska Native. • Asian. • Black or African American. • Middle Eastern or North African. • Native Hawaiian or Pacific Islander. • White. • Other Race. • Two or More Races. • Asked But No Answer. • Unknown.

	Ethnicity. (Refer to *General Guideline: Race and Ethnicity Stratification*.) • Hispanic or Latino. • Not Hispanic or Latino. • Asked But No Answer. • Unknown.
Risk adjustment	None.
Improvement notation	Increased score indicates improvement.
Guidance	**Data collection methodology:** Administrative. Refer to *General Guideline: Data Collection Methods* for additional information. **Date specificity:** Dates must be specific enough to determine the event occurred in the period being measured. **What services count?** • When using claims, include all paid, suspended, pending and denied claims. • Organizations may have different methods for billing intensive outpatient visits and partial hospitalizations. Some methods may be comparable to outpatient billing, with separate claims for each date of service; others may be comparable to inpatient billing, with an admission date, a discharge date and units of service. Organizations whose billing methods are comparable to inpatient billing may count each unit of service as an individual visit. The unit of service must have occurred during the required time frame for the rate. **Medication lists:** • Methadone is not included on the medication lists for this measure. Methadone for opioid use disorder (OUD), administered or dispensed by federally certified opioid treatment programs (OTP) is billed on a medical claim. A pharmacy claim for methadone would indicate treatment for pain rather than for OUD. • If an organization uses both pharmacy data (NDC codes) and clinical data (RxNorm codes) for reporting, *and* there are both NDC and RxNorm codes on the same date of service, use only one data source for the date of service. **Other guidance:** The measure is based on episodes; therefore, it is possible for the denominator to include multiple events for the same person.
Definitions	
Date of service for services billed weekly or monthly	For an opioid treatment service that bills monthly or weekly (OUD Weekly Non Drug Service Value Set; OUD Monthly Office Based Treatment Value Set; OUD Weekly Drug Treatment Service Value Set), if the service includes a range of dates, then use the earliest date as the date of service. Use this date for all relevant events (the SUD episode date, negative diagnosis history and numerator events).

Direct transfer	The discharge date from the first inpatient setting precedes the admission date to a second inpatient setting by 1 calendar day or less. • *For example:* – An inpatient discharge on June 1, followed by an admission to another inpatient setting on June 1, *is a direct transfer.* – An inpatient discharge on June 1, followed by an admission to an inpatient setting on June 2, *is a direct transfer.* – An inpatient discharge on June 1, followed by an admission to another inpatient setting on June 3, *is not a direct transfer;* these are two distinct inpatient stays. Use the following method to identify admissions to and discharges from inpatient settings. 1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set). 2. Identify the admission and discharge dates for the stay.
Intake period	November 15 of the year prior to the measurement period through November 14 of the measurement period. The intake period is used to capture new SUD episodes.
SUD episode	An encounter during the intake period with a diagnosis of SUD. For visits that result in an inpatient stay, the inpatient discharge is the SUD episode (an SUD diagnosis is not required for the inpatient stay; use the diagnosis from the visit that resulted in the inpatient stay to determine the diagnosis cohort).
SUD episode date	The date of service for an encounter during the intake period with a diagnosis of SUD. *For a visit (not resulting in an inpatient stay),* the SUD episode date is the date of service. *For an inpatient stay or for withdrawal management (i.e., detoxification)* that occurred during an inpatient stay, the SUD episode date is the date of discharge. *For withdrawal management (i.e., detoxification)* that did not occur during an inpatient stay, the SUD episode date is the date of service. *For direct transfers,* the SUD episode date is the discharge date from the last admission (an SUD diagnosis is not required for the transfer; use the diagnosis from the initial admission to determine the diagnosis cohort).
Initial population	*Measure item count:* Episode. *Attribution basis:* Enrollment. • *Benefits:* Medical, pharmacy and chemical dependency (inpatient and outpatient). ***Note***: *Withdrawal management/detoxification-only chemical dependency benefits do not meet these criteria.* • *Continuous enrollment:* 194 days prior to the SUD episode date through 47 days after the SUD episode date (242 days total).

- *Allowable gap:* None.

Ages: 13 years of age and older as of the SUD episode date.

Event: **New episode of SUD during the intake period.**

Step 1. Identify all SUD episodes. Any of the following meet criteria:

- An outpatient visit (Visit Setting Unspecified Value Set) ***with*** (Outpatient POS Value Set) ***with*** one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- An outpatient visit (BH Outpatient Value Set) ***with*** one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- An intensive outpatient encounter or partial hospitalization (Visit Setting Unspecified Value Set) ***with*** POS code 52 ***with*** one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- An intensive outpatient encounter or partial hospitalization (Partial Hospitalization or Intensive Outpatient Value Set) ***with*** one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- A non-residential substance abuse treatment facility visit (Visit Setting Unspecified Value Set) ***with*** (Nonresidential Substance Abuse Treatment Facility POS Value Set) ***with*** one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- A community mental health center visit (Visit Setting Unspecified Value Set) ***with*** POS code 53 ***with*** one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- A telehealth visit (Visit Setting Unspecified Value Set) ***with*** (Telehealth POS Value Set) ***with*** one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- A substance use disorder service (Substance Use Disorder Services Value Set) ***with*** one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- Substance use disorder counseling and surveillance (Substance Abuse Counseling and Surveillance Value Set*) ***with*** one of the following: Alcohol Abuse and Dependence Value Set*, Opioid Abuse and Dependence Value Set*, Other Drug Abuse and Dependence Value Set*.
- A withdrawal management event (Detoxification Value Set) ***with*** one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.

- An ED visit (ED Value Set) ***with*** one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- An acute or nonacute inpatient discharge ***with*** one of the following on the discharge claim: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set. To identify acute and nonacute inpatient discharges:
  1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
  2. Identify the discharge date for the stay.
- A telephone visit (Telephone Visits Value Set) ***with*** one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- An e-visit or virtual check-in (Online Assessments Value Set) ***with*** one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- An opioid treatment service (OUD Weekly Non Drug Service Value Set; OUD Monthly Office Based Treatment Value Set; OUD Weekly Drug Treatment Service Value Set) ***with*** a diagnosis of opioid abuse or dependence (Opioid Abuse and Dependence Value Set).

Step 2. Test for negative SUD diagnosis history.
Remove SUD episodes if the person had a SUD diagnosis (Alcohol Abuse and Dependence Value Set*, Opioid Abuse and Dependence Value Set*, Other Drug Abuse and Dependence Value Set*) during the 194 days prior to the SUD episode date. Do not include ED visits (ED Value Set) or withdrawal management events (Detoxification Value Set).

If the SUD episode was an inpatient stay, use the admission date to determine negative SUD history.

For visits with an SUD diagnosis that resulted in an inpatient stay (where the inpatient stay becomes the SUD episode), use the earliest date of service to determine the negative SUD diagnosis history (so that the visit that resulted in the inpatient stay is not considered a positive diagnosis history).

For direct transfers, use the first admission date to determine the negative SUD diagnosis history.

Step 3. Test for negative SUD medication history. Remove SUD episodes if any of the following occurred during the 194 days prior to the SUD episode date:

- An SUD medication treatment dispensing event (Alcohol Use Disorder Treatment Medications List; Naltrexone Injection Medications List; Buprenorphine Oral Medications List; Buprenorphine Injection Medications List; Buprenorphine Implant Medications List; Buprenorphine Naloxone Medications List).

	• An SUD medication administration event (Naltrexone Injection Value Set; Buprenorphine Oral Value Set; Buprenorphine Oral Weekly Value Set; Buprenorphine Injection Value Set; Buprenorphine Naloxone Value Set; Buprenorphine Implant Value Set; Methadone Oral Value Set; Methadone Oral Weekly Value Set). **Step 4.** Remove SUD episodes that do not meet continuous enrollment criteria. **Step 5.** Deduplicate eligible episodes. If a person has more than one eligible episode on the same day, include only one eligible episode. For example, if a person has two eligible episodes on January 1, only one eligible episode would be included; then, if applicable, include the next eligible episode that occurs after January 1. ***Note:*** *All eligible episodes that were not removed or deduplicated remain in the denominator.* **Step 6.** Identify the SUD diagnosis cohort for each SUD episode. • If the SUD episode has a diagnosis of alcohol use disorder (Alcohol Abuse and Dependence Value Set), include the episode in the *alcohol use disorder cohort*. • If the SUD episode has a diagnosis of opioid use disorder (Opioid Abuse and Dependence Value Set), include the episode in the *opioid use disorder cohort.* • If the SUD episode has a diagnosis of SUD that is neither for opioid nor alcohol (Other Drug Abuse and Dependence Value Set), include the person in the *other substance use disorder cohort*. Include SUD episodes in all SUD diagnosis cohorts for which they meet criteria. • *For example,* if the SUD episode has a diagnosis of alcohol use disorder and opioid use disorder, include the episode in the alcohol use disorder and opioid use disorder cohorts. **Coding Guidance** *Do not include laboratory claims (claims with POS code 81).
Denominator exclusions	**Persons with a date of death.** Death in the measurement period, identified using data sources determined by the organization. Method and data sources are subject to review during the HEDIS audit. **Persons in hospice or using hospice services.** Persons who use hospice services (Hospice Encounter Value Set; Hospice Intervention Value Set) or elect to use a hospice benefit any time during the measurement period. Organizations that use the Monthly Membership Detail Data File to identify these persons must use only the run date of the file.
Denominator	The initial population minus denominator exclusions.
Numerator	**Numerator 1: Initiation of SUD treatment.** Initiation of SUD treatment within 14 days of the SUD episode date. Follow the steps below to identify numerator compliance.

Step 1. *If the SUD episode was an inpatient discharge*, the inpatient stay is considered initiation of treatment and the SUD episode is compliant.

Step 2. *If the SUD episode was an opioid treatment service that bills monthly* (OUD Monthly Office Based Treatment Value Set), the opioid treatment service is considered initiation of treatment and the SUD episode is compliant.

Step 3. For remaining SUD episodes (those not compliant after steps 1–2), identify episodes with at least one of the following on the SUD episode date or during the 13 days after the SUD episode date (14 total days):

- An acute or nonacute inpatient admission ***with*** a diagnosis (on the discharge claim) of one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set. To identify acute and nonacute inpatient admissions:
  1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
  2. Identify the admission date for the stay.
- An outpatient visit (Visit Setting Unspecified Value Set) ***with*** (Outpatient POS Value Set) ***with*** one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- An outpatient visit (BH Outpatient Value Set) ***with*** one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- An intensive outpatient encounter or partial hospitalization (Visit Setting Unspecified Value Set) ***with*** POS code 52 ***with*** one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- An intensive outpatient encounter or partial hospitalization (Partial Hospitalization or Intensive Outpatient Value Set) ***with*** one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- A non-residential substance abuse treatment facility visit (Visit Setting Unspecified Value Set) ***with*** (Nonresidential Substance Abuse Treatment Facility POS Value Set) ***with*** one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- A community mental health center visit (Visit Setting Unspecified Value Set) ***with*** POS code 53 ***with*** one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- A telehealth visit (Visit Setting Unspecified Value Set) ***with*** (Telehealth POS Value Set) ***with*** one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.

- A substance use disorder service (Substance Use Disorder Services Value Set) ***with*** one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- Substance use disorder counseling and surveillance (Substance Abuse Counseling and Surveillance Value Set*) ***with*** one of the following: Alcohol Abuse and Dependence Value Set*, Opioid Abuse and Dependence Value Set*, Other Drug Abuse and Dependence Value Set*).
- A telephone visit (Telephone Visits Value Set) ***with*** one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- An e-visit or virtual check-in (Online Assessments Value Set) ***with*** one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- A weekly or monthly opioid treatment service (OUD Weekly Non Drug Service Value Set; OUD Monthly Office Based Treatment Value Set; OUD Weekly Drug Treatment Service Value Set).
- For SUD episodes in the alcohol use disorder cohort, an alcohol use disorder medication treatment dispensing event (Alcohol Use Disorder Treatment Medications List) or a medication administration event (Naltrexone Injection Value Set).
- For SUD episodes in the opioid use disorder cohort, an opioid use disorder medication treatment dispensing event (Naltrexone Oral Medications List; Naltrexone Injection Medications List; Buprenorphine Oral Medications List; Buprenorphine Injection Medications List; Buprenorphine Implant Medications List; Buprenorphine Naloxone Medications List) or a medication administration event (Naltrexone Injection Value Set, Buprenorphine Oral Value Set, Buprenorphine Oral Weekly Value Set, Buprenorphine Injection Value Set, Buprenorphine Implant Value Set, Buprenorphine Naloxone Value Set, Methadone Oral Value Set, Methadone Oral Weekly Value Set).

For all initiation events except medication treatment dispensing events and medication administration events, initiation on the same day as the SUD episode date must be with different providers in order to count.

Remove the person from the denominator for numerators 1 and 2 (Initiation of SUD Treatment and Engagement of SUD Treatment) if the initiation of treatment event is an inpatient stay with a discharge date after November 27 of the measurement period.

Numerator 2: Engagement of SUD treatment.
Follow the steps below to identify numerator compliance.

If the initiation of SUD treatment event from numerator 1 was an inpatient admission, the 34-day period for engagement begins the day after discharge.

Step 1. Identify all SUD episodes compliant for Numerator 1: Initiation of SUD Treatment. SUD episodes that are not compliant for Numerator 1: Initiation of SUD Treatment are not compliant for Numerator 2: Engagement of SUD Treatment.

Step 2. Identify SUD episodes that had at least one weekly or monthly opioid treatment service with medication administration (OUD Monthly Office Based Treatment Value Set; OUD Weekly Drug Treatment Service Value Set) on the day after the initiation encounter through 34 days after the initiation event. The opioid treatment service is considered engagement of treatment and the SUD episode is compliant.

Step 3. Identify SUD episodes with long-acting SUD medication administration events on the day after the initiation encounter through 34 days after the initiation event. The long-acting SUD medication administration event is considered engagement of treatment, and the SUD episode is compliant. Any of the following meet criteria:

- *For SUD episodes in the alcohol use disorder cohort,* an alcohol use disorder medication treatment dispensing event (Naltrexone Injection Medications List) or a medication administration event (Naltrexone Injection Value Set).
- *For SUD episodes in the opioid use disorder cohort,* an opioid use disorder medication treatment dispensing event (Naltrexone Injection Medications List; Buprenorphine Injection Medications List; Buprenorphine Implant Medications List) or a medication administration event (Naltrexone Injection Value Set; Buprenorphine Injection Value Set; Buprenorphine Implant Value Set).

Step 4. For remaining SUD episodes, identify episodes with at least two of the following (any combination) on the day after the initiation encounter through 34 days after the initiation event:

- Engagement visit.
- Engagement medication treatment event.

Two engagement visits may be on the same date of service, but must be with different providers to count as two events. An engagement visit on the same date of service as an engagement medication treatment event meets criteria (they are not required to be with different providers).

Refer to the descriptions below to identify engagement visits and engagement medication treatment events.

Engagement visit. Any of the following meet criteria for an engagement visit:

- An acute or nonacute inpatient admission ***with*** a diagnosis (on the discharge claim) of one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set. To identify acute or nonacute inpatient admissions:
  1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
  2. Identify the admission date for the stay.

	• An outpatient visit (Visit Setting Unspecified Value Set) ***with*** (Outpatient POS Value Set) ***with*** one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set. • An outpatient visit (BH Outpatient Value Set) ***with*** one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set. • An intensive outpatient encounter or partial hospitalization (Visit Setting Unspecified Value Set) ***with*** POS code 52 ***with*** one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set. • An intensive outpatient encounter or partial hospitalization (Partial Hospitalization or Intensive Outpatient Value Set) ***with*** one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set. • A non-residential substance abuse treatment facility visit (Visit Setting Unspecified Value Set) ***with*** (Nonresidential Substance Abuse Treatment Facility POS Value Set) ***with*** one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set. • A community mental health center visit (Visit Setting Unspecified Value Set) ***with*** POS code 53 ***with*** one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set. • A telehealth visit (Visit Setting Unspecified Value Set) ***with*** (Telehealth POS Value Set) ***with*** one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set. • A substance use disorder service (Substance Use Disorder Services Value Set) ***with*** one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set. • Substance use disorder counseling and surveillance (Substance Abuse Counseling and Surveillance Value Set*) ***with*** one of the following: Alcohol Abuse and Dependence Value Set*, Opioid Abuse and Dependence Value Set*, Other Drug Abuse and Dependence Value Set*). • A telephone visit (Telephone Visits Value Set) ***with*** one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set. • An e-visit or virtual check-in (Online Assessments Value Set) ***with*** one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set. • An opioid treatment service (OUD Weekly Non Drug Service Value Set).

<table>
<tr><td></td><td>

Engagement medication treatment events. Either of the following meets criteria for a medication treatment event:

- *For SUD episodes in the alcohol use disorder cohort,* an alcohol use disorder medication treatment dispensing event (Alcohol Use Disorder Treatment Medications List).
- *For SUD episodes in the opioid use disorder cohort,* an opioid use disorder medication treatment dispensing event (Naltrexone Oral Medications List; Buprenorphine Oral Medications List; Buprenorphine Naloxone Medications List) or a medication administration event (Buprenorphine Oral Value Set; Buprenorphine Oral Weekly Value Set; Buprenorphine Naloxone Value Set; Methadone Oral Value Set; Methadone Oral Weekly Value Set).

Coding Guidance
*Do not include laboratory claims (claims with POS code 81).
</td></tr>
<tr><td>Summary of changes</td><td>

- Updated the race and ethnicity stratification categories and Data Elements for Reporting table to align with OMB SPD 15 2024 and US Core Version 6.1.0 Model Definition.
</td></tr>
<tr><td>HEDIS for QRS-specific guidance</td><td>

- HEDIS for QRS does not require race and ethnicity stratification reporting.
</td></tr>
<tr><td>Data element table</td><td>

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

Table IET-A-4: Data Elements for Initiation and Engagement of Substance Use Disorder Treatment

Metric	Diagnosis	Age	Data Element	Reporting Instructions
Initiation	Alcohol	13-17	Benefit	Metadata
Engagement	Opioid	18-64	InitialPopulation	For each Stratification, repeat per Metric
	Other	65+	Exclusions	For each Stratification, repeat per Metric
	Total	Total	Denominator	For each Stratification, repeat per Metric
			NumeratorByAdmin	For each Metric and Stratification
			Rate	(Percent)

</td></tr>
</table>

Table IET-B-4: Data Elements for Initiation and Engagement of Substance Use Disorder Treatment: Stratifications by Race

Metric	Race	Data Element	Reporting Instructions
Initiation	AmericanIndianOrAlaskaNative	Denominator	For each Stratification, repeat per Metric
Engagement	Asian	Numerator	For each Metric and Stratification
	BlackOrAfricanAmerican	Rate	(Percent)
	MiddleEasternOrNorthAfrican		
	NativeHawaiianOrPacificIslander		
	White		
	OtherRace		
	TwoOrMoreRaces		
	AskedButNoAnswer		
	Unknown		

Table IET-C-4: Data Elements for Initiation and Engagement of Substance Use Disorder Treatment: Stratifications by Ethnicity

Metric	Ethnicity	Data Element	Reporting Instructions
Initiation	HispanicOrLatino	Denominator	For each Stratification, repeat per Metric
Engagement	NotHispanicOrLatino	Numerator	For each Metric and Stratification
	AskedButNoAnswer	Rate	(Percent)
	Unknown		

Kidney Health Evaluation for Patients With Diabetes (KED)

Measure title	Kidney Health Evaluation for Patients With Diabetes*****	**Measure ID**	KED
Description	The percentage of persons 18–85 years of age with diabetes (type 1 or type 2) who received a kidney health evaluation, defined by an estimated glomerular filtration rate (eGFR) ***and*** a urine albumin-creatinine ratio (uACR), during the measurement period.		
Measurement period	January 1–December 31.		
Copyright and disclaimer notice	**This measure was developed by NCQA with input from the National Kidney Foundation.* Refer to the complete copyright and disclaimer information at the front of the NCQA Measure Specifications. NCQA website: www.ncqa.org. Submit policy clarification support questions via My NCQA (https://my.ncqa.org).		
Clinical recommendation statement/ rationale	American Diabetes Association (2025) • Assess kidney function (i.e., spot urine albumin-to-creatinine ratio [UACR]) and estimated glomerular filtration rate [eGFR] in people with type 1 diabetes with duration of ≥5 years and in all people with type 2 diabetes regardless of treatment. Level of evidence: B National Kidney Foundation (2007, updated 2012) • Patients with diabetes should be screened annually for diabetic kidney disease. Initial screening should commence: – 5 years after the diagnosis of Type 1 diabetes. Grade of evidence: A; ***or*** – From diagnosis of Type 2 diabetes. Grade of evidence: B • Screening should include: – Measurement of urinary albumin-creatinine ratio (ACR) in a spot urine sample. Grade of evidence: B – Measurement of serum creatinine and estimation of GFR. Grade of evidence: B For adults with diabetes, guidelines recommend measuring both albumin and creatinine simultaneously from a random spot urine sample to assess albumin-to-creatinine ratio (uACR). The intent of the measure is to align with this recommendation even if separate billing codes are used for urine albumin and urine creatinine.		
Citations	American Diabetes Association Professional Practice Committee. 2025. "11. Chronic Kidney Disease and Risk Management: Standards of Care in Diabetes—2025." *Diabetes Care* 48(Suppl. 1):S239–51.		

	National Kidney Foundation. 2012. "KDOQI Clinical Practice Guideline for Diabetes and CKD: 2012 Update." *Am J Kidney Dis* 60(5):850–86. http://dx.doi.org/10.1053/j.ajkd.2012.07.005
Characteristics	
Scoring	Proportion.
Type	Process.
Product line	Exchange.
Stratifications	Age as of the last day of the measurement period. • 18–64 years. • 65–75 years. • 76–85 years. Race. (Refer to *General Guideline: Race and Ethnicity Stratification.*) • American Indian or Alaska Native. • Asian. • Black or African American. • Middle Eastern or North African. • Native Hawaiian or Pacific Islander. • White. • Other Race. • Two or More Races. • Asked But No Answer. • Unknown. Ethnicity. (Refer to *General Guideline: Race and Ethnicity Stratification.*) • Hispanic or Latino. • Not Hispanic or Latino. • Asked But No Answer. • Unknown.
Risk adjustment	None.
Improvement notation	Increased score indicates improvement.
Guidance	**Data collection methodology:** Administrative. Refer to *General Guideline: Data Collection Methods* for additional information. **Date specificity:** Dates must be specific enough to determine the event occurred in the period being measured. **What services count?** When using claims, include all paid, suspended, pending and denied claims.

Initial population	*Measure item count:* Person. *Attribution basis:* Enrollment. • *Benefits:* Medical. • *Continuous enrollment:* The measurement period. • *Allowable gap:* No more than one gap of ≤45 days during the measurement period. No gaps on the last day of the measurement period. *Ages:* 18–85 years of age as of the last day of the measurement period. *Event:* **Identify persons with a diagnosis of diabetes.** Either of the following meets criteria: • *Claim/encounter data.* At least two diagnoses of diabetes (Diabetes Value Set*) on different dates of service during the measurement period or the year prior to the measurement period. • *Pharmacy data.* At least one diagnosis of diabetes (Diabetes Value Set*) ***and*** at least one diabetes medication dispensing event of insulin or a hypoglycemic/antihyperglycemic medication (Diabetes Medications List) during the measurement period or the year prior to the measurement period. **Coding Guidance** *Do not include laboratory claims (claims with POS code 81).
Denominator exclusions	**Persons with a date of death.** Death in the measurement period, identified using data sources determined by the organization. Method and data sources are subject to review during the HEDIS audit. **Persons in hospice or using hospice services.** Persons who use hospice services (Hospice Encounter Value Set; Hospice Intervention Value Set) or elect to use a hospice benefit any time during the measurement period. Organizations that use the Monthly Membership Detail Data File to identify these persons must use only the run date of the file. **Persons receiving palliative care.** Persons receiving palliative care (Palliative Care Assessment Value Set; Palliative Care Encounter Value Set; Palliative Care Intervention Value Set) or who had an encounter for palliative care (ICD-10-CM code Z51.5*) any time during the measurement period. **Persons 66–80 years of age by the last day of the measurement period, with both frailty and advanced illness.** 1. **Frailty.** At least two indications of frailty (Frailty Device Value Set; Frailty Diagnosis Value Set*; Frailty Encounter Value Set; Frailty Symptom Value Set*) with different dates of service during the measurement period. 2. **Advanced illness.** Either of the following during the measurement period or the year prior to the measurement period: – Advanced illness (Advanced Illness Value Set*) on at least two different dates of service. – Dispensed dementia medication (Dementia Medications List).

<table>
<tr><td></td><td>Persons 81 years of age and older as of the last day of the measurement period, with frailty.
Persons with at least two indications of frailty (Frailty Device Value Set; Frailty Diagnosis Value Set*; Frailty Encounter Value Set; Frailty Symptom Value Set*) with different dates of service during the measurement period.

ESRD or dialysis.
Persons with a diagnosis of ESRD (ESRD Diagnosis Value Set*) or who had dialysis (Dialysis Procedure Value Set) any time during the person's history on or prior to the last day of the measurement period.

Coding Guidance
*Do not include laboratory claims (claims with POS code 81).</td></tr>
<tr><td>Denominator</td><td>The initial population minus denominator exclusions.</td></tr>
<tr><td>Numerator</td><td>Kidney health evaluation.
Persons who received both an eGFR and a uACR during the measurement period on the same or different dates of service:
At least one eGFR (Estimated Glomerular Filtration Rate Lab Test Value Set).
At least one uACR identified by either of the following:
Both a quantitative urine albumin test (Quantitative Urine Albumin Lab Test Value Set) and a urine creatinine test (Urine Creatinine Lab Test Value Set) with service dates four days or less apart.
For example, if the service date for the quantitative urine albumin test was December 1 of the measurement period, then the urine creatinine test must have a service date on or between November 27 and December 5 of the measurement period.
A uACR (Urine Albumin Creatinine Ratio Lab Test Value Set).</td></tr>
<tr><td>Summary of changes</td><td>Updated the race and ethnicity stratification categories and Data Elements for Reporting table to align with OMB SPD 15 2024 and US Core Version 6.1.0 Model Definition.</td></tr>
<tr><td>HEDIS for QRS-specific guidance</td><td>HEDIS for QRS does not require race and ethnicity stratification reporting.</td></tr>
<tr><td>Data element tables</td><td>Organizations that submit HEDIS data to NCQA must provide the following data elements.

Table KED-A-4: Data Elements for Kidney Health Evaluation for Patients With Diabetes
<table>
<tr><th>Metric</th><th>Age</th><th>Data Element</th><th>Reporting Instructions</th></tr>
<tr><td rowspan="6">KidneyHealthEvaluation</td><td>18-64</td><td>InitialPopulation</td><td>For each Stratification</td></tr>
<tr><td>65-75</td><td>Exclusions</td><td>For each Stratification</td></tr>
<tr><td>76-85</td><td>Denominator</td><td>For each Stratification</td></tr>
<tr><td>Total</td><td>NumeratorByAdmin</td><td>For each Stratification</td></tr>
<tr><td></td><td>NumeratorBySupplemental</td><td>For each Stratification</td></tr>
<tr><td></td><td>Rate</td><td>(Percent)</td></tr>
</table></td></tr>
</table>

Table KED-B-4: Data Elements for Kidney Health Evaluation for Patients With Diabetes: Stratifications by Race

Metric	Race	Data Element	Reporting Instructions
KidneyHealthEvaluation	AmericanIndianOrAlaskaNative	Denominator	For each Stratification
	Asian	Numerator	For each Stratification
	BlackOrAfricanAmerican	Rate	(Percent)
	MiddleEasternOrNorthAfrican		
	NativeHawaiianOrPacificIslander		
	White		
	OtherRace		
	TwoOrMoreRaces		
	AskedButNoAnswer		
	Unknown		

Table KED-C-4: Data Elements for Kidney Health Evaluation for Patients With Diabetes: Stratifications by Ethnicity

Metric	Ethnicity	Data Element	Reporting Instructions
KidneyHealthEvaluation	HispanicOrLatino	Denominator	For each Stratification
	NotHispanicOrLatino	Numerator	For each Stratification
	AskedButNoAnswer	Rate	(Percent)
	Unknown		

Oral Evaluation, Dental Services (OED)

Measure title	Oral Evaluation, Dental Services*	**Measure ID**	OED
Description	The percentage of persons under 21 years of age who received a comprehensive or periodic oral evaluation with a dental provider during the measurement period.		
Measurement period	January 1–December 31.		
Copyright and disclaimer notice	**This measure has been adapted for HEDIS, with permission, from a measure owned by the American Dental Association (ADA) on behalf of the Dental Quality Alliance (DQA). ©ADA (on behalf of DQA). The ADA (on behalf of the DQA) is the steward for the CBE-endorsed measure ID 2517.* Refer to the complete copyright and disclaimer information at the front of the NCQA Measure Specifications. NCQA website: www.ncqa.org. Submit policy clarification support questions via My NCQA (https://my.ncqa.org).		
Clinical recommendation statement/ rationale	The American Academy of Pediatric Dentistry (AAPD) recommends that children receive their first clinical oral examination at the time of their first tooth eruption and no later than their first birthday; thereafter, it is recommended that the frequency of examinations be based on the child's individual needs and susceptibility to disease.		
Citations	AAPD. 2018. Periodicity of Examination, Preventive Dental Services, "Anticipatory Guidance/Counseling, and Oral Treatment for Infants, Children, and Adolescents." *The Reference Manual of Pediatric Dentistry* 232–42.		
Characteristics			
Scoring	Proportion.		
Type	Process.		
Product line	Exchange.		
Stratifications	Age as of the last day of the measurement period. • 0–2 years. • 3–5 years. • 6–14 years. • 15–20 years.		
Risk adjustment	None.		
Improvement notation	Increased score indicates better performance.		

Guidance	**Data collection methodology:** Administrative. Refer to *General Guideline: Data Collection Methods* for additional information. **Date specificity:** Dates must be specific enough to determine the event occurred in the period being measured. **Which services count?** Use all paid, suspended, pending and denied claims. **Other guidance:** For persons who meet the 180-day continuous enrollment requirement for two different Exchange products in the measurement period, report them in both HEDIS reports.
Initial population	*Measure item count:* Person. *Attribution basis:* Enrollment. • *Benefits:* Dental. • *Continuous enrollment:* 180 days during the measurement period. • *Allowable gap:* None. *Ages:* Under 21 years of age as of the last day of the measurement period. *Event:* None.
Denominator exclusions	**Persons with a date of death.** Death in the measurement period, identified using data sources determined by the organization. Method and data sources are subject to review during the HEDIS audit. **Persons in hospice or using hospice services.** Persons who use hospice services (Hospice Encounter Value Set; Hospice Intervention Value Set) or elect to use a hospice benefit any time during the measurement period. Organizations that use the Monthly Membership Detail Data File to identify these persons must use only the run date of the file.
Denominator	The initial population minus denominator exclusions.
Numerator	**A comprehensive or periodic oral evaluation.** A comprehensive or periodic oral evaluation (Oral Evaluation Value Set) with a dental provider (Dental Provider Value Set) during the measurement period.
Summary of changes	• Revised the continuous enrollment criteria.

Data element tables

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

Table OED-4: Data Elements for Oral Evaluation, Dental Services

Metric	Age	Data Element	Reporting Instructions
OralEvaluationDentalServices	0-2	Benefit	Metadata
	3-5	InitialPopulation	For each Stratification
	6-14	Exclusions	For each Stratification
	15-20	Denominator	For each Stratification

Metric	Age	Data Element	Reporting Instructions
	Total	NumeratorByAdmin	For each Stratification
		NumeratorBySupplemental	For each Stratification
		Rate	(Percent)

Plan All-Cause Readmissions (PCR)

Measure title	Plan All-Cause Readmissions	**Measure ID**	PCR
Description	For persons 18-64 years of age, the risk-adjusted ratio of observed-to-expected unplanned acute readmissions (inpatient and observation stays) for any diagnosis within 30 days of an acute hospitalization (inpatient and observation stays).		
Measurement period	January 1–December 31.		
Copyright and disclaimer notice	Refer to the complete copyright and disclaimer information at the front of the NCQA Measure Specifications. NCQA website: www.ncqa.org. Submit policy clarification support questions via My NCQA (https://my.ncqa.org).		
Clinical recommendation statement/ rationale	Readmission to the hospital within 30 days of discharge is frequently avoidable and can lead to adverse outcomes for patients. Any preventable hospitalization can have a negative impact on health outcomes, particularly for older adults and adults with multiple chronic conditions. Health risks associated with hospitalization include infection, adverse drug events, loss of function, isolation, lower quality of life and readmission.		
Citations	Medicare Payment Advisory Commission. "Data Book: Health Care Spending and the Medicare Program." Baltimore, MD: MedPAC, 2015. Available at http://medpac.gov/documents/reports/june-2015-report-to-the-congress-medicare-and-the-health-care-delivery-system.pdf?sfvrsn=0 Burke, R.E., E.A. Whitfield, D. Hittle, S.J. Min, C. Levy, A.V. Prochazka, E.A. Coleman, R. Schwartz, A.A. Ginde. 2016. "Hospital Readmission from Post-Acute Care Facilities: Risk Factors, Timing, and Outcomes." *J Am Med Dir Assoc* 17(3):249–55. doi: 10.1016/j.jamda.2015.11.005 Hakkarainen, T.W., S. Arbabi, M.M. Willis, G.H. Davidson, D.R. Flum. 2016. "Outcomes of Patients Discharged to Skilled Nursing Facilities After Acute Care Hospitalizations." *Ann Surg* 263(2):280–5. doi:10.1097/SLA.0000000000001367.		
Characteristics			
Scoring	Ratio.		
Product line	Exchange.		
Stratifications	Age as of the index discharge date. • 18–44 years. • 45–54 years. • 55–64 years.		

Guidance	***Programming Guidance*** **Facilities:** The measure includes acute discharges from any type of facility (including behavioral health care facilities). ***Risk Adjustment Measure-Specific Guidance*** **Observation stays:** For observation stays (Observation Stay Value Set) that do not have a recorded admission or discharge date, set the admission date to the earliest date of service on the claim and set the discharge date to the last date of service on the claim. **Which services count?** • Use all paid, suspended, pending, and denied claims when applying risk adjustment comorbidity category determination and the hospice exclusion. • Do not include denied claims when identifying all other events (e.g., the IHS in the PCR measure or observed events in the other risk adjusted utilization measures); only report claims the organization paid for or expects to pay for (i.e., claims incurred but not paid). **Supplemental data exceptions:** Supplemental data may only be used for the hospice exclusion. **Transfers:** • Treat transfers *between* institutions as separate admissions. • Base transfer reports *within* an institution on the type and level of services provided. • Report separate admissions when the transfer is between acute and nonacute levels of service or between mental health/chemical dependency services and non-mental health/chemical dependency services. • Count only one admission when the transfer takes place within the same service category, but to a different level of care (e.g., from intensive care to a lesser level of care; from a lesser level of care to intensive care). **Risk adjustment:** Organizations may not use risk assessment protocols to supplement diagnoses for calculation of the risk adjustment scores for these measures. The measurement model was developed and tested using only claims-based diagnoses; diagnoses from additional data sources would affect the validity of the models as they are currently implemented in the specification. ***General Rules*** **Data collection methodology:** Administrative. Refer to *General Guideline: Data Collection Methods* for additional information. **Date specificity:** Dates must be specific enough to determine the event occurred in the period being measured. **Other guidance**: The measure is based on episodes; therefore, it is possible for the denominator to include multiple events for the same person. **Improvement notation:** To interpret the rate as better or worse than expected, the rate must be calibrated. Organizations can calibrate rates by dividing individual organization rates or national percentiles by the national average rate. Organizations may be more successful at achieving fewer readmissions

	than expected, given the types of cases treated by the organization (calibrated rate with a value <1.0), or may be less successful (calibrated rate with a value >1.0).
Definitions	
Direct transfer	When the discharge date from the initial stay precedes the admission date to a subsequent stay by 1 calendar day or less. • *For example:* – A discharge on June 1, followed by a subsequent admission on June 1 or June 2, *is a direct transfer.* – A discharge on June 1, followed by a subsequent admission on June 3, *is not a direct transfer;* these are two distinct stays. – A discharge on June 1, followed by a subsequent admission on June 2 (with discharge on June 3), followed by a subsequent admission on June 4, *is a direct transfer.* Direct transfers may occur between different facilities, and between acute inpatient and observation.
IHS	Index hospital stay. An acute inpatient or observation stay with a discharge on or between January 1 and December 1 of the measurement period, as identified in the denominator.
Index admission date	The IHS admission date.
Index discharge date	The IHS discharge date. The index discharge date must occur on or between January 1 and December 1 of the measurement period.
Index readmission stay	An acute inpatient or observation stay for any diagnosis with an admission date within 30 days of a previous index discharge date.
Index readmission date	The admission date associated with the index readmission stay.
Planned hospital stay	A hospital stay is considered planned if it meets criteria as described in step 3 (exclusions) of the numerator.
Plan population	Persons in the initial population prior to exclusion of outliers. The plan population is only used as a denominator for the outlier rate. Persons must be 18 years and older as of the earliest index discharge date. The plan population is based on persons, not on discharges. Count persons only once in the plan population. Assign persons to the product/product line in which they are enrolled at the start of the continuous enrollment period of their earliest IHS. If there is a gap at the beginning of this continuous enrollment period, assign the person to the product/product line in which they were enrolled as of their first enrollment segment during this continuous enrollment period.
Outlier	Exchange enrollees in the initial population with three or more IHS between January 1 and December 1 of the measurement period.

	When assigning outlier status, assign enrollees to the product/product line in which they are enrolled at the start of the continuous enrollment period of their earliest IHS. If there is a gap at the beginning of the continuous enrollment period, assign enrollees to the product/product line in which they were enrolled as of their first enrollment segment during the continuous enrollment period.
Nonoutlier	Exchange enrollees in the initial population with two or fewer IHS between January 1 and December 1 of the measurement period.
Initial population	*Measure item count:* Episode. *Attribution basis:* Enrollment. • *Benefits:* Medical. • *Continuous enrollment:* 365 days prior to the index discharge date through 30 days after the index discharge date. • *Allowable gap:* – *365 days to 1 day prior to the index discharge date:* No more than one gap of ≤45 days. – *Index discharge date and 30 days following the index discharge date:* None. *Ages:*18–64 years as of the index discharge date. *Gender/Sex criteria:* • Administrative Gender of Female (AdministrativeGender code female). • Administrative Gender of Male (AdministrativeGender code male). *Exclusion:* **Persons in hospice or using hospice services.** Persons who use hospice services (Hospice Encounter Value Set; Hospice Intervention Value Set) or elect to use a hospice benefit any time during the measurement period. Organizations that use the Monthly Membership Detail Data File to identify these persons must use only the run date of the file.
Denominator	**Acute inpatient or observation stay discharges.** **Step 1.** Identify all acute inpatient and observation stay discharges on or between January 1 and December 1 of the measurement period. To identify acute inpatient and observation stay discharges: 1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set) and observation stays (Observation Stay Value Set). 2. Exclude nonacute inpatient stays (Nonacute Inpatient Stay Value Set). 3. Identify the discharge date for the stay. Inpatient and observation stays where the discharge date from the first setting and the admission date to the second setting are 2 or more calendar days apart must be considered distinct stays. **Step 2.** For discharges with one or more direct transfers, use the last discharge.

	Using the discharges identified in step 1, identify direct transfers between acute inpatient and observation using the definition of "direct transfer." Exclude the hospital stay if the direct transfer's discharge date occurs after December 1 of the measurement period. **Step 3.** Exclude hospital stays where the index admission date is the same as the index discharge date. **Step 4.** Exclude hospital stays for any of the following reasons: • The person died during the stay. • A principal diagnosis of pregnancy (Pregnancy Value Set) or a condition originating in the perinatal period (Perinatal Conditions Value Set) on the discharge claim. ***Note:*** *For hospital stays where there was a direct transfer (identified in step 2), use the original stay and any direct transfer stays to identify exclusions in this step.* **Step 5.** Calculate continuous enrollment. **Step 6.** Remove hospital stays for outliers and report these persons as outliers in Table PCR-A-4. ***Note:*** *Count discharges with one or more direct transfers (identified in step 2) as one discharge when identifying outliers.* **Step 7.** Assign each remaining acute inpatient or observation stay to an age and stratification category using the reporting instructions below.
Risk adjustment factors	***Risk Adjustment Determination*** For each IHS among nonoutliers, identify risk adjustment weights based on observation stay status at discharge, surgeries, discharge condition, COVID-19 discharge, comorbidity, age and gender. Use the **Commercial** Risk Weights for risk adjustment. Refer to the reporting indicator column in the risk adjustment tables to ensure that weights are linked appropriately. **Observation stay:** Determine if the IHS at discharge was an observation stay (Observation Stay Value Set). For direct transfers, determine the hospitalization status using the last discharge. **Surgeries:** Determine if the person underwent surgery during the stay. Consider an IHS to include a surgery if at least one procedure code (Surgery Procedure Value Set) is present from any provider between the admission and discharge dates. **Discharge condition:** Assign a discharge Clinical Condition (CC) category code or codes to the IHS based on its principal discharge diagnosis, using Table CC—Mapping. For direct transfers, use the principal discharge diagnosis from the last discharge. Exclude diagnoses that cannot be mapped to Table CC—Mapping.

Comorbidities:

Step 1. Identify all diagnoses for encounters during the 365 days prior to and on the date of the index discharge date. Exclude the principal discharge diagnosis on the IHS. Include the following when identifying encounters:

- Outpatient visits, ED visits, telephone visits, nonacute inpatient encounters and acute inpatient encounters (Outpatient, ED, Telephone, Acute Inpatient and Nonacute Inpatient Value Set) with a date of service in the period from 365 days before the index discharge date to (and including) the index discharge date.
- Acute and nonacute inpatient discharges (Inpatient Stay Value Set) with a discharge date in the period from 365 days before the index discharge date to (and including) the index discharge date.

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

Exclude all diagnoses that cannot be assigned to a comorbid CC category. For denominator units with no qualifying diagnoses from face-to-face encounters, skip to *Risk Adjustment Calculation*.

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

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

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

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

For comorbid CCs that do not match to Table HCC—Rank, use the comorbid CC as the HCC and assign a rank of 1. One comorbid CC can map to multiple HCCs; each HCC can have one or more comorbid CCs.

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

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

- *For example,* assume a denominator unit with the following comorbid CCs: CC-85, CC-17 and CC-19 (assume no other CCs).
  - CC-85 does not have a map to the ranking table and becomes HCC-85.
  - HCC-17 and HCC-19 are part of Diabetes Ranking Group 1. Because CC-17 is ranked higher than CC-19 in Ranking Group Diabetes 1, the comorbidity is assigned as HCC-17 for Ranking Group 1.

The final comorbidities for this denominator unit are HCC-17 and HCC-85.

Table HCC—Rank

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

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

Some combinations suggest a greater amount of risk when observed together.

- *For example,* when diabetes and CHF are present, an increased amount of risk is evident. Additional HCCs are selected to account for these relationships.

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

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

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

Table HCC—Comb

Comorbid HCC 1	Comorbid HCC 2	Comorbid HCC 3	HCC-Combination	HCC-Comb Description
HCC-17	HCC-85	NA	HCC-901	Combination: Diabetes and CHF
HCC-18	HCC-85	NA	HCC-901	Combination: Diabetes and CHF
HCC-19	HCC-85	NA	HCC-901	Combination: Diabetes and CHF

Risk adjustment

Risk Adjustment Calculation

For each IHS among nonoutliers, use the following steps to identify risk adjustment weights based on observation stays status at discharge, surgeries, discharge condition, COVID-19, comorbidity, age and gender.

Step 1. For each IHS discharge that is an observation stay, link the observation stay IHS weight.

Step 2. For each IHS with a surgery, link the surgery weight.

Step 3. For each IHS with a discharge CC category, link the primary discharge weights.

	Step 4. For each IHS with a comorbidity HCC category, link the comorbidity weights. **Step 5.** Link the age and gender weights for each IHS. **Step 6.** Sum all weights (observation stay, presence of surgery, principal discharge diagnosis, comorbidities, age and gender) associated with the IHS and use the formula below to calculate the estimated readmission risk for each IHS: $$\text{Estimated Readmission Risk} = \frac{e^{(\sum \text{WeightsForIHS})}}{1+e^{(\sum \text{WeightsForIHS})}}$$ ***OR*** Estimated Readmission Risk = [exp (sum of weights for IHS)] / [1 + exp (sum of weights for IHS)] ***Note:*** *"Exp" refers to the exponential or antilog function.* Truncate the estimated readmission risk for each IHS to 10 decimal places. Do not truncate or round in previous steps. **Step 7.** Calculate the count of expected readmissions for each age and stratification category. The count of expected readmissions is the sum of the estimated readmission risk calculated in step 6 for each IHS in each age and stratification category. $$Count\ of\ Expected\ Readmissions = \sum (\text{Estimated Readmission Risk})$$ **Step 8.** Use the formula below and the estimated readmission risk calculated in step 6 to calculate the variance for each IHS. Variance = Estimated Readmission Risk x (1 – Estimated Readmission Risk) Truncate the variance *for each IHS* to 10 decimal places. • *For example*: If the estimated readmission risk is 0.1518450741 for an IHS, then the variance for this IHS is 0.1518450741 x 0.8481549259 = 0.1287881475. ***Note:*** *Organizations must sum the variances for each stratification and age when populating the Variance cells in the reporting tables. When reporting, round the variance to 4 decimal places using the .5 rule.*
Numerator	**At least one acute readmission for any diagnosis within 30 days of the index discharge date.** **Step 1.** Identify all acute inpatient and observation stays with an admission date on or between January 3 and December 31 of the measurement period: 1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set) and observation stays (Observation Stay Value Set). 2. Exclude nonacute inpatient stays (Nonacute Inpatient Stay Value Set). 3. Identify the admission date for the stay.

	Step 2. For discharges with one or more direct transfers, use the last discharge. Using the discharges identified in step 1, identify direct transfers between acute inpatient and observation using the definition of direct transfer. **Step 3.** Exclude acute hospitalizations with any of the following criteria on the discharge claim: • A principal diagnosis of pregnancy (Pregnancy Value Set) or a condition originating in the perinatal period (Perinatal Conditions Value Set). • A planned hospital stay using any of the following: – A principal diagnosis of maintenance chemotherapy (Chemotherapy Encounter Value Set). – A principal diagnosis of rehabilitation (Rehabilitation Value Set). – An organ transplant (Kidney Transplant Value Set, Bone Marrow Transplant Value Set, Organ Transplant Other Than Kidney Value Set, Introduction of Autologous Pancreatic Cells Value Set). – A potentially planned procedure (Potentially Planned Procedures Value Set) without a principal acute diagnosis (Acute Condition Value Set). ***Note:*** *For hospital stays where there was a direct transfer (identified in step 2), use the original stay and any direct transfer stays to identify exclusions in this step.* **Step 4.** For each IHS identified in the denominator, determine if any of the acute inpatient and observation stays identified in the numerator have an admission date within 30 days after the index discharge date. ***Note*** • *Count each acute hospitalization only once toward the numerator for the last denominator event.* *If a single numerator event meets criteria for multiple denominator events, only count the last denominator event.* For example, *consider the following events:* – *Acute inpatient stay 1: May 1–10.* – *Acute inpatient stay 2: May 15–25 (principal diagnosis of maintenance chemotherapy).* – *Acute inpatient stay 3: May 30–June 5.* *All three acute inpatient stays are included as denominator events. Stay 2 is excluded from the numerator because it is a planned hospitalization. Stay 3 is within 30 days of stay 1 and stay 2. Count stay 3 as a numerator event only toward the last denominator event (stay 2, May 15–25).*
Summary of changes	• Updated the measure description. • Integrated the Risk Adjustment General Guidelines into the *Guidance* section. • Moved the instructions regarding facility type from step 1 of the denominator to the *Guidance* section. • Moved the definition of “classification period” to the *Risk adjustment comorbidity category determination* section.

	• Added "direct transfer" to the *Definitions* section. • Added administrative gender codes to the initial population.
HEDIS for QRS-specific guidance	• HEDIS for QRS uses the commercial risk weights for risk adjustment.
Data element tables	***Reporting:* Number of persons in plan population** **Step 1.** Determine the person's age as of the earliest index discharge date. **Step 2.** Report the count of persons in the plan population for each age group as the PersonCount. ***Reporting:* Number of outliers** **Step 1.** Determine the person's age as of the earliest index discharge date. **Step 2.** Report the count of outlier persons for each age group as the OutlierPersonCount. ***Calculated:* Outlier rate** The number of outlier persons (OutlierPersonCount) divided by the number of persons in the plan population (PersonCount), displayed as a permillage (multiplied by 1,000), for each age group and totals. Calculated by IDSS as the OutlierRate. ***Reporting:* Denominator** Count the number of IHS among nonoutlier persons for each age group. Report these values as the denominator. ***Reporting:* Numerator** Count the number of observed IHS among nonoutlier persons with a readmission within 30 days of discharge for each age group and report these values as the ObservedCount. ***Calculated:* Observed readmission rate** The count of observed 30-day readmissions (ObservedCount) divided by the count of index stays (Denominator) for each age group and totals. Calculated by IDSS as the ObservedRate. ***Reporting:* Count of expected 30-day readmissions** **Step 1.** Calculate the count of expected readmissions among nonoutliers for each age group. **Step 2.** Round to 4 decimal places using the .5 rule and report these values as the ExpectedCount. ***Calculated:* Expected readmissions rate** The count of expected 30-day readmissions (ExpectedCount) divided by the count of index stays (Denominator) for each age group and totals. Calculated by IDSS as the ExpectedRate. ***Reporting*: Variance** **Step 1.** Calculate the total (sum) variance for each age group. **Step 2.** Round to 4 decimal places using the .5 rule and report these values as the CountVariance.

***Calculated:* O/E ratio**
The count of observed 30-day readmissions (ObservedCount) divided by the count of expected 30-day readmissions (ExpectedCount) for each age group and totals. Calculated by IDSS as the OE.

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

Table PCR-A-4: Data Element for Plan All-Cause Readmissions

Metric	Age	Data Element	Reporting Instructions
PlanAllCauseReadmissions	18-44	PersonCount	For each Stratification
	45-54	OutlierPersonCount	For each Stratification
	55-64	OutlierRate	OutlierPersonCount / PersonCount (Permille)
	18-64	Denominator	For each Stratification
		ObservedCount	For each Stratification
		ObservedRate	ObservedCount / Denominator (Percent)
		ExpectedCount	For each Stratification
		ExpectedRate	ExpectedCount / Denominator (Percent)
		CountVariance	For each Stratification
		OE	ObservedCount / ExpectedCount

Prenatal and Postpartum Care (PPC)

Measure title	Prenatal and Postpartum Care	**Measure ID**	PPC
Description	The percentage of deliveries of live births on or between October 8 of the year prior to the measurement period and October 7 of the measurement period. For these persons, the measure assesses the following facets of prenatal and postpartum care: • *Timeliness of Prenatal Care.* The percentage of deliveries that received a prenatal care visit in the first trimester on or before the enrollment start date or within 42 days of enrollment in the organization. • *Postpartum Care.* The percentage of deliveries that had a postpartum visit on or between 7 and 84 days after delivery.		
Measurement period	January 1–December 31.		
Copyright and disclaimer notice	Refer to the complete copyright and disclaimer information at the front of the NCQA Measure Specifications. NCQA website: www.ncqa.org. Submit policy clarification support questions via My NCQA (https://my.ncqa.org).		
Clinical recommendation statement/ rationale	According to the National Institutes of Health (NIH), prenatal care can minimize the risk of pregnancy complications and negative birth outcomes. Similarly, comprehensive postpartum care is critical for setting the stage for the long-term health and well-being of new mothers and their infants. Common issues after birth include lack of sleep, fatigue, pain, stress, breastfeeding difficulties, mental health disorders and pre-existing health and social concerns. In addition, more than half of maternal deaths occur after birth. Joint guidelines published by ACOG and the American Academy of Pediatrics (AAP) recommend a prenatal visit in the first trimester of pregnancy. In May 2018, ACOG published a committee opinion recommending that all women have an initial assessment with a maternal care provider within 21 days after birth to address acute postpartum issues. The initial assessment should then be followed by ongoing care as needed and conclude with a comprehensive visit within 12 weeks after birth. The Department of Defense, Veteran's Administration (DoD/VA) clinical practice guidelines recommend a postpartum visit within 6 weeks, and no later than 8 weeks, after delivery.		
Citations	National Institutes of Health (NIH). 2012. Eunice Kennedy Shriver National Institute of Child Health and Human Development. What Is Prenatal Care & Why Is It Important? www.nichd.nih.gov/health/topics/pregnancy/conditioninfo/Pages/prenatal-care.asp		

	American College of Obstetricians and Gynecologists (ACOG). 2018. "Optimizing Postpartum Care." ACOG Committee Opinion No. 736. *Obstet Gynecol* 131:140–50. Kassebaum, N., A. Bertozzi-Villa, M. Coggeshall, K. Shackelford, C. Steiner, K. Heuton, and D. Gonzalez-Medina.2015. "Global, Regional, and National Levels and Causes of Maternal Mortality During 1990-2013." Obstetric Anesthesia Digest 35(4), 196–7. doi:10.1097/01.aoa.0000472714.57328.86. American Academy of Pediatrics, American College of Obstetricians and Gynecologists. 2017. Guidelines for Perinatal Care. 8th Ed. Elk Grove Village, Ill. American Academy of Pediatrics, and Washington, DC. Department of Veteran's Affairs. Department of Defense. 2018. VA/DoD Clinical Practice Guideline for Management of Pregnancy. https://www.healthquality.va.gov/guidelines/WH/up/VADoDPregnancyCPG4102018.pdf
Characteristics	
Scoring	Proportion.
Type	Process.
Product line	Exchange.
Stratifications	Race. (Refer to *General Guideline: Race and Ethnicity Stratification*.) • American Indian or Alaska Native. • Asian. • Black or African American. • Middle Eastern or North African. • Native Hawaiian or Pacific Islander. • White. • Other Race. • Two or More Races. • Asked But No Answer. • Unknown. Ethnicity. (Refer to *General Guideline: Race and Ethnicity Stratification*.) • Hispanic or Latino. • Not Hispanic or Latino. • Asked But No Answer. • Unknown.
Risk adjustment	None.
Improvement notation	Increased score indicates improvement.

Guidance	**Data collection methodology:** Administrative and hybrid. Refer to *General Guideline: Data Collection Methods* for additional information. **Date specificity:** Dates must be specific enough to determine the event occurred in the period being measured. **What services count?** • When using claims, include all paid, suspended, pending and denied claims. • Services that occur over multiple visits count toward this measure if all services are within the time frame established in the measure. Ultrasound and lab results alone are not considered a visit; they must be combined with an office visit with an appropriate practitioner in order to count for this measure. **Other guidance:** • Criteria for identifying prenatal care for persons who were not enrolled during the first trimester allow more flexibility than criteria for persons who were enrolled. – *For persons who were enrolled at least 219 days before delivery,* the organization has sufficient opportunity to provide prenatal care by the end of the first trimester. – *For persons who were not enrolled at least 219 days before delivery,* the organization has sufficient opportunity to provide prenatal care within 42 days after enrollment. • Refer to Appendix 1 for the definition of *PCP* and *OB/GYN and other prenatal care practitioner.* • Ancillary services (lab, ultrasound) may be delivered by an ancillary provider. Nonancillary services (e.g., fetal heart tone, prenatal risk assessment) must be delivered by the required provider type. • For both rates and for both Administrative and Hybrid data collection methods, services provided during a telephone visit, e-visit or virtual check-in are eligible for use in reporting. • For each person, the organization must use one date (date of delivery or estimated delivery date [EDD]) to define the start and end of the first trimester. If multiple EDDs are documented, the organization must define a method to determine which EDD to use, and use that date consistently. If the organization elects to use EDD, and the EDD is not on or between October 8 of the year prior to the measurement period and October 7 of the measurement period, the person is removed as a valid data error and replaced by the next person in the oversample. The LMP may not be used to determine the first trimester. • The EDD may be used to identify the first trimester for the Timeliness of Prenatal Care rate and use the date of delivery for the Postpartum Care rate. • The measure is based on deliveries; therefore, it is possible for denominator to include multiple deliveries for the same person.

Definitions	
First trimester	280–176 days prior to delivery (or estimated delivery date [EDD]).
Initial population	*Measure item count:* Episode. *Attribution basis:* Enrollment. • *Benefits:* Medical. • *Continuous enrollment:* 43 days prior to delivery through 60 days after delivery. • *Allowable gap:* None. *Ages:* None. *Event:* **Deliveries.** Live birth deliveries in any setting on or between October 8 of the year prior to the measurement period and October 7 of the measurement period. **Step 1.** Identify all persons with a delivery (Deliveries Value Set) on or between October 8 of the year prior to the measurement period and October 7 of the measurement period. ***Note:*** *The intent is to identify the date of delivery (the date of the "procedure"). If the date of delivery cannot be interpreted on the claim, use the date of service or, for inpatient claims, the date of discharge.* **Step 2.** Remove non-live births (Non Live Births Value Set). **Step 3.** Identify continuous enrollment. Determine if enrollment was continuous 43 days prior to delivery through 60 days after delivery, with no gaps. **Step 4.** Remove multiple deliveries in a 180-day period. If a person has more than one delivery in a 180-day period, include only the first eligible delivery. Then, if applicable, include the next delivery that occurs after the 180-day period. Identify deliveries chronologically, including only one per 180-day period. ***Note:*** *The initial population for this measure is based on deliveries, not on persons. All eligible deliveries that were not removed in steps 1–4 remain in the initial population.*
Denominator exclusions	**Persons with a date of death.** Death in the measurement period, identified using data sources determined by the organization. Method and data sources are subject to review during the HEDIS audit. **Persons in hospice or using hospice services.** Persons who use hospice services (Hospice Encounter Value Set; Hospice Intervention Value Set) or elect to use a hospice benefit any time during the measurement period. Organizations that use the Monthly Membership Detail Data File to identify these persons must use only the run date of the file.

Denominator	***ADMINISTRATIVE*** The initial population minus denominator exclusions. ***HYBRID*** A systematic sample drawn from the administrative denominator. Organizations may reduce the sample size using the current year's administrative rate or the prior year's audited, product line-specific rate for the lower of the two indicators. Refer to the *Guidelines for Calculations and Sampling* for information on reducing the sample size.
Numerator	***ADMINISTRATIVE*** **Numerator 1: Timeliness of prenatal care.** A prenatal visit during the required time frame. Follow the steps below to identify numerator compliance. **Step 1.** Identify persons who were continuously enrolled (with no gaps) from at least 219 days before delivery (or EDD) through 60 days after delivery. These persons must have a prenatal visit during the first trimester. **Step 2.** Identify persons who were not continuously enrolled from at least 219 days before delivery (or EDD) through 60 days after delivery. These persons must have a prenatal visit any time during the period that begins 280 days prior to delivery and ends 42 days after the enrollment start date. Do not count visits that occur on or after the date of delivery. Visits that occur prior to the person's enrollment start date during the pregnancy meet criteria. **Step 3.** Identify prenatal visits that occurred during the required time frame (the time frame identified in step 1 or 2). Any of the following, where the practitioner type is an OB/GYN or other prenatal care practitioner or PCP, meet criteria for a prenatal visit: • A bundled service (Prenatal Bundled Services Value Set) where the organization can identify the date when prenatal care was initiated (because bundled service codes are used on the date of delivery, these codes may be used only if the claim form indicates when prenatal care was initiated). • A visit for prenatal care (Stand Alone Prenatal Visits Value Set†). • A prenatal visit (Prenatal Visits Value Set) ***with*** a pregnancy-related diagnosis code (Pregnancy Diagnosis Value Set). **Numerator 2*:* Postpartum care.** A postpartum visit on or between 7 and 84 days after delivery. Any of the following meet criteria: • A postpartum visit (Postpartum Care Value Set†). • An encounter for postpartum care (Encounter for Postpartum Care Value Set*).

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

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

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

Coding Guidance
*Do not include laboratory claims (claims with POS code 81).
†Do not use codes with a modifier (CPT CAT II Modifier Value Set).

HYBRID

Administrative: Refer to administrative specifications to identify positive numerator hits from administrative data.

Numerator 1*: Timeliness of prenatal care.*
A prenatal visit during the required time frame. Refer to *Administrative Specification* to identify the required time frame for each person based on the date of enrollment in the organization and the gaps in enrollment during the pregnancy.

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

- Documentation indicating the person is pregnant or references to the pregnancy.

  For example:
  - Documentation in a standardized prenatal flow sheet, ***or***
  - Documentation of last menstrual period (LMP), EDD or gestational age, ***or***
  - A positive pregnancy test result, ***or***
  - Documentation of gravidity and parity, ***or***
  - Documentation of complete obstetrical history, ***or***
  - Documentation of prenatal risk assessment and counseling/ education.
- A basic physical obstetrical examination that includes auscultation for fetal heart tone, ***or*** pelvic exam with obstetric observations, ***or*** measurement of fundus height (a standardized prenatal flow sheet may be used).
- Evidence that a prenatal care procedure was performed, such as:
  - Screening test in the form of an obstetric panel (must include all of the following: hematocrit, differential WBC count, platelet count, hepatitis

B surface antigen, rubella antibody, syphilis test, RBC antibody screen, Rh and ABO blood typing), ***or***
- TORCH antibody panel alone, ***or***
- A rubella antibody test/titer with an Rh incompatibility (ABO/Rh) blood typing, ***or***
- Ultrasound of a pregnant uterus.

Numerator 2*:* Postpartum care.
A postpartum visit on or between 7 and 84 days after delivery, as documented through either administrative data or medical record review.

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

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

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

Note

- *A Pap test does not count as a prenatal care visit for the administrative and hybrid specification of the Timeliness of Prenatal Care rate but is acceptable for the Postpartum Care rate as evidence of a pelvic exam. A colposcopy alone is not numerator compliant for either rate.*
- *Services that occur over multiple visits count toward this measure if all services are within the time frame established in the measure. Ultrasound and lab results alone are not considered a visit; they must be combined with an office visit with an appropriate practitioner in order to count for this measure.*
- *The intent is to assess whether prenatal and preventive care was rendered on a routine, outpatient basis rather than assessing treatment for emergent events.*

Summary of changes

- Updated the race and ethnicity stratification categories and Data Elements for Reporting table to align with OMB SPD 15 2024 and US Core Version 6.1.0 Model Definition.

HEDIS for QRS-specific guidance

- HEDIS for QRS does not require race and ethnicity stratification reporting.

Data element tables

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

Table PPC-A-4: Data Elements for Prenatal and Postpartum Care

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

Table PPC-B-4: Data Elements for Prenatal and Postpartum Care: Stratifications by Race

Metric
TimelinessPrenatalCare
PostpartumCare

Race	Data Element	Reporting Instructions	A
AmericanIndianOrAlaskaNative	CollectionMethod	For each Metric, repeat per Stratification	✓
Asian	Denominator*	For each Stratification, repeat per Metric	✓
BlackOrAfricanAmerican	Numerator	For each Metric and Stratification	✓
MiddleEasternOrNorthAfrican	Rate	(Percent)	✓

Race	Data Element	Reporting Instructions	A
NativeHawaiianOrPacificIslander			
White			
OtherRace			
TwoOrMoreRaces			
AskedButNoAnswer			
Unknown			

Table PPC-C-4: Data Elements for Prenatal and Postpartum Care: Stratifications by Ethnicity

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

*****Repeat the InitialPopulation, Exclusions and Denominator values for metrics using the Administrative Method.

Use of Imaging Studies for Low Back Pain (LBP)

Measure title	Use of Imaging Studies for Low Back Pain	**Measure ID**	LBP
Description	The percentage of persons 18–75 years of age with a principal diagnosis of low back pain who did not have an imaging study (plain X-ray, MRI, CT scan) within 28 days of the diagnosis.		
Measurement period	January 1–December 31.		
Copyright and disclaimer notice	Refer to the complete copyright and disclaimer information at the front of the NCQA Measure Specifications. NCQA website: www.ncqa.org. Submit policy clarification support questions via My NCQA (https://my.ncqa.org).		
Clinical recommendation statement/ rationale	Approximately 2.6 million emergency department visits in the U.S. each year are due to a low back pain-related disorder. Nine specialty societies have published recommendations regarding the use of imaging for patients with low back pain, indicating the topic's importance to health care providers. Clinical guidelines for treating patients with acute low back pain strongly recommend against imaging in the absence of "red flags" (i.e., indications of a serious underlying pathology such as a fracture or tumor). Organizations can provide information, best-care practice models and other support to providers, imaging centers and members to increase knowledge and ensure that imaging studies are used appropriately for evaluation of lower back pain patients, based on the duration of symptoms and the presence of red flags.		
Citations	Deyo, R.A., S.K. Mirza, B.I. Martin. 2006. "Back Pain Prevalence and Visit Rates: Estimates from U.S. National Surveys, 2002." *Spine* 31(23):2724–7. Downie, A., et al. 2013. "Red Flags to Screen for Malignancy and Fracture in Patients with Low Back Pain: Systematic Review." *BMJ* 347:f7095. doi: 10.1136/bmj.f7095. Friedman, B.W., M. Chilstrom, P.E. Bijur, & E.J. Gallagher. 2010. "Diagnostic Testing and Treatment of Low Back Pain in US Emergency Departments. A National Perspective." *Spine* 35(24), E1406–11. https://doi.org/10.1097/BRS.0b013e3181d952a5		
Characteristics			
Scoring	Proportion.		
Type	Process.		
Product line	Exchange.		

Stratifications	Age as of the last day of measurement period. • 18–64 years. • 65–75 years.
Risk adjustment	None.
Improvement notation	Increased score indicates improvement.
Guidance	**Data collection methodology:** Administrative. Refer to *General Guideline: Data Collection Methods* for additional information. **Date specificity:** Dates must be specific enough to determine the event occurred in the period being measured. **Which services count?** • Include all paid, suspended, pending and denied claims to identify the initial population and denominator exclusions. • Do not include denied claims when identifying numerator events; only include claims the organization paid for or expects to pay for (i.e., claims incurred but not paid). **Supplemental data exceptions:** Supplemental data may not be used for this measure, except for denominator exclusions. **Other guidance:** Reported as an inverted rate [1– (numerator/denominator)]. A higher score indicates appropriate treatment of low back pain (i.e., the proportion for whom imaging studies did not occur).
Definitions	
IESD	Index episode start date. The earliest date of service for an eligible encounter during the intake period with a principal diagnosis of low back pain.
Intake period	January 1–December 3 of the measurement period. The intake period is used to identify the first eligible encounter with a principal diagnosis of low back pain.
Negative diagnosis history	A period of 180 days prior to the IESD when the person had no claims/ encounters with any diagnosis of low back pain.
Initial population	*Measure item count:* Person. *Attribution basis:* Enrollment. • *Benefits:* Medical. • *Continuous enrollment:* 180 days prior to the IESD through 28 days after the IESD. • *Allowable gap:* None. *Ages:* 18–75 years of age as of the last day of measurement period. *Event:* **Low back pain diagnosis.**

	Step 1. Identify persons with a principal diagnosis of uncomplicated low back pain (Uncomplicated Low Back Pain Value Set*) during the intake period. Do not include inpatient stays (Inpatient Stay Value Set) or visits that result in an inpatient stay (Inpatient Stay Value Set). **Step 2.** Determine the IESD. For each person identified in step 1, determine the earliest episode of low back pain. If the person had more than one encounter, include only the first encounter. **Step 3.** Test for negative diagnosis history. Remove persons with a diagnosis of uncomplicated low back pain (Uncomplicated Low Back Pain Value Set*) during the 180 days prior to the IESD. **Step 4.** Calculate continuous enrollment. **Coding Guidance** *Do not include laboratory claims (claims with POS code 81).
Denominator exclusions	**Persons with a date of death.** Death in the measurement period, identified using data sources determined by the organization. Method and data sources are subject to review during the HEDIS audit. **Persons in hospice or using hospice services.** Persons who use hospice services (Hospice Encounter Value Set; Hospice Intervention Value Set) or elect to use a hospice benefit any time during the measurement period. Organizations that use the Monthly Membership Detail Data File to identify these persons must use only the run date of the file. **Persons receiving palliative care.** Persons receiving palliative care (Palliative Care Assessment Value Set; Palliative Care Encounter Value Set; Palliative Care Intervention Value Set) or who had an encounter for palliative care (ICD-10-CM code Z51.5*) any time during the measurement period. **Persons 66 years of age and older by the last day of the measurement period, with both frailty and advanced illness.** 1. **Frailty.** At least two indications of frailty (Frailty Device Value Set; Frailty Diagnosis Value Set*; Frailty Encounter Value Set; Frailty Symptom Value Set*) with different dates of service during the measurement period. 2. **Advanced illness.** Either of the following during the measurement period or the year prior to the measurement period: – Advanced illness (Advanced Illness Value Set*) on at least two different dates of service. – Dispensed dementia medication (Dementia Medications List). **Persons with the following diagnoses or procedures that may warrant imaging any time during the person's history through 28 days after the IESD:** • Cancer, HIV, history of organ transplant, osteoporosis or spondylopathy (Diagnosis History That May Warrant Imaging Value Set*). • Organ transplant, lumbar surgery or medication treatment for osteoporosis (Procedure History That May Warrant Imaging Value Set).

	• A dispensed prescription to treat osteoporosis (Osteoporosis Medications List). **Persons with a recent diagnosis that may warrant imaging any time during the 365 days prior to the IESD through 28 days after the IESD.** IV drug abuse, neurologic impairment or spinal infection (Recent Diagnoses That May Warrant Imaging Value Set*). **Persons with a recent injury that may warrant imaging any time during the 90 days prior to the IESD through 28 days after the IESD.** Trauma or a fragility fracture (Recent Injuries That May Warrant Imaging Value Set*). **Persons with prolonged use of corticosteroids.** 90 consecutive days of corticosteroid treatment any time during the 366-day period that begins 365 days prior to the IESD and ends on the IESD. To identify consecutive treatment days, identify calendar days covered by at least one dispensed corticosteroid (Corticosteroid Medications List). For overlapping prescriptions and multiple prescriptions on the same day assume the person started taking the second prescription after exhausting the first prescription. • *For example*, if there is a 30-day prescription dispensed on June 1 and a 30-day prescription dispensed on June 26, there are 60 covered calendar days (June 1–July 30). Count only medications dispensed during the 365 days prior to and including the IESD. When identifying consecutive treatment days, do not count days supply that extend beyond the IESD. • *For example*, if there is a 90-day prescription dispensed on the IESD, there is one covered calendar day (the IESD). No gaps are allowed. **Coding Guidance** *Do not include laboratory claims (claims with POS code 81).
Denominator	The initial population minus denominator exclusions.
Numerator	**An imaging study *with* a diagnosis of uncomplicated low back pain.** An imaging study (Imaging Study Value Set) with a diagnosis of uncomplicated low back pain (Uncomplicated Low Back Pain Value Set) on the IESD or in the 28 days following the IESD.
Summary of changes	• No changes to this measure.

Data element tables

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

Table LBP-4: Data Elements for Use of Imaging Studies for Low Back Pain

Metric	Age	Data Element	Reporting Instructions
LowBackPainImaging	18-64	InitialPopulation	For each Stratification
	65-75	Exclusions	For each Stratification
	Total	Denominator	For each Stratification
		NumeratorByAdmin	For each Stratification
		Rate	(Percent)

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

Measure title	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents	**Measure ID**	WCC
Description	The percentage of persons 3–17 years of age who had an outpatient visit with a PCP or OB/GYN and who had evidence of the following during the measurement period: • BMI Percentile*****. • Counseling for Nutrition. • Counseling for Physical Activity. **Because BMI norms for youth vary with age and gender, this measure evaluates whether BMI percentile is assessed rather than an absolute BMI value.*		
Measurement period	January 1–December 31.		
Copyright and disclaimer notice	Refer to the complete copyright and disclaimer information at the front of the NCQA Measure Specifications. NCQA website: www.ncqa.org. Submit policy clarification support questions via My NCQA (https://my.ncqa.org).		
Clinical recommendation statement/ rationale	The American Academy of Pediatrics (AAP) recommends providers assess the BMI percentile, nutrition, and physical activity status of children and adolescents aged 3 to 17 to promote healthy weight management and activity. The Centers for Disease Control and Prevention (CDC) and the AAP recommend that health care practitioners in primary care settings in the United States use the 2000 CDC Growth Reference Charts to monitor the growth of children and teens aged between 2 and 20 years.		
Citations	Hagan, J.F., J.S. Shaw, and P.M. Duncan, eds. *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents*. Fourth edition. Elk Grove Village, IL: Bright Futures/American Academy of Pediatrics, 2017. "Overview of the CDC Growth Charts for Use in the United States Among Children and Teens Aged 2 Years to 20 Years CDC," December 13, 2022. https://www.cdc.gov/nccdphp/dnpao/growthcharts/training/overview/index.html		

Characteristics	
Scoring	Proportion.
Type	Process.
Product line	Exchange.

Stratifications	Age as of the last day of the measurement period. • 3–11 years. • 12–17 years.
Risk adjustment	None.
Improvement notation	Increased score indicates improvement.
Guidance	**Data collection methodology:** Administrative and hybrid. Refer to *General Guideline: Data Collection Methods* for additional information. **Date specificity:** Dates must be specific enough to determine the event occurred in the period being measured. **Which services count?** When using claims, include all paid, suspended, pending and denied claims. **Other guidance:** Refer to Appendix 1 for the definition of *PCP* and *OB/GYN and other prenatal care practitioner.*
Definitions	
BMI percentile	The percentile ranking based on the CDC's BMI-for-age growth charts, which indicates the relative position of a person's BMI number among others of the same gender and age.
Initial population	*Measure item count:* Person. *Attribution basis:* Enrollment. • *Benefits:* Medical. • *Continuous enrollment:* The measurement period. • *Allowable gap:* No more than one gap of ≤45 days during the measurement period. No gaps on the last day of the measurement period. *Ages:* 3–17 years of age as of the last day of the measurement period. *Event:* **Persons with an outpatient visit with a PCP or an OB/GYN.** An outpatient visit (Outpatient Value Set) with a PCP or an OB/GYN during the measurement period.
Denominator exclusions	**Persons with a date of death.** Death in the measurement period, identified using data sources determined by the organization. Method and data sources are subject to review during the HEDIS audit. **Persons in hospice or using hospice services.** Persons who use hospice services (Hospice Encounter Value Set; Hospice Intervention Value Set) or elect to use a hospice benefit any time during the measurement period. Organizations that use the Monthly Membership Detail Data File to identify these persons must use only the run date of the file.

	Diagnosis of pregnancy. Persons with a diagnosis of pregnancy (Pregnancy Value Set*) any time during the measurement period. **Coding Guidance** *Do not include laboratory claims (claims with POS code 81).
Denominator	***ADMINISTRATIVE*** The initial population minus denominator exclusions. ***HYBRID*** A systematic sample drawn from the administrative denominator for each product line for the total age band (3–17 years). The total sample is stratified by age to report rates for the 3–11 and 12–17 age stratifications. Organizations may reduce the sample size using the current year's administrative rate or the prior year's audited, product line-specific rate for the lowest of the three indicator rates for the total age band. Refer to the *Guidelines for Calculations and Sampling* for information on reducing the sample size.
Numerator	***ADMINISTRATIVE*** **Numerator 1: BMI percentile.** Persons with BMI percentile (BMI Percentile Value Set*) assessed during the measurement period. **Numerator 2*:* Counseling for nutrition.** Persons who received counseling for nutrition (Nutrition Counseling Value Set, ICD10CM code Z71.3*) during the measurement period. **Numerator 3*:* Counseling for physical activity.** Persons who received counseling for physical activity (Physical Activity Counseling Value Set, Encounter for Physical Activity Counseling Value Set*) during the measurement period. **Coding Guidance** *****Do not include laboratory claims (claims with POS code 81). ***HYBRID*** *Administrative:* Refer to the administrative specifications to identify positive numerator hits from administrative data. **Numerator 1: BMI percentile.** BMI percentile during the measurement period as identified by administrative data or medical record review. *Medical record:* Documentation must include height, weight and BMI percentile during the measurement period. The height, weight and BMI percentile must be from the same data source. Either of the following meets criteria for BMI percentile: • BMI percentile documented as a value (e.g., 85th percentile). • BMI percentile plotted on an age-growth chart.

	Only evidence of the BMI percentile or BMI percentile plotted on an age-growth chart meets criteria. Member-collected biometric values (height, weight, BMI percentile) that meet the requirements of *General Guideline: Self-Reported Services and Biometric Values* are eligible for use in reporting. Ranges and thresholds do not meet criteria for this indicator. A distinct BMI percentile is required for numerator compliance. Documentation of >99% or <1% meets criteria because a distinct BMI percentile is evident (i.e., 100% or 0%). **Numerator 2: Counseling for nutrition.** Documentation of counseling for nutrition or referral for nutrition education during the measurement period as identified by administrative data or medical record review. *Medical record:* Documentation must include a note indicating the date and at least one of the following: • Discussion of current nutrition behaviors (e.g., eating habits, dieting behaviors). • Checklist indicating nutrition was addressed. • Counseling or referral for nutrition education. • Received educational materials on nutrition during a face-to-face visit. • Anticipatory guidance specific to nutrition. • Weight or obesity counseling. **Numerator 3*:* Counseling for physical activity.** Documentation of counseling for physical activity or referral for physical activity during the measurement period as identified by administrative data or medical record review. *Medical record:* Documentation must include a note indicating the date and at least one of the following: • Discussion of current physical activity behaviors (e.g., exercise routine, participation in sports activities, exam for sports participation). • Checklist indicating physical activity was addressed. • Counseling or referral for physical activity. • Received educational materials on physical activity during a face-to-face visit. • Anticipatory guidance specific to physical activity. • Weight or obesity counseling.

Note

- *The following notations or examples of documentation do not count as numerator compliant:*
  - ***BMI***
    - *No BMI percentile documented in medical record or plotted on age-growth chart.*
    - *Notation of BMI value only.*
    - *Notation of height and weight only.*
  - ***Nutrition***
    - *No counseling/education on nutrition and diet.*
    - *Counseling/education before or after the measurement period.*
    - *Notation of "health education" or "anticipatory guidance" without specific mention of nutrition.*
    - *A physical exam finding or observation alone (e.g., well-nourished) is not compliant because it does not indicate counseling for nutrition.*
    - *Documentation related to "appetite" does not meet criteria.*
  - ***Physical Activity***
    - *No counseling/education on physical activity.*
    - *Notation of "cleared for gym class" alone without documentation of a discussion.*
    - *Counseling/education before or after the measurement period.*
    - *Notation of "health education" or "anticipatory guidance" without specific mention of physical activity.*
    - *Notation of anticipatory guidance related solely to safety (e.g., wears helmet or water safety) without specific mention of physical activity recommendations.*
    - *Notation solely related to screen time (computer or television) without specific mention of physical activity.*
- *Services may be rendered during a visit other than a well-child visit. These services count if the specified documentation is present, regardless of the primary intent of the visit; however, services specific to the assessment or treatment of an acute or chronic condition do not count toward the Counseling for Nutrition and Counseling for Physical Activity indicators.*
- *The following documentation is specific to the assessment or treatment of an acute or chronic condition and does not meet criteria:*
  - *Notation that a person with chronic knee pain is able to run without limping.*
  - *Notation that a person has exercise-induced asthma.*
  - *Notation that a person with diarrhea is following the BRAT diet.*
  - *Notation that a person has decreased appetite as a result of an acute or chronic condition.*
- *Services rendered for obesity or eating disorders may be used to meet criteria for the Counseling for Nutrition and Counseling for Physical Activity indicators if the specified documentation is present.*
- *Referral to the Special Supplemental Nutrition Program for Women, Infants and Children (WIC) may be used to meet criteria for the Counseling for Nutrition indicator.*

<table>
<tr><td></td><td>

- *The BMI Percentile, Counseling for Nutrition and Counseling for Physical Activity indicators do not require a specific setting; therefore, services rendered during a telephone visit, e-visit or virtual check-in meet criteria.*

</td></tr>
<tr><td>Summary of changes</td><td>

- No changes to this measure.

</td></tr>
<tr><td>Data element tables</td><td>

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

Table WCC-4: Data Elements for Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents

<table>
<tr><th></th><th>Age</th><th>Data Element</th><th>Reporting Instructions</th><th>A</th></tr>
<tr><td>BMIPercentile</td><td>3-11</td><td>CollectionMethod</td><td>For each Metric, repeat per Stratification</td><td>✓</td></tr>
<tr><td>NutritionCounseling</td><td>12-17</td><td>InitialPopulation*</td><td>For each Metric and Stratification</td><td>✓</td></tr>
<tr><td>PhysicalActivityCounseling</td><td>Total</td><td>Exclusions*</td><td>For each Metric and Stratification</td><td>✓</td></tr>
<tr><td></td><td></td><td>Denominator*</td><td>For each Stratification, repeat per Metric</td><td>✓</td></tr>
<tr><td></td><td></td><td>NumeratorByAdminDenom</td><td>For each Metric and Stratification</td><td></td></tr>
<tr><td></td><td></td><td>CYAR</td><td>Only for Total (Percent)</td><td></td></tr>
<tr><td></td><td></td><td>MinReqSampleSize</td><td>Repeat per Metric and Stratification</td><td></td></tr>
<tr><td></td><td></td><td>OversampleRate</td><td>Repeat per Metric and Stratification</td><td></td></tr>
<tr><td></td><td></td><td>OversampleRecordsNumber</td><td>(Count)</td><td></td></tr>
<tr><td></td><td></td><td>ExclusionValidDataErrors</td><td>Repeat per Metric and Stratification</td><td></td></tr>
<tr><td></td><td></td><td>ExclusionEmployeeOrDep</td><td>Repeat per Metric and Stratification</td><td></td></tr>
<tr><td></td><td></td><td>OversampleRecsAdded</td><td>Repeat per Metric and Stratification</td><td></td></tr>
<tr><td></td><td></td><td>NumeratorByAdmin</td><td>For each Metric and Stratification</td><td>✓</td></tr>
<tr><td></td><td></td><td>NumeratorByMedicalRecords</td><td>For each Metric and Stratification</td><td></td></tr>
<tr><td></td><td></td><td>NumeratorBySupplemental</td><td>For each Metric and Stratification</td><td>✓</td></tr>
<tr><td></td><td></td><td>Rate</td><td>(Percent)</td><td>✓</td></tr>
</table>

*Repeat the InitialPopulation, Exclusions and Denominator values for metrics using the Administrative Method.

</td></tr>
</table>

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

Measure title	Well-Child Visits in the First 30 Months of Life	**Measure ID**	W30
Description	The percentage of persons who had the following number of well-child visits with a PCP during the last 15 months. The following rates are reported: 1. *Well-Child Visits in the First 15 Months*. Persons who turned 15 months old during the measurement period: Six or more well-child visits. 2. *Well-Child Visits for Age 15 Months–30 Months*. Persons who turned 30 months old during the measurement period: Two or more well-child visits.		
Measurement period	January 1–December 31.		
Copyright and disclaimer notice	Refer to the complete copyright and disclaimer information at the front of the NCQA Measure Specifications. NCQA website: www.ncqa.org. Submit policy clarification support questions via My NCQA (https://my.ncqa.org).		
Clinical recommendation statement/ rationale	This measure is based on the American Academy of Pediatrics Bright Futures guidelines for Health Supervision of Infants, Children and Adolescents. In addition to the Bright Futures Guidelines, the AAP publishes a recommended schedule of screenings and assessments, known as the periodicity schedule, that outlines what to do at every visit, from infancy to adolescence. Bright Futures recommends more frequent well-child visits in the first years of life and one or more annual well-child visits from age 3–21. They recommend that the well-child visits include, but are not limited to, an initial/interval medical history, physical exam, developmental assessment, immunization and anticipatory guidance. The AAP/Bright Futures guidelines also recommend two or more visits between 15 months and 30 months, an important period for early assessment and screenings. Early identification of developmental disorders is critical to the well-being of children and their families. It is an integral function of the primary care medical home and an appropriate responsibility of all pediatric health care professionals. Research shows that early intervention treatment services can greatly improve a child's development. Early intervention services help children from birth through 3 years of age (36 months) learn important skills.		
Citations	Hagan, J.F., J.S. Shaw, and P.M. Duncan, eds. 2017. *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents.* Fourth edition. Elk Grove Village, IL: Bright Futures/American Academy of Pediatrics. Bright Futures & American Academy of Pediatrics. 2025. *Periodicity Schedule—Recommendations for Preventive Pediatric Health Care.* https://downloads.aap.org/AAP/PDF/periodicity_schedule.pdf		

Characteristics	
Scoring	Proportion.
Type	Process.
Product line	Exchange.
Stratifications	Race. (Refer to *General Guideline: Race and Ethnicity Stratification.*) • American Indian or Alaska Native. • Asian. • Black or African American. • Middle Eastern or North African. • Native Hawaiian or Pacific Islander. • White. • Other Race. • Two or More Races. • Asked But No Answer. • Unknown. Ethnicity. (Refer to *General Guideline: Race and Ethnicity Stratification.*) • Hispanic or Latino. • Not Hispanic or Latino. • Asked But No Answer. • Unknown.
Risk adjustment	None.
Improvement notation	Increased score indicates improvement.
Guidance	**Data collection methodology:** Administrative. Refer to *General Guideline: Data Collection Methods* for additional information. **Date specificity:** Dates must be specific enough to determine the event occurred in the period being measured. **Which services count?** When using claims, include all paid, suspended, pending and denied claims. **Other guidance:** • Refer to Appendix 1 for the definition of *PCP.* • The well-child visit must occur with a PCP, but the PCP does not have to be the practitioner assigned to the child.
Initial population	*Measure item count:* Person. *Attribution basis:* Enrollment. • *Benefits:* Medical.

	• *Continuous enrollment:* – *Initial population 1:* 31 days through 15 months of age. Calculate 31 days of age by adding 31 days to the date of birth. – *Initial population 2:* 15 months plus 1 day through 30 months of age. Calculate the 15-month birthday plus 1 day as the first birthday plus 91 days. • *Allowable gap:* – *Initial population 1:* No more than one gap of ≤45 days during the continuous enrollment period. No gaps on the 15-month birthday. – *Initial population 2:* No more than one gap of ≤45 days during the continuous enrollment period. No gaps on the 30-month birthday. *Ages:* • *Initial population 1:* Persons who turn 15 months old during the measurement period. Calculate the 15-month birthday as the first birthday plus 90 days. • *Initial population 2:* Persons who turn 30 months old during the measurement period. Calculate the 30-month birthday as the second birthday plus 180 days. *Event:* None.
Denominator exclusions	**Persons with a date of death.** Death in the measurement period, identified using data sources determined by the organization. Method and data sources are subject to review during the HEDIS audit. **Persons in hospice or using hospice services.** Persons who use hospice services (Hospice Encounter Value Set; Hospice Intervention Value Set) or elect to use a hospice benefit any time during the measurement period. Organizations that use the Monthly Membership Detail Data File to identify these persons must use only the run date of the file.
Denominator	**Denominator 1: Well-child visits in the first 15 months.** The initial population 1 minus denominator exclusions. **Denominator 2: Well-child visits for 15 months–30 months of age.** The initial population 2 minus denominator exclusions.
Numerator	**Numerator 1: Well-child visits in the first 15 months.** Persons with six or more well-child visits on different dates of service with a PCP on or before the 15-month birthday. Either of the following meet criteria: • A well-care visit (Well Care Visit Value Set). • An encounter for well-care (Encounter for Well Care Value Set*). Do not include telehealth visits (visits billed with a code that indicates telehealth: Telehealth POS Value Set; Virtual Encounters Value Set).

Numerator 2: Well-child visits for age 15 months–30 months
Two or more well-child visits on different dates of service with a PCP between the child's 15-month birthday plus 1 day and the 30-month birthday. Either of the following meets criteria:

- A well-care visit (Well Care Visit Value Set).
- An encounter for well-care (Encounter for Well Care Value Set*).

Do not include telehealth visits (visits billed with a code that indicates telehealth: Telehealth POS Value Set; Virtual Encounters Value Set).

Coding Guidance
*Do not include laboratory claims (claims with POS code 81).

Summary of changes

- Updated the race and ethnicity stratification categories and Data Elements for Reporting table to align with OMB SPD 15 2024 and US Core Version 6.1.0 Model Definition.

HEDIS for QRS-specific guidance

- HEDIS for QRS does not require race and ethnicity stratification reporting.

Data element tables

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

Table W30-A-4: Data Elements for Well-Child Visits in the First 30 Months of Life

Metric	Data Element	Reporting Instructions
Age15Months	InitialPopulation	For each Metric
Age15To30Months	Exclusions	For each Metric
	Denominator	For each Metric
	NumeratorByAdmin	For each Metric
	NumeratorBySupplemental	For each Metric
	Rate	(Percent)

Table W30-B-4: Data Elements for Well-Child Visits in the First 30 Months of Life: Stratifications by Race

Metric	Race	Data Element	Reporting Instructions
Age15Months	AmericanIndianOrAlaskaNative	Denominator	For each Metric and Stratification
Age15To30Months	Asian	Numerator	For each Metric and Stratification
	BlackOrAfricanAmerican	Rate	(Percent)
	MiddleEasternOrNorthAfrican		
	NativeHawaiianOrPacificIslander		
	White		
	OtherRace		
	TwoOrMoreRaces		
	AskedButNoAnswer		
	Unknown		

Table W30-C-4: Data Elements for Well-Child Visits in the First 30 Months of Life: Stratifications by Ethnicity

Metric	Ethnicity	Data Element	Reporting Instructions
Age15Months	HispanicOrLatino	Denominator	For each Metric and Stratification
Age15To30Months	NotHispanicOrLatino	Numerator	For each Metric and Stratification
	AskedButNoAnswer	Rate	(Percent)
	Unknown		

Measures Reported Using Electronic Clinical Data Systems

Adult Immunization Status (AIS-E)

Measure title	Adult Immunization Status*	**Measure ID**	AIS-E
Description	The percentage of persons 19 years of age and older who are up to date on recommended routine vaccines for influenza, tetanus and diphtheria (Td) or tetanus, diphtheria and acellular pertussis (Tdap), zoster, pneumococcal, and hepatitis B.		
Measurement period	January 1–December 31.		
Copyright and disclaimer notice	**Developed with support from the Department of Health and Human Services (DHHS), Office of the Assistant Secretary for Health (OASH), National Vaccine Program Office (NVPO) and The Hepatitis Education Project.* Refer to the complete copyright and disclaimer information at the front of the NCQA Measure Specifications. NCQA website: www.ncqa.org. Submit policy clarification support questions via My NCQA (https://my.ncqa.org).		
Clinical recommendation statement/ rationale	The Advisory Committee on Immunization Practices recommends annual influenza vaccination; and tetanus, diphtheria and acellular pertussis (Tdap) and/or tetanus and diphtheria (Td) vaccine; herpes zoster, pneumococcal, and hepatitis B vaccination for adults at various ages.		
Citations	Wodi, A.P, A.N. Issa, C.A. Moser, S. Cineas. 2025. "Advisory Committee on Immunization Practices Recommended Immunization Schedule for Adults Aged 19 Years or Older—United States, 2025." *MMWR Morb Mortal Wkly Rep* 74:30–33. doi: http://dx.doi.org/10.15585/mmwr.mm7402a3		
Characteristics			
Scoring	Proportion.		
Type	Process.		
Product line	Exchange.		
Stratifications	Influenza and Td/Tdap: Age as of the start of the measurement period. • 19–64 years. • 65 years and older. Zoster: Age as of the start of the measurement period. • 50–64 years. • 65 years and older. Pneumococcal: Age as of the start of the measurement period. • 65 years and older.		

	Hepatitis B: Age as of the start of the measurement period. • 19–30 years. • 31–59 years. Race. (Refer to *General Guideline: Race and Ethnicity Stratification*.) • American Indian or Alaska Native. • Asian. • Black or African American. • Middle Eastern or North African. • Native Hawaiian or Pacific Islander. • White. • Other Race. • Two or More Races. • Asked But No Answer. • Unknown. Ethnicity. (Refer to *General Guideline: Race and Ethnicity Stratification.*) • Hispanic or Latino. • Not Hispanic or Latino. • Asked But No Answer. • Unknown.
Risk adjustment	None.
Improvement notation	Increased score indicates improvement.
Guidance	**Data collection methodology:** ECDS. Refer to *General Guideline: Data Collection Methods* for additional information. **Date specificity:** Dates must be specific enough to determine the event occurred in the period being measured. **Which services count?** When using claims, include all paid, suspended, pending and denied claims. **Other guidance:** Measure rates are specific to clinical guideline recommendations for the age group included in the rates.
Initial population	*Measure item count:* Person. *Attribution basis:* Enrollment. • *Benefits:* Medical. • *Continuous enrollment:* The measurement period. • *Allowable gap:* No more than one gap of ≤45 days during the measurement period. No gaps on the last day of the measurement period.

	Ages: • *Initial populations 1 and 2:* 19 years of age and older at the start of the measurement period. • *Initial population 3*: 50 years of age and older at the start of the measurement period. • *Initial populations 4*: 65 years of age and older at the start of the measurement period. • *Initial population 5*: 19–59 years of age at the start of the measurement period. *Event:* None.
Denominator exclusions	**Persons with a date of death.** Death in the measurement period, identified using data sources determined by the organization. Method and data sources are subject to review during the HEDIS audit. **Persons in hospice or using hospice services.** Persons who use hospice services (Hospice Encounter Value Set; Hospice Intervention Value Set) or elect to use a hospice benefit any time during the measurement period. Organizations that use the Monthly Membership Detail Data File to identify these persons must use only the run date of the file.
Denominator	**Denominator 1 and Denominator 2: Immunization status—Influenza and Td/Tdap.** The initial populations 1 and 2 minus denominator exclusions. **Denominator 3: Immunization status—Zoster.** The initial population 3 minus denominator exclusions. **Denominator 4: Immunization status—Pneumococcal.** The initial population 4 minus denominator exclusions. **Denominator 5: Immunization status—Hepatitis B.** The initial population 5 minus denominator exclusions.
Numerator	**Numerator 1: Immunization status—Influenza.** Persons who meet either of the following criteria: • Received the influenza vaccine (Adult Influenza Immunization Value Set; Adult Influenza Vaccine Procedure Value Set; Influenza Virus LAIV Immunization Value Set; Influenza Virus LAIV Vaccine Procedure Value Set; NDC code 66019011251) on or between July 1 of the year prior to the measurement period and June 30 of the measurement period. • Had anaphylaxis due to the influenza vaccine (SNOMED CT code 471361000124100) any time before or during the measurement period. **Numerator 2: Immunization status—Td/Tdap.** Persons who meet any of the following criteria: • Received at least one Td or Tdap vaccine (Td Immunization Value Set; CPT code 90714, CVX code 115; CPT code 90715) between 9 years prior to the start of the measurement period and the last day of the measurement period.

- Had anaphylaxis due to the diphtheria, tetanus or pertussis vaccine (Anaphylaxis Due to Diphtheria, Tetanus or Pertussis Vaccine Value Set) any time before or during the measurement period.
- Had encephalitis due to the diphtheria, tetanus or pertussis vaccine (Encephalitis Due to Diphtheria, Tetanus or Pertussis Vaccine Value Set) any time before or during the measurement period.

Numerator 3: Immunization status—Zoster.
Persons who meet either of the following criteria:

- Received two doses of the herpes zoster recombinant vaccine (CVX code 187; CPT code 90750) at least 28 days apart, on October 20, 2017, through the last day of the measurement period.
- Had anaphylaxis due to the herpes zoster vaccine (Anaphylaxis Due to Herpes Zoster Vaccine Value Set) any time before or during the measurement period.

Numerator 4: Immunization status—Pneumococcal.
Persons who meet either of the following criteria:

- Received at least one dose of adult pneumococcal vaccine (Adult Pneumococcal Immunization Value Set; Adult Pneumococcal Vaccine Procedure Value Set) on or after their 19th birthday***,*** any time before or during the measurement period.
- Had anaphylaxis due to the pneumococcal vaccine (SNOMED CT code 471141000124102) any time before or during the measurement period.

Numerator 5: Immunization status—Hepatitis B.
Persons who meet any of the following criteria:

- Received at least three doses of the childhood Hepatitis B vaccine (Hepatitis B Immunization Value Set; Hepatitis B Vaccine Procedure Value Set) with different dates of service on or before their 19th birthday.
  - One of the three vaccinations can be a newborn hepatitis B vaccination (ICD-10-PCS code 3E0234Z) during the 8-day period that begins on the date of birth and ends 7 days after the date of birth.
- Received Hepatitis B vaccine series on or after their 19th birthday, before or during the measurement period, including either of the following:
  - At least two doses of the recommended two-dose adult Hepatitis B vaccine (CVX code 189; Adult Hepatitis B Vaccine Procedure (2 dose) Value Set) administered at least 28 days apart; ***or***
  - At least three doses of any other recommended adult Hepatitis B vaccine (Adult Hepatitis B Immunization (3 dose) Value Set; Adult Hepatitis B Vaccine Procedure (3 dose) Value Set) administered on different days of service.
- Had a hepatitis B surface antigen, hepatitis B surface antibody or total antibody to hepatitis B core antigen test with a finding of immunity any time before or during the measurement period, including either of the following:
  - A test (Hepatitis B Tests With Threshold of 10 Value Set) with a result greater than 10 mIU/mL.

<table>
<tr><td></td><td>
– A test (Hepatitis B Prevaccination Tests Value Set) with a finding of immunity (Positive Hepatitis B Test Result or Finding Value Set).
• History of or immunity to hepatitis B illness (Positive Hepatitis B Status Value Set*) any time before or during the measurement period.
• Had anaphylaxis due to the hepatitis B vaccine (SNOMED CT code 428321000124101) any time before or during the measurement period.
Coding Guidance
*Do not include laboratory claims (claims with POS code 81).
</td></tr>
<tr><td>Summary of changes</td><td>
• Removed the definitions of “participation” and “participation period.”
• Updated Numerator 1 to add an NDC code for identifying LAIV vaccines that are self-administered.
• Updated history of hepatitis B illness value set in Numerator 5.
• Updated the citation for clinical recommendation statement and rationale.
• Updated the race and ethnicity stratification categories and Data Elements for Reporting table to align with OMB SPD 15 2024 and US Core Version 6.1.0 Model Definition.
• Removed the SSoR data elements from the data element tables.
</td></tr>
<tr><td>HEDIS for QRS-specific guidance</td><td>
• HEDIS for QRS does not require race and ethnicity stratification reporting.
• HEDIS for QRS reports only the vaccination status for influenza, tetanus and diphtheria (Td) or tetanus, diphtheria and acellular pertussis (Tdap), zoster, pneumococcal and hepatitis B vaccines.
</td></tr>
<tr><td>Data element tables</td><td>
Organizations that submit HEDIS data to NCQA must provide the following data elements.

Table AIS-E-A-4 Data Elements for Adult Immunization Status
<table>
<tr><th>Metric</th><th>Age</th><th>Data Element</th><th>Reporting Instructions</th></tr>
<tr><td>Influenza</td><td>19-64</td><td>InitialPopulation</td><td>For each Metric and Stratification</td></tr>
<tr><td>TdTdap</td><td>65+</td><td>Exclusions</td><td>For each Metric and Stratification</td></tr>
<tr><td></td><td>Total</td><td>Denominator</td><td>For each Metric and Stratification</td></tr>
<tr><td></td><td></td><td>Numerator</td><td>For each Metric and Stratification</td></tr>
<tr><td>Zoster</td><td>50-64</td><td>Rate</td><td>(Percent)</td></tr>
<tr><td></td><td>65+</td><td></td><td></td></tr>
<tr><td></td><td>Total</td><td></td><td></td></tr>
<tr><td></td><td></td><td></td><td></td></tr>
<tr><td>Pneumococcal</td><td>65+</td><td></td><td></td></tr>
<tr><td></td><td></td><td></td><td></td></tr>
<tr><td>HepatitisB</td><td>19-30</td><td></td><td></td></tr>
<tr><td></td><td>31-59</td><td></td><td></td></tr>
<tr><td></td><td>Total</td><td></td><td></td></tr>
</table>
</td></tr>
</table>

Table AIS-E-B-4: Data Elements for Adult Immunization Status: Stratifications by Race

Metric	Race	Data Element	Reporting Instructions
Influenza	AmericanIndianOrAlaskaNative	InitialPopulation	For each Metric and Stratification
TdTdap	Asian	Exclusions	For each Metric and Stratification
Zoster	BlackOrAfricanAmerican	Denominator	For each Metric and Stratification
Pneumococcal	MiddleEasternOrNorthAfrican	Numerator	For each Metric and Stratification
HepatitisB	NativeHawaiianOrPacificIslander	Rate	(Percent)
	White		
	OtherRace		
	TwoOrMoreRaces		
	AskedButNoAnswer		
	Unknown		

Table AIS-E-C-4: Data Elements for Adult Immunization Status: Stratifications by Ethnicity

Metric	Ethnicity	Data Element	Reporting Instructions
Influenza	HispanicOrLatino	InitialPopulation	For each Metric and Stratification
TdTdap	NotHispanicOrLatino	Exclusions	For each Metric and Stratification
Zoster	AskedButNoAnswer	Denominator	For each Metric and Stratification
Pneumococcal	Unknown	Numerator	For each Metric and Stratification
HepatitisB		Rate	(Percent)

Blood Pressure Control for Patients With Hypertension (BPC-E)

Measure title	Blood Pressure Control for Patients With Hypertension	**Measure ID**	BPC-E
Description	The percentage of persons 18–85 years of age who had a diagnosis of hypertension (HTN) and whose most recent blood pressure (BP) was <140/90 mm Hg during the measurement period.		
Measurement period	January 1–December 31.		
Copyright and disclaimer notice	Refer to the complete copyright and disclaimer information at the front of the NCQA Measure Specifications. NCQA website: www.ncqa.org. Submit policy clarification support questions via My NCQA (https://my.ncqa.org).		
Clinical recommendation statement/ rationale	The American Academy of Family Physicians (AAFP) strongly recommends clinicians treat adults who have hypertension to a standard blood pressure target (<140/90 mm Hg) to reduce the risk of all-cause and cardiovascular mortality. The Joint National Committee recommends that pharmacologic treatment be initiated in the general population <60 years, to lower systolic BP ≥140 mm Hg (and treat to a goal of systolic BP <140 mm Hg) and to lower diastolic BP ≥90 mm Hg (and treat to a goal of diastolic BP <90 mm Hg). The American College of Cardiology (ACC) and American Heart Association (AHA) recommend a target BP of less than 130/80 mm Hg for adults with confirmed hypertension and known cardiovascular disease (CVD) or 10-year atherosclerotic CVD event risk of 10% or higher. In addition, they have determined that a reasonable target BP for adults with confirmed hypertension, without additional markers of increased CVD risk, is less than 130/80 mm Hg.		
Citations	Coles, S., L. Fisher, K. Lin, C. Lyon, A. Vosooney, and M. Bird. November 14, 2022. *Blood Pressure Targets in Adults With Hypertension: A Clinical Practice Guideline From the AAFP.* James, P.A., S. Oparil, B.L. Carter, W.C. Cushman, C. Dennison-Himmelfarb, J. Handler, D.T. Lackland, et al. February 5, 2014. "2014 Evidence-Based Guideline for the Management of High Blood Pressure in Adults: Report From the Panel Members Appointed to the Eighth Joint National Committee (JNC 8)." *JAMA* 311, no. 5: 507–20. https://doi.org/10.1001/jama.2013.284427 Whelton, P.K., R.M. Carey, W.S. Aronow, D.E. Casey, K.J. Collins, C. Dennison Himmelfarb, S.M. DePalma, et al. June 2018. "2017 ACC/AHA/ AAPA/ABC/ ACPM/AGS/ APhA/ASH/ASPC/NMA/PCNA Guideline for the Prevention, Detection, Evaluation, and Management of High Blood Pressure in Adults: A Report of the American College of Cardiology/American Heart Association Task Force on Clinical Practice Guidelines." *Hypertension* 71, no. 6: e13–115. https://doi.org/10.1161/HYP.0000000000000065		

Characteristics	
Scoring	Proportion.
Type	Outcome.
Product line	Exchange.
Stratifications	Race. (Refer to *General Guideline: Race and Ethnicity Stratification.*) • American Indian or Alaska Native. • Asian. • Black or African American. • Middle Eastern or North African. • Native Hawaiian or Pacific Islander. • White. • Other Race. • Two or More Races. • Asked But No Answer. • Unknown. Ethnicity. (Refer to *General Guideline: Race and Ethnicity Stratification.*) • Hispanic or Latino. • Not Hispanic or Latino. • Asked But No Answer. • Unknown.
Risk adjustment	None.
Improvement notation	Increased score indicates improvement.
Guidance	**Data collection methodology:** ECDS. Refer to *General Guideline: Data Collection Methods* for additional information. **Date specificity:** Dates must be specific enough to determine the event occurred in the period being measured. **Which services count?** When using claims, include all paid, suspended, pending and denied claims.
Initial population	*Measure item count:* Person. *Attribution basis:* Enrollment. • *Benefits:* Medical. • *Continuous enrollment:* The measurement period. • *Allowable gap:* No more than one gap of ≤45 days during the measurement period. No gaps on the last day of the measurement period.

	Ages: 18–85 years of age as of the last day of the measurement period. *Event:* **Persons with a diagnosis of hypertension.** Persons who meet either of the following criteria: • At least two outpatient visits, telephone visits, e-visits or virtual check-ins (Outpatient and Telehealth Without UBREV Value Set) on different dates of service with a diagnosis of hypertension (Essential Hypertension Value Set) on or between January 1 of the year prior to the measurement period and June 30 of the measurement period. • At least one outpatient visit, telephone visit, e-visit or virtual check-in (Outpatient and Telehealth Without UBREV Value Set) with a diagnosis of hypertension (Essential Hypertension Value Set) and at least one dispensed antihypertensive medication (Antihypertensive Medications List) on or between January 1 of the year prior to the measurement period and June 30 of the measurement period.
Denominator exclusions	**Persons with a date of death.** Death in the measurement period, identified using data sources determined by the organization. Method and data sources are subject to review during the HEDIS audit. **Persons in hospice or using hospice services.** Persons who use hospice services (Hospice Encounter Value Set; Hospice Intervention Value Set) or elect to use a hospice benefit any time during the measurement period. Organizations that use the Monthly Membership Detail Data File to identify these persons must use only the run date of the file. **Persons receiving palliative care.** Persons receiving palliative care (Palliative Care Assessment Value Set; Palliative Care Encounter Value Set; Palliative Care Intervention Value Set) or who had an encounter for palliative care (ICD-10-CM code Z51.5*) any time during the measurement period. **Persons 66–80 years of age by the last day of the measurement period, with both frailty and advanced illness.** 1. **Frailty.** At least two indications of frailty (Frailty Device Value Set; Frailty Diagnosis Value Set*; Frailty Encounter Value Set; Frailty Symptom Value Set*) with different dates of service during the measurement period. 2. **Advanced illness.** Either of the following during the measurement period or the year prior to the measurement period: – Advanced illness (Advanced Illness Value Set*) on at least two different dates of service. – Dispensed dementia medication (Dementia Medications List). **Persons 81 years of age or older by the last day of the measurement period, with frailty.** Persons 81 years of age and older as of the last day of the measurement period with at least two indications of frailty (Frailty Device Value Set; Frailty Diagnosis Value Set*; Frailty Encounter Value Set; Frailty Symptom Value Set*) with different dates of service during the measurement period.

	End-stage renal disease (ESRD). Persons with any of the following during their history on or prior to the last day of the measurement period: • Diagnosis that indicates end-stage renal disease (ESRD) (ESRD Diagnosis Value Set*; History of Nephrectomy or Kidney Transplant Value Set*). • Procedure that indicates ESRD: dialysis (Dialysis Procedure Value Set), nephrectomy (Total Nephrectomy Value Set; Partial Nephrectomy Value Set) or kidney transplant (Kidney Transplant Value Set). **Diagnosis of pregnancy.** Persons with a diagnosis of pregnancy (Pregnancy Value Set*) any time during the measurement period. **Nonacute inpatient admission.** Persons with a nonacute inpatient admission during the measurement period. To identify nonacute inpatient admissions: 1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set). 2. Confirm the stay was for nonacute care based on the presence of a nonacute code (Nonacute Inpatient Stay Value Set) on the claim. 3. Identify the admission date for the stay. **Coding Guidance** *Do not include laboratory claims (claims with POS code 81).
Denominator	The initial population minus denominator exclusions.
Numerator	**Both a systolic and diastolic reading <140/90 mm Hg.** Identify the most recent systolic and diastolic BP readings (Systolic Blood Pressure Value Set; Diastolic Blood Pressure Value Set) taken during the measurement period *on or after* the second diagnosis of hypertension event (identified using the initial population criteria). Do not include CPT Category II codes (Systolic and Diastolic Result Value Set) with a modifier (CPT CAT II Modifier Value Set). Do not include BPs taken in an acute inpatient setting (Acute Inpatient Value Set; Acute Inpatient POS Value Set) or ED visit (ED Value Set; POS code 23). If multiple readings were recorded for a single date, use the lowest systolic and lowest diastolic BP on that date as the representative BP. The systolic and diastolic results do not need to be from the same reading. • *Compliant*: BP is <140/90 mm Hg. • *Non-compliant*: BP is ≥140/90 mm Hg; no BP reading during the measurement period; or if the reading is incomplete (e.g., the systolic or diastolic level is missing). If the most recent blood pressure was identified based on a CPT Category II code (Systolic and Diastolic Result Value Set) use the following to determine compliance: • *Systolic compliant*: Systolic Less Than 140 Value Set. • *Systolic not compliant*: CPT-CAT-II code 3077F.

<table>
<tr><td></td><td>

- *Diastolic compliant*: Diastolic Less Than 90 Value Set.
- *Diastolic not compliant*: CPT-CAT-II code 3080F.

</td></tr>
<tr><td>Summary of changes</td><td>

- Updated the race and ethnicity stratification categories and Data Elements for Reporting table to align with OMB SPD 15 2024 and US Core Version 6.1.0 Model Definition.
- Removed the definitions of participation and participation period.
- Removed the SSoR data elements from the data element tables.

</td></tr>
<tr><td>HEDIS for QRS-specific guidance</td><td>

- HEDIS for QRS does not require race and ethnicity stratification reporting.

</td></tr>
<tr><td>Data element tables</td><td>

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

Table BPC-E-A-4: Data Elements for Blood Pressure Control for Patients With Hypertension

Metric	Data Element	Reporting Instructions
BPUnder140Over90	InitialPopulation	Report once
	Exclusions	Report once
	Denominator	Report once
	Numerator	Report once
	Rate	(Percent)

Table BPC-E-B-4: Data Elements for Blood Pressure Control for Patients With Hypertension: Stratifications by Race

Metric	Race	Data Element	Reporting Instructions
BPUnder140Over90	AmericanIndianOrAlaskaNative	InitialPopulation	For each Stratification
	Asian	Exclusions	For each Stratification
	BlackOrAfricanAmerican	Denominator	For each Stratification
	MiddleEasternOrNorthAfrican	Numerator	For each Stratification
	NativeHawaiianOrPacificIslander	Rate	(Percent)
	White		
	OtherRace		
	TwoOrMoreRaces		
	AskedButNoAnswer		
	Unknown		

</td></tr>
</table>

Table BPC-E-C-4: Data Elements for Blood Pressure Control for Patients With Hypertension: Stratifications by Ethnicity

Metric	Ethnicity	Data Element	Reporting Instructions
BPUnder140Over90	HispanicOrLatino	InitialPopulation	For each Stratification
	NotHispanicOrLatino	Exclusions	For each Stratification
	AskedButNoAnswer	Denominator	For each Stratification
	Unknown	Numerator	For each Stratification
		Rate	(Percent)

Breast Cancer Screening (BCS-E)

Measure title	Breast Cancer Screening	**Measure ID**	BCS-E
Description	The percentage of persons 40–74 years of age who were recommended for routine breast cancer screening and had a mammogram to screen for breast cancer.		
Measurement period	January 1–December 31.		
Copyright and disclaimer notice	Refer to the complete copyright and disclaimer information at the front of the NCQA Measure Specifications. NCQA website: www.ncqa.org. Submit policy clarification support questions via My NCQA (https://my.ncqa.org).		
Clinical recommendation statement/ rationale	The U.S. Preventive Services Task Force (USPSTF) recommends biennial screening mammography for women aged 40–74 years. (B recommendation) The Fenway Institute recommends that for patients assigned female at birth who have not undergone chest reconstruction (including those who have had breast reduction), breast/chest screening recommendations are the same as for cisgender women of a similar age and medical history. The University of California San Francisco Center of Excellence for Transgender Health recommends that transgender men who have not undergone bilateral mastectomy, or who have only undergone breast reduction, undergo screening according to current guidelines for non-transgender women. The World Professional Association for Transgender Health recommends health care professionals follow local breast cancer screening guidelines developed for cisgender women in their care of transgender and gender diverse people with breasts from natal puberty who have not had gender-affirming chest surgery.		
Citations	U.S. Preventive Services Task Force. Nicholson, W.K., M. Silverstein, J.B. Wong, M.J. Barry, D. Chelmow, T. Rucker Coker, et al. June 11, 2024. "Screening for Breast Cancer: U.S. Preventive Services Task Force Recommendation Statement." *JAMA* 331, no. 22: 1918. https://doi.org/10.1001/jama.2024.5534 Fenway Health. 2021. *Medical Care of Trans and Gender Diverse Adults*. https://fenwayhealth.org/wp-content/uploads/Medical-Care-of-Trans-and-Gender-Diverse-Adults-Spring-2021-1.pdf University of California San Francisco Center of Excellence for Transgender Health. 2016. *Guidelines for the Primary and Gender-Affirming Care of Transgender and Gender Nonbinary People*. https://transcare.ucsf.edu/sites/transcare.ucsf.edu/files/Transgender-PGACG-6-17-16.pdf		

	World Professional Association for Transgender Health. 2022. *Standards of Care for the Health of Transgender and Gender Diverse People, Version 8.* https://www.tandfonline.com/doi/pdf/10.1080/26895269.2022.2100644
Characteristics	
Scoring	Proportion.
Type	Process.
Product line	Exchange.
Stratifications	Age as of the last day of the measurement period. • 42–51 years. • 52–74 years. Race. (Refer to *General Guideline: Race and Ethnicity Stratification*.) • American Indian or Alaska Native. • Asian. • Black or African American. • Middle Eastern or North African. • Native Hawaiian or Pacific Islander. • White. • Other Race. • Two or More Races. • Asked But No Answer. • Unknown. Ethnicity. (Refer to *General Guideline: Race and Ethnicity Stratification*.) • Hispanic or Latino. • Not Hispanic or Latino. • Asked But No Answer. • Unknown.
Risk adjustment	None.
Improvement notation	Increased score indicates improvement.
Guidance	**Data collection methodology:** ECDS. Refer to *General Guideline: Data Collection Methods* for additional information. **Date specificity:** Dates must be specific enough to determine the event occurred in the period being measured. **Which services count?** When using claims, include all paid, suspended, pending and denied claims.

Initial population	*Measure item count:* Person. *Attribution basis:* Enrollment. • *Benefits:* Medical. • *Continuous enrollment:* October 1 two years prior to the measurement period through the last day of the measurement period. • *Allowable gap:* – *Measurement period*: No more than one gap of ≤45 days. No gaps on the last day of the measurement period. – *Year prior to the measurement period:* No more than one gap of ≤45 days. – *October 1 two years prior to the measurement period through December 31 two years prior to the measurement period*: None. *Ages:* 42–74 years of age as of the last day of the measurement period. *Gender/sex criteria (persons recommended for routine breast cancer screening):* • Administrative Gender of Female (AdministrativeGender code female) any time in the person's history. • Sex assigned at birth (LOINC code 76689-9) of Female (Female Value Set) any time in the person's history. • Sex Parameter for Clinical Use of Female (SexParameterForClinicalUse code female-typical) during the measurement period. *Event:* None.
Denominator exclusions	**Persons with a date of death.** Death in the measurement period, identified using data sources determined by the organization. Method and data sources are subject to review during the HEDIS audit. **Persons in hospice or using hospice services.** Persons who use hospice services (Hospice Encounter Value Set; Hospice Intervention Value Set) or elect to use a hospice benefit any time during the measurement period. Organizations that use the Monthly Membership Detail Data File to identify these persons must use only the run date of the file. **Persons receiving palliative care.** Persons receiving palliative care (Palliative Care Assessment Value Set; Palliative Care Encounter Value Set; Palliative Care Intervention Value Set) or who had an encounter for palliative care (ICD-10-CM code Z51.5*) any time during the measurement period. **Persons 66 years of age or older by the last day of the measurement period, with both frailty and advanced illness.** 1. **Frailty.** At least two indications of frailty (Frailty Device Value Set; Frailty Diagnosis Value Set*; Frailty Encounter Value Set; Frailty Symptom Value Set*) with different dates of service during the measurement period. 2. **Advanced illness.** Either of the following during the measurement period or the year prior to the measurement period:

	– Advanced illness (Advanced Illness Value Set*) on at least two different dates of service. – Dispensed dementia medication (Dementia Medications List). **Persons who had a bilateral mastectomy or both right and left unilateral mastectomies any time during their history through the last day of the measurement period.** Any of the following meet the criteria for bilateral mastectomy. • Bilateral mastectomy (Bilateral Mastectomy Value Set). • Unilateral mastectomy (Unilateral Mastectomy Value Set) with a bilateral modifier (CPT Modifier code 50) (same procedure). • History of bilateral mastectomy (History of Bilateral Mastectomy Value Set). • Any combination that indicates a mastectomy of **both** the **left** and **right** side on the same date of service or different dates of service: – **Left mastectomy:** ▪ Unilateral mastectomy (Unilateral Mastectomy Value Set) with a left-side modifier (CPT Modifier code LT) (same procedure). ▪ Unilateral mastectomy of the left breast found in clinical data (Clinical Unilateral Mastectomy Value Set *with* SNOMED CT code 361716006). ***Note:*** *The "clinical" mastectomy value sets identify mastectomy; the word "clinical" refers to the data source, not to the type of mastectomy.* ▪ Absence of the left breast (Absence of Left Breast Value Set*). ▪ Left unilateral mastectomy (Unilateral Mastectomy Left Value Set). – **Right mastectomy:** ▪ Unilateral mastectomy (Unilateral Mastectomy Value Set) ***with*** a right-side modifier (CPT Modifier code RT) (same procedure). ▪ Unilateral mastectomy of the right breast found in clinical data (Clinical Unilateral Mastectomy Value Set *with* SNOMED CT code 361715005). ▪ Absence of the right breast (Absence of Right Breast Value Set*). ▪ Right unilateral mastectomy (Unilateral Mastectomy Right Value Set). **Gender-affirming chest surgery** Persons who had gender-affirming chest surgery (CPT code 19318) with a diagnosis of gender dysphoria (Gender Dysphoria Value Set) any time during their history through the last day of the measurement period. **Coding Guidance** *Do not include laboratory claims (claims with POS code 81).
Denominator	The initial population minus denominator exclusions.
Numerator	**At least one mammogram.** One or more mammograms (Mammography Value Set) any time on or between October 1 two years prior to the measurement period and the last day of the measurement period.

Summary of changes

- Updated the race and ethnicity stratification categories and Data Elements for Reporting table to align with OMB SPD 15 2024 and US Core Version 6.1.0 Model Definition.
- Removed the definitions of "participation" and "participation period."
- Removed the SSoR data elements from the data element tables.
- The combination of unilateral mastectomy with a bilateral modifier was removed.

HEDIS for QRS-specific guidance

- HEDIS for QRS does not require race and ethnicity stratification reporting.

Data element tables

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

Table BCS-E-A-4: Data Elements for Breast Cancer Screening

Metric	Age	Data Element	Reporting Instructions
BreastCancerScreening	42-51	InitialPopulation	For each Stratification
	52-74	Exclusions	For each Stratification
	Total	Denominator	For each Stratification
		Numerator	For each Stratification
		Rate	(Percent)

Table BCS-E-B-4: Data Elements for Breast Cancer Screening: Stratifications by Race

Metric	Race	Data Element	Reporting Instructions
BreastCancerScreening	AmericanIndianOrAlaskaNative	InitialPopulation	For each Stratification
	Asian	Exclusions	For each Stratification
	BlackOrAfricanAmerican	Denominator	For each Stratification
	MiddleEasternOrNorthAfrican	Numerator	For each Stratification
	NativeHawaiianOrPacificIslander	Rate	(Percent)
	White		
	OtherRace		
	TwoOrMoreRaces		
	AskedButNoAnswer		
	Unknown		

Table BCS-E-C-4: Data Elements for Breast Cancer Screening: Stratifications by Ethnicity

Metric	Ethnicity	Data Element	Reporting Instructions
BreastCancerScreening	HispanicOrLatino	InitialPopulation	For each Stratification
	NotHispanicOrLatino	Exclusions	For each Stratification
	AskedButNoAnswer	Denominator	For each Stratification
	Unknown	Numerator	For each Stratification
		Rate	(Percent)

Cervical Cancer Screening (CCS-E)

Measure title	Cervical Cancer Screening	**Measure ID**	CCS-E
Description	The percentage of persons 21–64 years of age who were recommended for routine cervical cancer screening and were screened for cervical cancer using any of the following criteria: • Persons 21–64 years of age who were recommended for routine cervical cancer screening and had cervical cytology performed within the last 3 years. • Persons 30–64 years of age who were recommended for routine cervical cancer screening and had cervical high-risk human papillomavirus (hrHPV) testing performed within the last 5 years. • Persons 30–64 years of age who were recommended for routine cervical cancer screening and had cervical cytology/high-risk human papillomavirus (hrHPV) cotesting within the last 5 years.		
Measurement period	January 1–December 31.		
Copyright and disclaimer notice	Refer to the complete copyright and disclaimer information at the front of the NCQA Measure Specifications. NCQA website: www.ncqa.org. Submit policy clarification support questions via My NCQA (https://my.ncqa.org).		
Clinical recommendation statement/ rationale	The U.S. Preventive Services Task Force (USPSTF) recommends screening for cervical cancer every 3 years with cervical cytology alone in women aged 21–29 years. This recommendation statement applies to all asymptomatic individuals with a cervix. (A recommendation) The USPSTF recommends screening every 3 years with cervical cytology alone, every 5 years with hrHPV testing alone or every 5 years with hrHPV testing in combination with cytology (cotesting) in women aged 30–65 years. This recommendation statement applies to all asymptomatic individuals with a cervix. (A recommendation) The USPSTF recommends against screening for cervical cancer in women younger than 21 years. This recommendation statement applies to all asymptomatic individuals with a cervix. (D recommendation) The USPSTF recommends against screening for cervical cancer in women older than 65 years who have had adequate prior screening and are not otherwise at high risk for cervical cancer. This recommendation statement applies to all asymptomatic individuals with a cervix. (D recommendation). The USPSTF recommends against screening for cervical cancer in women who have had a hysterectomy with removal of the cervix, and do not have a history of a high-grade precancerous lesion or cervical cancer. (D recommendation)		

	The American Cancer Society recommends that individuals with a cervix initiate cervical cancer screening at age 25 years, and undergo primary HPV testing every 5 years through age 65 years (preferred). If primary HPV testing is not available, individuals aged 25–65 years should be screened with cotesting (HPV testing in combination with cytology) every 5 years, or cytology alone every 3 years (acceptable). The recommendations apply to all asymptomatic individuals with a cervix, regardless of their sexual history or HPV vaccination status, including those who have undergone supracervical hysterectomy and transgender men who retain their cervix. (Strong Recommendation) The Fenway Institute recommends that transgender and gender diverse patients who have a cervix have regular cervical pap tests, as per the published guidelines for cisgender women. The University of California San Francisco Center of Excellence for Transgender Health recommends that cervical cancer screening for transgender men, including intervals of screening and age to begin and end screening, follows recommendations for non-transgender women as endorsed by the American Cancer Society, the American Society of Colposcopy and Cervical Pathology, the American Society of Clinical Pathologists, the U.S. Preventive Services Task Force and the World Health Organization. The World Professional Association for Transgender Health recommends that health care professionals offer cervical cancer screening to transgender and gender diverse people who currently have or previously had a cervix, following local guidelines for cisgender women.
Citations	American Cancer Society. 2020. *Cervical Cancer Screening for Individuals at Average Risk: 2020 Guideline Update From the American Cancer Society.* https://acsjournals.onlinelibrary.wiley.com/doi/full/10.3322/caac.21628 Fenway Health. 2021. *Medical Care of Trans and Gender Diverse Adults.* https://fenwayhealth.org/wp-content/uploads/Medical-Care-of-Trans-and-Gender-Diverse-Adults-Spring-2021-1.pdf University of California San Francisco Center of Excellence for Transgender Health. 2016. *Guidelines for the Primary and Gender-Affirming Care of Transgender and Gender Nonbinary People.* https://transcare.ucsf.edu/sites/transcare.ucsf.edu/files/Transgender-PGACG-6-17-16.pdf U.S. Preventive Services Task Force. 2018. “Screening for Cervical Cancer: U.S. Preventive Services Task Force Recommendation Statement.” *JAMA* 320(7): 674–86. World Professional Association for Transgender Health. 2022. *Standards of Care for the Health of Transgender and Gender Diverse People, Version 8.* https://www.tandfonline.com/doi/pdf/10.1080/26895269.2022.2100644
Characteristics	
Scoring	Proportion.
Type	Process.

Product line	Exchange.
Stratifications	Race. (Refer to *General Guideline: Race and Ethnicity Stratification*.) • American Indian or Alaska Native. • Asian. • Black or African American. • Middle Eastern or North African. • Native Hawaiian or Pacific Islander. • White. • Other Race. • Two or More Races. • Asked But No Answer. • Unknown. Ethnicity. (Refer to *General Guideline: Race and Ethnicity Stratification*.) • Hispanic or Latino. • Not Hispanic or Latino. • Asked But No Answer. • Unknown.
Risk adjustment	None.
Improvement notation	Increased score indicates improvement.
Guidance	**Data collection methodology:** ECDS. Refer to *General Guideline: Data Collection Methods* for additional information. **Date specificity:** Dates must be specific enough to determine the event occurred in the period being measured. **What services count?** When using claims, include all paid, suspended, pending and denied claims.
Initial population	*Measure item count:* Person. *Attribution basis:* Enrollment. • *Benefits:* Medical. • *Continuous enrollment:* The measurement period. • *Allowable gap:* No more than one gap of ≤45 days each year of continuous enrollment. No gaps on the last day of the measurement period. *Ages:* 24–64 years of age as of the last day of the measurement period. *Gender/sex criteria (persons recommended for routine cervical cancer screening):* • Administrative Gender of Female (AdministrativeGender code female) any time in the person's history.

	• Sex Assigned at Birth (LOINC code 76689-9) of Female (Female Value Set) any time in the person's history. • Sex Parameter for Clinical Use of Female (SexParameterForClinicalUse code female-typical) during the measurement period. *Event:* None.
Denominator exclusions	**Persons with a date of death.** Death in the measurement period, identified using data sources determined by the organization. Method and data sources are subject to review during the HEDIS audit. **Persons in hospice or using hospice services.** Persons who use hospice services (Hospice Encounter Value Set; Hospice Intervention Value Set) or elect to use a hospice benefit any time during the measurement period. Organizations that use the Monthly Membership Detail Data File to identify these persons must use only the run date of the file. **Persons receiving palliative care.** Persons receiving palliative care (Palliative Care Assessment Value Set; Palliative Care Encounter Value Set; Palliative Care Intervention Value Set) or who had an encounter for palliative care (ICD-10-CM code Z51.5*) any time during the measurement period. **Persons with a hysterectomy with no residual cervix, cervical agenesis, or acquired absence of cervix.** Hysterectomy with no residual cervix (Hysterectomy With No Residual Cervix Value Set) or cervical agenesis or acquired absence of cervix (Absence of Cervix Diagnosis Value Set*) any time during the person's history through the last day of the measurement period. **Persons with sex assigned at birth of male.** Sex Assigned at Birth (LOINC code 76689-9) of Male (Male Value Set) any time during the person's history through the last day of the measurement period. **Coding Guidance** *Do not include laboratory claims (claims with POS code 81).
Denominator	The initial population minus denominator exclusions.
Numerator	**Persons recommended for routine cervical cancer screening who were screened for cervical cancer.** Either of the following meets criteria: • Persons 24–64 years of age by the last day of the measurement period who were recommended for routine cervical cancer screening and had cervical cytology (Cervical Cytology Lab Test Value Set; Cervical Cytology Result or Finding Value Set) during the measurement period or the 2 years prior to the measurement period. • Persons 30–64 years of age by the last day of the measurement period who were recommended for routine cervical cancer screening and had cervical high-risk human papillomavirus (hrHPV) testing (High Risk HPV Lab Test Value Set; SNOMED CT code 718591004) during the

<table>
<tr><td></td><td>measurement period or the 4 years prior to the measurement period, and who were 30 years of age or older on the test date.

Note: Evidence of hrHPV testing within the last 5 years also captures patients who had cotesting; therefore, additional methods to identify cotesting are not necessary.</td></tr>
<tr><td>Summary of changes</td><td>• Updated the race and ethnicity stratification categories and Data Elements for Reporting table to align with OMB SPD 15 2024 and US Core Version 6.1.0 Model Definition.
• Removed the definitions of “participation” and “participation period.”
• Removed the SSoR data elements from the data element tables.</td></tr>
<tr><td>HEDIS for QRS-specific guidance</td><td>• ECDS reporting is required for this measure.
• HEDIS for QRS does not require race and ethnicity stratification reporting.</td></tr>
<tr><td>Data element tables</td><td>Organizations that submit HEDIS data to NCQA must provide the following data elements.

Table CCS-E-A-4: Metadata Elements for Cervical Cancer Screening
<table>
<tr><th>Metric</th><th>Data Element</th><th>Reporting Instructions</th></tr>
<tr><td>CervicalCancerScreening</td><td>InitialPopulation</td><td>Report once</td></tr>
<tr><td></td><td>Exclusions</td><td>Report once</td></tr>
<tr><td></td><td>Denominator</td><td>Report once</td></tr>
<tr><td></td><td>Numerator</td><td>Report once</td></tr>
<tr><td></td><td>Rate</td><td>(Percent)</td></tr>
</table>
Table CCS-E-B-4: Data Elements for Cervical Cancer Screening: Stratifications by Race
<table>
<tr><th>Metric</th><th>Race</th><th>Data Element</th><th>Reporting Instructions</th></tr>
<tr><td>CervicalCancerScreening</td><td>AmericanIndianOrAlaskaNative</td><td>InitialPopulation</td><td>For each Stratification</td></tr>
<tr><td></td><td>Asian</td><td>Exclusions</td><td>For each Stratification</td></tr>
<tr><td></td><td>BlackOrAfricanAmerican</td><td>Denominator</td><td>For each Stratification</td></tr>
<tr><td></td><td>MiddleEasternOrNorthAfrican</td><td>Numerator</td><td>For each Stratification</td></tr>
<tr><td></td><td>NativeHawaiianOrPacificIslander</td><td>Rate</td><td>(Percent)</td></tr>
<tr><td></td><td>White</td><td></td><td></td></tr>
<tr><td></td><td>OtherRace</td><td></td><td></td></tr>
<tr><td></td><td>TwoOrMoreRaces</td><td></td><td></td></tr>
<tr><td></td><td>AskedButNoAnswer</td><td></td><td></td></tr>
<tr><td></td><td>Unknown</td><td></td><td></td></tr>
</table></td></tr>
</table>

Table CCS-E-C-4: Data Elements for Cervical Cancer Screening: Stratifications by Ethnicity

Metric	Ethnicity	Data Element	Reporting Instructions
CervicalCancerScreening	HispanicOrLatino	InitialPopulation	For each Stratification
	NotHispanicOrLatino	Exclusions	For each Stratification
	AskedButNoAnswer	Denominator	For each Stratification
	Unknown	Numerator	For each Stratification
		Rate	(Percent)

Childhood Immunization Status (CIS-E)

Measure title	Childhood Immunization Status	**Measure ID**	CIS-E
Description	The percentage of persons 2 years of age who had four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV); one measles, mumps and rubella (MMR); three haemophilus influenza type B (HiB); three hepatitis B (HepB), one chicken pox (VZV); four pneumococcal conjugate (PCV); one hepatitis A (HepA); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday. The measure calculates a rate for each vaccine and one combination rate.		
Measurement period	January 1–December 31.		
Copyright and disclaimer notice	Refer to the complete copyright and disclaimer information at the front of the NCQA Measure Specifications. NCQA website: www.ncqa.org. Submit policy clarification support questions via My NCQA (https://my.ncqa.org).		
Clinical recommendation statement/ rationale	This measure looks for childhood vaccinations that should be completed by age 2, in accordance with the Centers for Disease Control and Prevention Advisory Committee on Immunization Practices (ACIP) recommended child and adolescent immunization schedule.		
Citations	Issa, A.N., A.P. Wodi, C.A. Moser, S. Cineas, S. 2025. “Advisory Committee on Immunization Practices Recommended Immunization Schedule for Children and Adolescents Aged 18 Years or Younger—United States, 2025.” *MMWR Morb Mortal Wkly Rep* 74:26-29. doi: http://dx.doi.org/10.15585/mmwr.mm7402a2.		
Characteristics			
Scoring	Proportion.		
Type	Process.		
Product line	Exchange.		
Stratifications	Combination 10: Race. (Refer to *General Guideline: Race and Ethnicity Stratification*.) • American Indian or Alaska Native. • Asian. • Black or African American. • Middle Eastern or North African. • Native Hawaiian or Pacific Islander.		

<table>
<tr><td></td><td>

White.
Other Race.
Two or More Races.
Asked But No Answer.
Unknown.

Combination 10: Ethnicity. (Refer to General Guideline: Race and Ethnicity Stratification.)

Hispanic or Latino.
Not Hispanic or Latino.
Asked But No Answer.
Unknown.

</td></tr>
<tr><td>Risk adjustment</td><td>None.</td></tr>
<tr><td>Improvement notation</td><td>Increased score indicates improvement.</td></tr>
<tr><td>Guidance</td><td>
Data collection methodology: ECDS. Refer to General Guideline: Data Collection Methods for additional information.

Date specificity: Dates must be specific enough to determine the event occurred in the period being measured.

What services count? Use all paid, suspended, pending and denied claims.

Other guidance: Report rates for each vaccine and one combination rate.

Combination rate: Calculate the following rates for Combination 10.
<table>
<tr><th>Combination</th><th>DTaP</th><th>IPV</th><th>MMR</th><th>HiB</th><th>HepB</th><th>VZV</th><th>PCV</th><th>HepA</th><th>RV</th><th>Influenza</th></tr>
<tr><td>Combination 10</td><td>✓</td><td>✓</td><td>✓</td><td>✓</td><td>✓</td><td>✓</td><td>✓</td><td>✓</td><td>✓</td><td>✓</td></tr>
</table>
</td></tr>
<tr><td>Initial population</td><td>
Measure item count: Person.

Attribution basis: Enrollment.

Benefits: Medical.
Continuous enrollment: 365 days prior to the person’s second birthday and the second birthday.
Allowable gap: No more than one gap of ≤45 days during the continuous enrollment period. No gap on the second birthday.

Ages: Persons who turn 2 years of age during the measurement period.

Event: None.
</td></tr>
<tr><td>Denominator exclusions</td><td>
Persons with a date of death.
Death in the measurement period, identified using data sources determined by the organization. Method and data sources are subject to review during the HEDIS audit.
</td></tr>
</table>

	Persons in hospice or using hospice services. Persons who use hospice services (Hospice Encounter Value Set; Hospice Intervention Value Set) or elect to use a hospice benefit any time during the measurement period. Organizations that use the Monthly Membership Detail Data File to identify these persons must use only the run date of the file. **Contraindication to a childhood vaccine.** Persons who had a contraindication to a childhood vaccine (Contraindications to Childhood Vaccines Value Set*; Organ and Bone Marrow Transplants Value Set) on or before their second birthday. **Coding Guidance** *Do not include laboratory claims (claims with POS code 81).
Denominator	The initial population minus denominator exclusions.
Numerator	**Numerator 1: Immunization status—DTaP.** Persons who meet any of the following criteria on or before the second birthday: • At least four DTaP vaccinations (DTaP Immunization Value Set; DTaP Vaccine Procedure Value Set), with different dates of service. Do not count a vaccination administered prior to 42 days after birth. • Anaphylaxis due to the diphtheria, tetanus or pertussis vaccine (Anaphylaxis Due to Diphtheria, Tetanus or Pertussis Vaccine Value Set). • Encephalitis due to the diphtheria, tetanus or pertussis vaccine (Encephalitis Due to Diphtheria, Tetanus or Pertussis Vaccine Value Set). **Numerator 2: Immunization status—IPV.** Persons who meet either of the following criteria on or before the second birthday: • At least three IPV vaccinations (Inactivated Polio Vaccine (IPV) Immunization Value Set; Inactivated Polio Vaccine (IPV) Procedure Value Set) with different dates of service. Do not count a vaccination administered prior to 42 days after birth. • Anaphylaxis due to the IPV vaccine (SNOMED CT code 471321000124106). **Numerator 3: Immunization status—MMR.** Persons who meet any of the following criteria: • At least one MMR vaccination (Measles, Mumps and Rubella (MMR) Immunization Value Set; Measles, Mumps and Rubella (MMR) Vaccine Procedure Value Set) on or between the first and second birthdays. • All of the following any time on or before the second birthday (on the same or different date of service). – History of measles illness (Measles and History of Measles Value Set*). – History of mumps illness (Mumps and History of Mumps Value Set*). – History of rubella illness (Rubella and History of Rubella Value Set*).

- Anaphylaxis due to the MMR vaccine (SNOMED CT code 471331000124109) on or before the second birthday.

Numerator 4: Immunization status—HiB.
Persons who meet either of the following criteria on or before the second birthday:

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

Numerator 5: Immunization status—Hepatitis B.
Persons who meet any of the following criteria on or before the second birthday:

- At least three hepatitis B vaccinations (Hepatitis B Immunization Value Set; Hepatitis B Vaccine Procedure Value Set), with different dates of service.
  - One of the three vaccinations may be a newborn hepatitis B vaccination (ICD-10-PCS code 3E0234Z) during the 8-day period that begins on the date of birth and ends 7 days after the date of birth.
- History of hepatitis B illness (Hepatitis B and History of Hepatitis B Value Set*).
- Anaphylaxis due to the hepatitis B vaccine (SNOMED CT code 428321000124101).

Numerator 6: Immunization status—VZV.
Persons who meet any of the following criteria:

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

Numerator 7: Immunization status—Pneumococcal conjugate.
Persons who meet either of the following criteria on or before the second birthday:

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

Numerator 8: Immunization status—Hepatitis A.
Persons who meet any of the following criteria:

- At least one hepatitis A vaccination (Hepatitis A Immunization Value Set; CPT code 90633), with a date of service on or between the first and second birthdays.
- History of hepatitis A illness (Hepatitis A and History of Hepatitis A Value Set*) on or before the second birthday.
- Anaphylaxis due to the hepatitis A vaccine (SNOMED CT code 471311000124103) on or before the second birthday.

Numerator 9: Immunization status—Rotavirus.
Persons who meet any of the following criteria:

- At least two doses of the two-dose rotavirus vaccine (CVX code 119; CPT code 90681) on different dates of service on or before the second birthday. Do not count a vaccination administered prior to 42 days after birth.
- At least three doses of the three-dose rotavirus vaccine (Rotavirus (3 Dose Schedule) Immunization Value Set; CPT code 90680) on different dates of service on or before the second birthday. Do not count a vaccination administered prior to 42 days after birth.
- At least one dose of the two-dose rotavirus vaccine (CVX code 119; CPT code 90681) and at least two doses of the three-dose rotavirus vaccine (Rotavirus (3 Dose Schedule) Immunization Value Set; CPT code 90680), all on different dates of service, on or before the second birthday. Do not count a vaccination administered prior to 42 days after birth.
- Anaphylaxis due to the rotavirus vaccine (SNOMED CT code 428331000124103) on or before the second birthday.

Numerator 10: Immunization status—Influenza.
Persons who meet either of the following criteria on or before the second birthday:

- At least two influenza vaccinations (Influenza Immunization Value Set; Influenza Vaccine Procedure Value Set) with different dates of service. Do not count a vaccination administered prior to 180 days after birth.
  - An influenza vaccination recommended for children 2 years and older (e.g., LAIV) (Influenza Virus LAIV Immunization Value Set; Influenza Virus LAIV Vaccine Procedure Value Set; NDC code 66019011251) administered on the second birthday meets criteria for one of the two required vaccinations.
- Anaphylaxis due to the influenza vaccine (SNOMED CT code 471361000124100).

Numerator 13: Immunization status—Combination 10.
Persons who are numerator compliant for DTaP, IPV, MMR, HiB, hepatitis B, VZV, pneumococcal, hepatitis A, rotavirus and influenza indicators.

Coding Guidance
*Do not include laboratory claims (claims with POS code 81).

<table>
<tr><td>Summary of changes</td><td>

Updated the citation for clinical recommendation statement and rationale.
Updated the race and ethnicity stratification categories and Data Elements for Reporting table to align with OMB SPD 15 2024 and US Core Version 6.1.0 Model Definition.
Removed the definitions of “participation” and “participation period.”
Updated Numerator 10 to add an NDC code to identify LAIV vaccines that are self-administered by the patient or caregiver.
Removed the SSoR data elements from the data element tables.

</td></tr>
<tr><td>HEDIS for QRS-specific guidance</td><td>

HEDIS for QRS reports only Combination 10 and related antigens. Numerator aligns with HEDIS numbering.
ECDS reporting is required for this measure.
HEDIS for QRS does not require race and ethnicity stratification reporting.
This measure was proposed to be removed from the QRS measure set in the Draft 2026 Call Letter. Refer to the Final 2026 Call Letter and 2027 QRS and QHP Enrollee Survey Technical Guidance for guidance on reporting this measure.

</td></tr>
<tr><td>Data element tables</td><td>
Organizations that submit HEDIS data to NCQA must provide the following data elements.

Table CIS-E-A-4: Data Elements for Childhood Immunization Status
<table>
<tr><th>Metric</th><th>Data Element</th><th>Reporting Instructions</th></tr>
<tr><td>DTaP</td><td>InitialPopulation</td><td>Repeat per Metric</td></tr>
<tr><td>IPV</td><td>Exclusions</td><td>Repeat per Metric</td></tr>
<tr><td>MMR</td><td>Denominator</td><td>Repeat per Metric</td></tr>
<tr><td>HiB</td><td>Numerator</td><td>For each Metric</td></tr>
<tr><td>HepatitisB</td><td>Rate</td><td>(Percent)</td></tr>
<tr><td>VZV</td><td colspan="2" rowspan="8"></td></tr>
<tr><td>PneumococcalConjugate</td></tr>
<tr><td>HepatitisA</td></tr>
<tr><td>Rotavirus</td></tr>
<tr><td>Influenza</td></tr>
<tr><td>Combo10</td></tr>
</table>
</td></tr>
</table>

Table CIS-E-B-4: Data Elements for Childhood Immunization Status: Stratifications by Race

Metric	Race	Data Element	Reporting Instructions
Combo10	AmericanIndianOrAlaskaNative	InitialPopulation	For each Stratification
	Asian	Exclusions	For each Stratification
	BlackOrAfricanAmerican	Denominator	For each Stratification
	MiddleEasternOrNorthAfrican	Numerator	For each Stratification
	NativeHawaiianOrPacificIslander	Rate	(Percent)
	White		
	OtherRace		
	TwoOrMoreRaces		
	AskedButNoAnswer		
	Unknown		

Table CIS-E-C-4: Data Elements for Childhood Immunization Status: Stratifications by Ethnicity

Metric	Ethnicity	Data Element	Reporting Instructions
Combo10	HispanicOrLatino	InitialPopulation	For each Stratification
	NotHispanicOrLatino	Exclusions	For each Stratification
	AskedButNoAnswer	Denominator	For each Stratification
	Unknown	Numerator	For each Stratification
		Rate	(Percent)

Colorectal Cancer Screening (COL-E)

Measure title	Colorectal Cancer Screening	**Measure ID**	COL-E
Description	The percentage of persons 45–75 years of age who had appropriate screening for colorectal cancer.		
Measurement period	January 1–December 31.		
Copyright and disclaimer notice	Refer to the complete copyright and disclaimer information at the front of the NCQA Measure Specifications. NCQA website: www.ncqa.org. Submit policy clarification support questions via My NCQA (https://my.ncqa.org).		
Clinical recommendation statement/ rationale	The U.S. Preventive Services Task Force "recommends screening for colorectal cancer in all adults aged 50 to 75 years (A recommendation) and all adults aged 45 to 49 years (B recommendation)." Potential screening methods include an annual guaiac-based fecal occult blood test (gFOBT), annual fecal immunochemical test (FIT), multitargeted stool DNA with FIT test (sDNA FIT) every 3 years, colonoscopy every 10 years, CT colonography every 5 years, flexible sigmoidoscopy every 5 years or flexible sigmoidoscopy every 10 years, with FIT every year.		
Citations	USPSTF. 2021. "Screening for Colorectal Cancer: US Preventive Services Task Force Recommendation Statement." *JAMA* 325(19): 1965–77. doi:10.1001/jama.2021.6238.		
Characteristics			
Scoring	Proportion.		
Type	Process.		
Product line	Exchange.		
Stratifications	Age as of the last day of the measurement period. • 46–50 years. • 51–75 years. Race. (Refer to *General Guideline: Race and Ethnicity Stratification*.) • American Indian or Alaska Native. • Asian. • Black or African American. • Middle Eastern or North African. • Native Hawaiian or Pacific Islander. • White. • Other Race.		

	• Two or More Races. • Asked But No Answer. • Unknown. Ethnicity. (Refer to *General Guideline: Race and Ethnicity Stratification*.) • Hispanic or Latino. • Not Hispanic or Latino. • Asked But No Answer. • Unknown.
Risk adjustment	None.
Improvement notation	Increased score indicates improvement.
Guidance	**Data collection methodology:** ECDS. Refer to *General Guideline: Data Collection Methods* for additional information. **Date specificity:** Dates must be specific enough to determine the event occurred in the period being measured. **Which services count?** When using claims, include all paid, suspended, pending and denied claims.
Initial population	*Measure item count:* Person. *Attribution basis:* Enrollment. • *Benefits:* Medical. • *Continuous enrollment:* The measurement period and the year prior to the measurement period. • *Allowable gap:* No more than one gap of ≤45 days during each year of the continuous enrollment period. No gaps on the last day of the measurement period. *Ages:* 46–75 years of age as of the last day of the measurement period. *Event:* None.
Denominator exclusions	**Persons with a date of death.** Death in the measurement period, identified using data sources determined by the organization. Method and data sources are subject to review during the HEDIS audit. **Persons in hospice or using hospice services.** Persons who use hospice services (Hospice Encounter Value Set; Hospice Intervention Value Set) or elect to use a hospice benefit any time during the measurement period. Organizations that use the Monthly Membership Detail Data File to identify these persons must use only the run date of the file. **Persons receiving palliative care.** Persons receiving palliative care (Palliative Care Assessment Value Set; Palliative Care Encounter Value Set; Palliative Care Intervention Value Set) or who had an encounter for palliative care (ICD-10-CM code Z51.5*) any time during the measurement period.

	Persons 66 years of age or older by the last day of the measurement period, with both frailty and advanced illness. 1. **Frailty.** At least two indications of frailty (Frailty Device Value Set; Frailty Diagnosis Value Set*; Frailty Encounter Value Set; Frailty Symptom Value Set*) with different dates of service during the measurement period. 2. **Advanced illness.** Either of the following during the measurement period or the year prior to the measurement period: – Advanced illness (Advanced Illness Value Set*) on at least two different dates of service. – Dispensed dementia medication (Dementia Medications List). **History of colorectal cancer and/or total colectomy.** Colorectal cancer (Colorectal Cancer and History of Colorectal Cancer Value Set*) or a total colectomy (Total Colectomy Value Set; SNOMED CT code 119771000119101) any time during the person's history through the last day of the measurement period. **Coding Guidance** *Do not include laboratory claims (claims with POS code 81).
Denominator	The initial population minus denominator exclusions.
Numerator	**Persons with one or more screenings for colorectal cancer.** Any of the following meet criteria: • Fecal occult blood test (FOBT Lab Test Value Set; FOBT Test Result or Finding Value Set) during the measurement period. For administrative data, assume the required number of samples were returned, regardless of FOBT type. • Stool DNA (sDNA) with FIT test (sDNA FIT Lab Test Value Set; SNOMED CT code 708699002) during the measurement period or the 2 years prior to the measurement period. • Flexible sigmoidoscopy (Flexible Sigmoidoscopy Value Set; SNOMED CT code 841000119107) during the measurement period or the 4 years prior to the measurement period. • CT colonography (CT Colonography Value Set) during the measurement period or the 4 years prior to the measurement period. • Colonoscopy (Colonoscopy Value Set; SNOMED CT code 851000119109) during the measurement period or the 9 years prior to the measurement period.
Summary of changes	• Updated the race and ethnicity stratification categories and Data Elements for Reporting table to align with OMB SPD 15 2024 and US Core Version 6.1.0 Model Definition. • Removed the definitions of "participation" and "participation period." • Removed the SSoR data elements from the data elements tables.
HEDIS for QRS-specific guidance	• ECDS reporting is required for this measure. • HEDIS for QRS does not require race and ethnicity stratification reporting.

Data element tables

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

Table COL-E-A-4: Metadata Elements for Colorectal Cancer Screening

Metric	Age	Data Element	Reporting Instructions
ColorectalCancerScreening	46-50	InitialPopulation	For each Stratification
	51-75	Exclusions	For each Stratification
	Total	Denominator	For each Stratification
		Numerator	For each Stratification
		Rate	(Percent)

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

Metric	Race	Data Element	Reporting Instructions
ColorectalCancerScreening	AmericanIndianOrAlaskaNative	InitialPopulation	For each Stratification
	Asian	Exclusions	For each Stratification
	BlackOrAfricanAmerican	Denominator	For each Stratification
	MiddleEasternOrNorthAfrican	Numerator	For each Stratification
	NativeHawaiianOrPacificIslander	Rate	(Percent)
	White		
	OtherRace		
	TwoOrMoreRaces		
	AskedButNoAnswer		
	Unknown		

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

Metric	Ethnicity	Data Element	Reporting Instructions
ColorectalCancerScreening	HispanicOrLatino	InitialPopulation	For each Stratification
	NotHispanicOrLatino	Exclusions	For each Stratification
	AskedButNoAnswer	Denominator	For each Stratification
	Unknown	Numerator	For each Stratification
		Rate	(Percent)

Depression Screening and Follow-Up for Adolescents and Adults (DSF-E)

Measure title	Depression Screening and Follow-Up for Adolescents and Adults*	**Measure ID**	DSF-E
Description	The percentage of persons 12 years of age and older who were screened for clinical depression using a standardized instrument and, if screened positive, received follow-up care. • *Depression Screening.* The percentage of persons who were screened for clinical depression using a standardized instrument. • *Follow-Up on Positive Screen.* The percentage of persons who received follow-up care within 30 days of a positive depression screen finding.		
Measurement period	January 1–December 31.		
Copyright and disclaimer notice	**Adapted with financial support from the Centers for Medicare & Medicaid Services (CMS).* Refer to the complete copyright and disclaimer information at the front of the NCQA Measure Specifications. NCQA website: www.ncqa.org. Submit policy clarification support questions via My NCQA (https://my.ncqa.org).		
Clinical recommendation statement/ rationale	The U.S. Preventive Services Task Force (USPSTF) recommends screening for depression among adolescents 12–18 years and the general adult population, including pregnant and postpartum women. (B recommendation) The USPSTF also recommends that screening be implemented with adequate systems in place to ensure accurate diagnosis, effective treatment and appropriate follow-up. (B recommendation)		
Citations	US Preventive Services Task Force et al. 2023. "Screening for Depression and Suicide Risk in Adults: US Preventive Services Task Force Recommendation Statement." *JAMA* vol. 329,23: 2057–67. US Preventive Services Task Force et al. 2022. "Screening for Depression and Suicide Risk in Children and Adolescents: US Preventive Services Task Force Recommendation Statement." *JAMA* vol. 328,15: 1534–42.		
Characteristics			
Scoring	Proportion.		
Type	Process.		

Product line	Exchange.
Stratifications	Age as of the start of the measurement period. • 12–17 years. • 18–64 years. • 65 years and older.
Risk adjustment	None.
Improvement notation	Increased score indicates improvement.
Guidance	**Data collection methodology:** ECDS. Refer to *General Guideline: Data Collection Methods* for additional information. **Date specificity:** Dates must be specific enough to determine that the event occurred in the period being measured. **Which services count?** When using claims, include all paid, suspended, pending and denied claims. **Other guidance:** • Use the person's age to select an age-appropriate depression screening instrument. • Depression screening captured in health risk assessments or other types of health assessments are allowed if the questions align with a specific instrument that is validated for depression screening. – *For example,* a health risk assessment that includes questions from the PHQ-2 counts as screening if the questions are answered and a total score is calculated.

Definitions

Depression screening instrument

A standard assessment instrument normalized and validated for the appropriate patient population. Eligible screening instruments with thresholds for positive findings include:

Instruments for Adolescents (≤17 Years)	Total Score LOINC Codes	Positive Finding
Patient Health Questionnaire (PHQ-9)®	44261-6	Total score ≥10
Patient Health Questionnaire Modified for Teens (PHQ-9M)®	89204-2	Total score ≥10
Patient Health Questionnaire-2 (PHQ-2)®[1]	55758-7	Total score ≥3
Beck Depression Inventory-Fast Screen (BDI-FS)®[1,2]	89208-3	Total score ≥8
Center for Epidemiologic Studies Depression Scale—Revised (CESD-R)	89205-9	Total score ≥17

Instruments for Adolescents (≤17 Years)	Total Score LOINC Codes	Positive Finding
Edinburgh Postnatal Depression Scale (EPDS)	99046-5	Total score ≥10
PROMIS Depression	71965-8	Total score (T Score) ≥60

Instruments for Adults (18+ Years)	Total Score LOINC Codes	Positive Finding
Patient Health Questionnaire (PHQ-9)®	44261-6	Total score ≥10
Patient Health Questionnaire-2 (PHQ-2)®[1]	55758-7	Total score ≥3
Beck Depression Inventory-Fast Screen (BDI-FS)®[1,2]	89208-3	Total score ≥8
Beck Depression Inventory (BDI-II)	89209-1	Total score ≥20
Center for Epidemiologic Studies Depression Scale—Revised (CESD-R)	89205-9	Total score ≥17
Duke Anxiety—Depression Scale (DUKE-AD)®[2]	90853-3	Total score ≥30
Geriatric Depression Scale Short Form (GDS)[1]	48545-8	Total score ≥5
Geriatric Depression Scale Long Form (GDS)	48544-1	Total score ≥10
Edinburgh Postnatal Depression Scale (EPDS)	99046-5	Total score ≥10
My Mood Monitor (M-3)®	71777-7	Total score ≥5
PROMIS Depression	71965-8	Total score (T Score) ≥60
PROMIS Emotional Distress—Depression—Short Form	77861-3	Total score (T Score) ≥60
Clinically Useful Depression Outcome Scale (CUDOS)	90221-3	Total score ≥31

[1]Brief screening instrument. All other instruments are full-length.

[2]Proprietary; may be cost or licensing requirement associated with use.

Initial population

Measure item count: Person.

Attribution basis: Enrollment.

- *Benefits:* Medical.
- *Continuous enrollment:* The measurement period.
- *Allowable gap:* No more than one gap of ≤45 days during the measurement period. No gaps on the last day of the measurement period.

	Ages: 12 years of age and older at the start of the measurement period. *Event:* None.
Denominator exclusions	**Persons with a date of death.** Death in the measurement period, identified using data sources determined by the organization. Method and data sources are subject to review during the HEDIS audit. **Persons in hospice or using hospice services.** Persons who use hospice services (Hospice Encounter Value Set; Hospice Intervention Value Set) or elect to use a hospice benefit any time during the measurement period. Organizations that use the Monthly Membership Detail Data File to identify these persons must use only the run date of the file. **Persons with a history of bipolar disorder.** Persons with a history of bipolar disorder (Bipolar Disorder Value Set*; Other Bipolar Disorder Value Set*) any time during the person's history through the last day of the year prior to the measurement period. **Persons with depression.** Persons with depression (Depression Value Set*) that starts during the year prior to the measurement period. **Coding Guidance** *Do not include laboratory claims (claims with POS code 81).
Denominator	**Denominator 1:** The initial population minus denominator exclusions. **Denominator 2:** Persons from numerator 1 with a positive finding for depression between January 1 and December 1 of the measurement period.
Numerator	**Numerator 1—Depression screening.** Persons with a documented result for depression screening, using an age-appropriate standardized instrument, performed between January 1 and December 1 of the measurement period. **Numerator 2—Follow-up on positive screen.** Persons who received follow-up care on or up to 30 days after the date of the first positive screen (31 total days). Any of the following on or up to 30 days after the first positive screen: • An outpatient, telephone, e-visit or virtual check-in follow-up visit (Follow Up Visit Value Set) with a diagnosis of depression or other behavioral health condition (Depression or Other Behavioral Health Condition Value Set). • A depression case management encounter (Depression Case Management Encounter Value Set) that documents assessment for symptoms of depression (Symptoms of Depression Value Set) or a diagnosis of depression or other behavioral health condition (Depression or Other Behavioral Health Condition Value Set). • A behavioral health encounter, including assessment, therapy, collaborative care or medication management (Behavioral Health Encounter Value Set).

<table>
<tr><td></td><td>

A diagnosis of encounter for exercise counseling (ICD-10-CM code Z71.82*).
A dispensed antidepressant medication (Antidepressant Medications List).

OR

Documentation of additional depression screening on a full-length instrument indicating either no depression or no symptoms that require follow-up (i.e., a negative screen) on the same day as a positive screen on a brief screening instrument.

For example, if there is a positive screen resulting from a PHQ-2 score, documentation of a negative finding from a PHQ-9 performed on the same day qualifies as evidence of follow-up.

Coding Guidance
*Do not include laboratory claims (claims with POS code 81).
</td></tr>
<tr><td>Summary of changes</td><td>

Removed the definitions of “participation” and “participation period.”
Added the PROMIS Emotional Distress—Depression—Short Form instrument to the list of depression screening instruments for adults 18+ years of age.
Removed the SSoR data elements from the data element tables.

</td></tr>
<tr><td>Data element tables</td><td>
Organizations that submit HEDIS data to NCQA must provide the following data elements.

Table DSF-E-4: Data Elements for Depression Screening and Follow-Up for Adolescents and Adults
<table>
<tr><th>Metric</th><th>Age</th><th>Data Element</th><th>Reporting Instructions</th></tr>
<tr><td>Screening</td><td>12-17</td><td>InitialPopulation</td><td>For each stratification, repeat per metric</td></tr>
<tr><td>FollowUp</td><td>18-64</td><td>Exclusions</td><td>For each stratification, repeat per metric</td></tr>
<tr><td></td><td>65+</td><td>Denominator</td><td>For each Metric and Stratification</td></tr>
<tr><td></td><td>Total</td><td>Numerator</td><td>For each Metric and Stratification</td></tr>
<tr><td></td><td></td><td>Rate</td><td>(Percent)</td></tr>
</table>
</td></tr>
</table>

Follow-Up After Acute and Urgent Care Visits for Asthma (AAF-E)

Measure title	Follow-Up After Acute and Urgent Care Visits for Asthma	**Measure ID**	AAF-E
Description	The percentage of persons 5-64 years of age with an urgent care visit, acute inpatient discharge, observation stay discharge or ED visit with a diagnosis of asthma that had a corresponding outpatient follow-up visit with a diagnosis of asthma within 30 days.		
Measurement period	January 1–December 31.		
Copyright and disclaimer notice	Refer to the complete copyright and disclaimer information at the front of the NCQA Measure Specifications. NCQA website: www.ncqa.org. Submit policy clarification support questions via My NCQA (https://my.ncqa.org).		
Clinical recommendation statement/ rationale	Non-clinical factors (e.g., socioeconomic status, environmental exposures, access to care) can limit individual efficacy in managing chronic conditions such as asthma, leading to higher use of urgent care, emergency departments, and hospitalizations instead of preventive care. An accountability mechanism that drives individuals towards non-acute care may help to improve poor and disparate asthma outcomes.		
Citations	McIvor A., Kaplan A. 2020. “A Call to Action for Improving Clinical Outcomes in Patients with Asthma.” Primary Care Respiratory Medicine 30(54). National Asthma Education and Prevention Program (NAEPP) Coordinating Committee Expert Working Group. 2020. 2020 Focused Updates to the Asthma Management Guidelines. https://www.nhlbi.nih.gov/resources/2020-focused-updatesasthma-management-guidelines Global Initiative for Asthma (GINA). 2024. Global Strategy for Asthma Management and Prevention. https://ginasthma.org/wp-content/uploads/2024/05/GINA-2024- Strategy-Report-24_05_22_WMS.pdf		
Characteristics			
Scoring	Proportion.		
Type	Process.		
Product line	Exchange.		
Stratifications	Age as of the episode date. • 5–11 years. • 12–17 years. • 18–50 years. • 51–64 years.		

	COPD diagnosis. • Persons diagnosed with COPD (COPD Value Set*) any time during the person's history through the last day of the measurement period. • Persons who did not meet criteria for the stratification above (i.e., did not have a diagnosis of COPD any time during the person's history through the last day of the measurement period). **Coding Guidance** *Do not include laboratory claims (claims with POS code 81).
Risk adjustment	None.
Improvement notation	Increased score indicates improvement.
Guidance	**Data collection methodology:** ECDS. Refer to *General Guideline: Data Collection Methods* for additional information. **Date specificity:** Dates must be specific enough to determine the episode occurred in the period being measured. **Observation stays:** For observation stays (Observation Stay Value Set) that do not have a recorded admission or discharge date, set the admission date to the earliest date of service on the claim and set the discharge date to the last date of service on the claim. **Which services count?** When using claims, include all paid, suspended, pending and denied claims. **Other guidance:** The measure is based on episodes; therefore, it is possible for the denominator to include multiple events for the same person.
Definitions	
Asthma episode	An encounter between January 1 and December 1 with a diagnosis of asthma. *For urgent care visits that result in an ED visit*, the ED visit is the episode. *For urgent care or ED visits that result in a nonacute inpatient stay*, the urgent care or ED visit is the episode. *For acute inpatient or observation stays that result in a nonacute inpatient stay*, the acute inpatient or observation stay discharge is the episode.
Asthma episode date	The date of service for the asthma episode. *For acute inpatient or observation stay discharges,* the episode date is the date of discharge. *For direct transfers,* the episode date is the discharge date from the last transfer admission. *For ED or urgent care visits,* the episode date is the date of service.

Direct transfer	When the discharge date from the initial stay precedes the admission date to a subsequent stay by one calendar day or less. • *For example:* – An inpatient discharge on June 1, followed by an admission to another inpatient setting on June 1, is a direct transfer. – An inpatient discharge on June 1, followed by an admission to an inpatient setting on June 2, is a direct transfer. – An inpatient discharge on June 1, followed by an admission to another inpatient setting on June 3, is not a direct transfer; these are two distinct inpatient stays. Direct transfers may occur between different facilities and between inpatient and observation stays.
Initial population	*Measure item count:* Episode. *Attribution basis:* Enrollment. • *Benefits:* Medical. • *Continuous enrollment:* Episode date through 30 days after episode date (31 total days). • *Allowable gap:* None. *Ages:* 5–64 years of age as of the episode date. *Event:* **Acute visits for asthma on or between January 1 and December 1 of the measurement period.** **Step 1.** Identify all urgent care visits, ED visits, acute inpatient discharges and observation stay discharges on or between January 1 and December 1 of the measurement period: • An urgent care visit (Outpatient and Telehealth Value Set ***with*** POS code 20) ***with*** a diagnosis of asthma (Asthma Value Set). • An ED visit (ED Value Set) ***with*** a diagnosis of asthma (Asthma Value Set). • Acute inpatient or observation discharges with a diagnosis of asthma (Asthma Value Set) on the discharge claim. To identify an acute inpatient or observation discharge: 1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set) and observation stays (Observation Stay Value Set). 2. Exclude nonacute inpatient stays (Nonacute Inpatient Stay Value Set). 3. Identify the discharge date for the stay. **Step 2.** Exclude ED and urgent care visits followed by admission to an acute inpatient or observation stay care setting on the date of the ED or urgent care visit, or within 30 days after the ED or urgent care visit (31 total days), regardless of diagnosis for the admission. To identify admissions to an acute inpatient or observation stay care setting: 1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set) and observation stays (Observation Stay Value Set).

2. Exclude nonacute inpatient stays (Nonacute Inpatient Stay Value Set).
3. Identify the admission date for the stay.

Step 3. Determine all asthma episode dates. Multiple visits/discharges that occur on the same date count as one episode.

Step 4. Test for direct transfers.

For discharges with one or more direct transfers, use the last discharge. Exclude the episode if the direct transfer's discharge date occurs after December 1 of the measurement period.

For episodes with a direct transfer to an acute setting for any diagnosis, the episode date is the discharge date from the last admission.

To identify admissions to and discharges from acute inpatient settings:

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

Note: *For acute inpatient or observation stays where there was a direct transfer, use the original stay and any direct transfer stays to identify eligible episode dates in this step.*

Step 5. Calculate continuous enrollment.

Step 6. Multiple episodes within a 31-day period.

Identify ED or urgent care visits chronologically, including only the first episode in each 31-day period.

- *For example,* consider the following events:
  - ED visit: January 1.
  - Urgent care visit: January 15.
  - ED visit: January 20.

  Include the ED visit on January 1 as a denominator event. Exclude the urgent care visit on January 15 and the ED visit on January 20.

Identify acute inpatient or observation stay discharges chronologically, including only the last discharge in each 31-day period.

- *For example,* consider the following events:
  - Acute inpatient discharge: March 5.
  - Observation stay discharge: March 9.
  - Acute inpatient discharge: March 22.

  Include the acute inpatient discharge on March 22 as a denominator event. Exclude the discharges on March 5 and March 9.

For 31-day periods that include an eligible acute inpatient or observation stay discharge followed by an ED or urgent care visit, include only the acute inpatient or observation stay discharge.

- *For example,* consider the following events:
  - Acute inpatient discharge: March 5.
  - ED visit: March 12.

	– Urgent care visit: March 20. Include the acute inpatient discharge on March 5 as a denominator event. Exclude the ED visit on March 12 and urgent care visit on March 20. ***Note:*** *Removal of multiple episodes in a 31-day period is based on eligible episode dates. Assess each episode for eligibility before removing multiple episodes in a 31-day period.*
Denominator exclusions	**Persons with a date of death.** Death in the measurement period, identified using data sources determined by the organization. Method and data sources are subject to review during the HEDIS audit. **Persons in hospice or using hospice services.** Persons who use hospice services (Hospice Encounter Value Set; Hospice Intervention Value Set) or elect to use a hospice benefit any time during the measurement period. Organizations that use the Monthly Membership Detail Data File to identify these persons must use only the run date of the file. **Persons with a diagnosis of cystic fibrosis.** Persons with a diagnosis of cystic fibrosis (Cystic Fibrosis Value Set*) at any time in the person's history through the last day of the measurement period. **Coding Guidance** *Do not include laboratory claims (claims with POS code 81).
Denominator	The initial population minus denominator exclusions.
Numerator	**30-day follow-up.** An outpatient visit, telephone visit, e-visit or virtual check-in (Outpatient and Telehealth Value Set) with a diagnosis of asthma (Asthma Value Set) within 30 days after the asthma episode. Do not include visits that occur on the same day as the asthma episode. Do not include services provided in an urgent care setting (POS code 20).
Summary of changes	• This is a first-year measure.
HEDIS for QRS-specific guidance	• This measure was proposed to be added to the QRS measure set in the Draft 2026 Call Letter. Refer to the Final 2026 Call Letter and 2027 QRS and QHP Enrollee Survey Technical Guidance for guidance on reporting this measure.

Data element tables

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

Table AAF-E-4: Data Elements for Follow-Up After Acute and Urgent Care Visits for Asthma

Metric	Age	Diagnosis	Data Element	Reporting Instructions
FollowUpVisit	5-11	COPDDiagnosed	InitialPopulation	For each Stratification
	12-17	COPDNotDiagnosed	Exclusions	For each Stratification
	18-50		Denominator	For each Stratification
	51-64		Numerator	For each Stratification
	Total		Rate	(Percent)

Immunizations for Adolescents (IMA-E)

Measure title	Immunizations for Adolescents*	**Measure ID**	IMA-E
Description	The percentage of persons 13 years of age who had one dose of meningococcal vaccine, one tetanus, diphtheria toxoids and acellular pertussis (Tdap) vaccine, and have completed the human papillomavirus (HPV) vaccine series by their 13th birthday. The measure calculates a rate for each vaccine and one combination rate.		
Measurement period	January 1–December 31.		
Copyright and disclaimer notice	**Adapted with financial support from the Centers for Disease Control & Prevention (CDC).* Refer to the complete copyright and disclaimer information at the front of the NCQA Measure Specifications. NCQA website: www.ncqa.org. Submit policy clarification support questions via My NCQA (https://my.ncqa.org).		
Clinical recommendation statement/ rationale	*HPV*: The Advisory Committee on Immunization Practices (ACIP) recommends routine HPV vaccination for adolescents at age 11 or 12 years; vaccination may be given starting at age 9 years. In a two-dose schedule of HPV vaccine, the minimum interval between the first and second doses is 5 months. Persons who initiated vaccination with 9vHPV, 4vHPV or 2vHPV before their 15th birthday and received 2 doses of any HPV vaccine at the recommended dosing schedule (0, 6–12 months), or received three doses of any HPV vaccine at the recommended dosing schedule (0, 1–2, 6 months), are considered adequately vaccinated. *Tdap*: ACIP recommends a single dose of vaccine be administered at age 11 or 12 years. *Meningococcal*: ACIP recommends routine vaccination with a quadrivalent meningococcal conjugate vaccine (MenACWY) for adolescents aged 11 or 12 years, with a booster dose at age 16 years, or vaccination with a pentavalent vaccine for adolescents ages 10 years and older when both meningococcal B and meningococcal A, C, W and Y are indicated.		
Citations	Centers for Disease Control and Prevention (CDC). 2024. "Recommended Vaccines for Preteens and Teens." https://www.cdc.gov/meningococcal/vaccines/preteens-teens.html Liang, J.L., T. Tiwari, P. Moro, N.E. Messonnier, A. Reingold, M. Sawyer, T.A. Clark. 2018. "Prevention of Pertussis, Tetanus, and Diphtheria with Vaccines in the United States: Recommendations of the Advisory Committee on Immunization Practices (ACIP)." *MMWR Morb Mortal Wkly Rep* 67(2):1–44. doi: http://dx.doi.org/10.15585/mmwr.rr6702a1.		

	Mbaeyi, S.A., C.H. Bozio, J. Duffy, et al. 2020. "Meningococcal Vaccination: Recommendations of the Advisory Committee on Immunization Practices, United States, 2020." MMWR Recomm Rep 69(No. RR-9):1–41. doi: http://dx.doi.org/10.15585/mmwr.rr6909a1. Meites, E., A. Kempe, L.E. Markowitz. 2016. "Use of a 2-Dose Schedule for Human Papillomavirus Vaccination—Updated Recommendations of the Advisory Committee on Immunization Practices." MMWR Morb Mortal Wkly Rep 65:1405–08. doi: http://dx.doi.org/10.15585/mmwr.mm6549a5.
Characteristics	
Scoring	Proportion.
Type	Process.
Product line	Exchange.
Stratifications	Race. (Refer to *General Guideline: Race and Ethnicity Stratification*.) • American Indian or Alaska Native. • Asian. • Black or African American. • Middle Eastern or North African. • Native Hawaiian or Pacific Islander. • White. • Other Race. • Two or More Races. • Asked But No Answer. • Unknown. Ethnicity. (Refer to *General Guideline: Race and Ethnicity Stratification.*) • Hispanic or Latino. • Not Hispanic or Latino. • Asked But No Answer. • Unknown.
Risk adjustment	None.
Improvement notation	Increased score indicates improvement.
Guidance	**Data collection methodology:** ECDS. Refer to *General Guideline: Data Collection Methods* for additional information. **Date specificity:** Dates must be specific enough to determine the event occurred in the period being measured. **Which services count?** When using claims, include all paid, suspended, pending and denied claims.

<table>
<tr><td></td><td>Other guidance: To align with ACIP recommendations:
Only the quadrivalent meningococcal vaccine (serogroups A, C, W, Y) is included in the measure.
The minimum interval for the two-dose HPV vaccination schedule is 150 days, with a 4-day grace period (146 days).
Report rates for each vaccine and one combination rate.
Combination rate: Calculate the following rates for Combination 2.<table><tr><th>Combination</th><th>Meningococcal</th><th>Tdap</th><th>HPV</th></tr><tr><td>Combination 2</td><td>✓</td><td>✓</td><td>✓</td></tr></table></td></tr>
<tr><td>Initial population</td><td>Measure item count: Person.
Attribution basis: Enrollment.
Benefits: Medical.
Continuous enrollment: 365 days prior to the person’s 13th birthday and the 13th birthday.
Allowable gap: No more than one gap of ≤45 days during the measurement period. No gap on 13th birthday.
Ages: Persons who turn 13 years of age during the measurement period.
Event: None.</td></tr>
<tr><td>Denominator exclusions</td><td>Persons with a date of death.
Death in the measurement period, identified using data sources determined by the organization. Method and data sources are subject to review during the HEDIS audit.
Persons in hospice or using hospice services.
Persons who use hospice services (Hospice Encounter Value Set; Hospice Intervention Value Set) or elect to use a hospice benefit any time during the measurement period. Organizations that use the Monthly Membership Detail Data File to identify these persons must use only the run date of the file.</td></tr>
<tr><td>Denominator</td><td>The initial population minus denominator exclusions.</td></tr>
<tr><td>Numerator</td><td>Numerator 1: Immunization status— Meningococcal serogroups A, C, W, Y.
Persons who meet either of the following criteria:
At least one meningococcal vaccine (serogroups A, C, W, Y or A, C, W, Y, B) (Meningococcal Immunization Value Set; Meningococcal Vaccine Procedure Value Set) with a date of service on or between the 10th and 13th birthdays.
Anaphylaxis due to the meningococcal vaccine (SNOMED CT code 428301000124106) any time on or before the 13th birthday.</td></tr>
</table>

	Numerator 2: Immunization status—Tdap. Persons who meet any of the following criteria: • At least one tetanus, diphtheria toxoids and acellular pertussis (Tdap) vaccine (CVX code 115; CPT code 90715) with a date of service on or between the 10th and 13th birthdays. • Anaphylaxis due to the tetanus, diphtheria or pertussis vaccine (Anaphylaxis Due to Diphtheria, Tetanus or Pertussis Vaccine Value Set) any time on or before the 13th birthday. • Encephalitis due to the tetanus, diphtheria or pertussis vaccine (Encephalitis Due to Diphtheria, Tetanus or Pertussis Vaccine Value Set) any time on or before the 13th birthday. **Numerator 3: Immunization status—HPV.** Persons who meet any of the following criteria: • At least two HPV vaccines (HPV Immunization Value Set; HPV Vaccine Procedure Value Set) on or between the 9th and 13th birthdays and with dates of service at least 146 days apart. • At least three HPV vaccines (HPV Immunization Value Set; HPV Vaccine Procedure Value Set) with different dates of service on or between the 9th and 13th birthdays. • Anaphylaxis due to the HPV vaccine (SNOMED CT code 428241000124101) any time on or before the 13th birthday. **Numerator 5: Immunization status—Combination 2.** Persons who are numerator compliant for all three indicators (meningococcal, Tdap, HPV).
Summary of changes	• Updated citations for clinical recommendation statement and rationale. • Updated the race and ethnicity stratification categories and Data Elements for Reporting Table to align with OMB SPD 15 2024 and US Core Version 6.1.0 Model Definition. • Removed the definitions of “participation” and “participation period.” • Removed the SSoR data elements from the data elements tables.
HEDIS for QRS-specific guidance	• HEDIS for QRS only reports Combination 2 and related antigens. Numerator aligns with HEDIS numbering. • HEDIS for QRS does not require race and ethnicity stratification reporting. • This measure was proposed to be removed from the QRS measure set in the Draft 2026 Call Letter. Refer to the Final 2026 Call Letter and 2027 QRS and QHP Enrollee Survey Technical Guidance for guidance on reporting this measure.

Data element tables

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

Table IMA-E-A-4: Data Elements for Immunizations for Adolescents

Metric	Data Element	Reporting Instructions
Meningococcal	InitialPopulation	Repeat per Metric
Tdap	Exclusions	Repeat per Metric
HPV	Denominator	Repeat per Metric
Combo2	Numerator	For each Metric
	Rate	(Percent)

Table IMA-E-B-4: Data Elements for Immunizations for Adolescents: Stratifications by Race

Metric	Race	Data Element	Reporting Instructions
Meningococcal	AmericanIndianOrAlaskaNative	InitialPopulation	For each Stratification, repeat per Metric
Tdap	Asian	Exclusions	For each Stratification, repeat per Metric
HPV	BlackOrAfricanAmerican	Denominator	For each Stratification, repeat per Metric
Combo2	MiddleEasternOrNorthAfrican	Numerator	For each Metric and Stratification
	NativeHawaiianOrPacificIslander	Rate	(Percent)
	White		
	OtherRace		
	TwoOrMoreRaces		
	AskedButNoAnswer		
	Unknown		

Table IMA-E-C-4: Data Elements for Immunizations for Adolescents: Stratifications by Ethnicity

Metric	Ethnicity	Data Element	Reporting Instructions
Meningococcal	HispanicOrLatino	InitialPopulation	For each Stratification, repeat per Metric
Tdap	NotHispanicOrLatino	Exclusions	For each Stratification, repeat per Metric
HPV	AskedButNoAnswer	Denominator	For each Stratification, repeat per Metric
Combo2	Unknown	Numerator	For each Metric and Stratification
		Rate	(Percent)

Tobacco Use Screening and Cessation Intervention (TSC-E)

Measure title	Tobacco Use Screening and Cessation Intervention	**Measure ID**	TSC-E
Description	The percentage of persons 12 years of age and older who were screened for commercial tobacco product use at least once during the measurement period, and who received tobacco cessation intervention if identified as a tobacco user. Two rates are reported: 1. *Tobacco Use Screening.* The percentage of persons who were screened for tobacco use. 2. *Cessation Intervention.* The percentage of persons who were identified as a tobacco user and who received tobacco cessation intervention.		
Measurement period	January 1–December 31.		
Copyright and disclaimer notice	Refer to the complete copyright and disclaimer information at the front of the NCQA Measure Specifications. NCQA website: www.ncqa.org. Submit policy clarification support questions via My NCQA (https://my.ncqa.org).		
Clinical recommendation statement	The U.S. Preventive Services Task Force (USPSTF) recommends that clinicians ask all adults about tobacco use, advise them to stop using tobacco and provide behavioral interventions and U.S. Food and Drug Administration (FDA)-approved pharmacotherapy for cessation to nonpregnant adults who use tobacco (Grade A Recommendation) (U.S. Preventive Services Task Force, 2021). The USPSTF recommends that clinicians ask all pregnant persons about tobacco use, advise them to stop using tobacco and provide behavioral interventions for cessation to pregnant persons who use tobacco (Grade A Recommendation) (U.S. Preventive Services Task Force, 2021). The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of pharmacotherapy interventions for tobacco cessation in pregnant women (Grade I Statement) (U.S. Preventive Services Task Force, 2021). The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of electronic cigarettes (e-cigarettes) for tobacco cessation in adults, including pregnant persons. The USPSTF recommends that clinicians direct patients who use tobacco to other tobacco cessation interventions with proven effectiveness and established safety (Grade I Statement) (U.S. Preventive Services Task Force, 2021). The USPSTF recommends that primary care clinicians provide interventions, including education or brief counseling, to prevent initiation of tobacco use among school-aged children and adolescents (Grade B Statement) (U.S. Preventive Services Task Force, 2020).		

	The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of primary care—feasible interventions for the cessation of tobacco use among school-aged children and adolescents (Grade I Statement) (U.S. Preventive Services Task Force, 2020). All patients should be asked if they use tobacco and should have their tobacco use status documented on a regular basis. Evidence has shown that clinic screening systems, such as expanding the vital signs to include tobacco use status or the use of other reminder systems such as chart stickers or computer prompts, significantly increase rates of clinician intervention. (Strength of Evidence = A) (U.S. Department of Health and Human Services. Public Health Service, 2008). All physicians should strongly advise every patient who smokes to quit because evidence shows that physician advice to quit smoking increases abstinence rates. (Strength of Evidence = A) (U.S. Department of Health and Human Services. Public Health Service, 2008). Minimal interventions lasting less than three minutes increase overall tobacco abstinence rates. Every tobacco user should be offered at least a minimal intervention, whether or not he or she is referred to an intensive intervention. (Strength of Evidence = A) (U.S. Department of Health and Human Services. Public Health Service, 2008). The combination of counseling and medication is more effective for smoking cessation than either medication or counseling alone. Therefore, whenever feasible and appropriate, both counseling and medication should be provided to patients trying to quit smoking. (Strength of Evidence = A) (U.S. Department of Health and Human Services. Public Health Service, 2008). For adolescents 11 to 17, the American Academy of Pediatrics recommends the ACT method to assess tobacco product use. Ask: Screen for tobacco use with all youth, during every clinical encounter. Counsel: Advise all youth who use tobacco to quit and have them set a quit date within two weeks. Treat: Link youth to behavioral treatment extenders and prescribe pharmacologic support when indicated. After the visit, follow-up to assess progress and offer support. (American Academy of Pediatrics, 2022).
Citations	US Preventive Services Task Force. 2021. “Interventions for Tobacco Smoking Cessation in Adults, Including Pregnant Persons. US Preventive Services Task Force Recommendation Statement.” *JAMA* 325(3), 265–79. doi:10.1001/jama.2020.25019. US Preventive Services Task Force. 2020. “Primary Care Interventions for Prevention and Cessation of Tobacco Use in Children and Adolescents. US Preventive Services Task Force Recommendation Statement.” *JAMA* 323(16):1590–8. doi:10.1001/jama.2020.4679. Agency for Healthcare Research and Quality. 2008. *Treating Tobacco Use and Dependence: 2008 Update.* https://www.ahrq.gov/prevention/guidelines/tobacco/index.html American Academy of Pediatrics. 2022. “Youth Tobacco Use: Considerations for Clinicians.” *JAMA.* https://downloads.aap.org/AAP/PDF/AAP_Youth_Tobacco_Cessation_Considerations_for_Clinicians.pdf

Characteristics	
Scoring	Proportion.
Type	Process.
Product line	Exchange.
Stratifications	Age as of 180 days prior to the measurement period. • 12–17 years. • 18–64 years. • 65 and older.
Risk adjustment	None.
Improvement notation	Increased score indicates improvement.
Guidance	**Data collection methodology**: ECDS. Refer to the *General Guideline: Data Collection Methods* for additional information. **Date specificity:** Dates must be specific enough to determine that the event occurred in the period being measured. **Which services count?** When using claims, include all paid, suspended, pending and denied claims.
Definitions	
Positive tobacco user	Persons who were screened for tobacco use and had a documented positive result. Any of the following meet criteria: • Tobacco Use Screening Value Set ***with*** Yes Value Set. • LOINC code 72166-2 ***with*** Positive Tobacco Use Status Value Set.
Negative tobacco user	Persons who were screened for tobacco use and had a documented negative result. Any of the following meet criteria: • Tobacco Use Screening Value Set ***with*** No Value Set. • LOINC code 72166-2 ***with*** Negative Tobacco Use Status Value Set.
Initial population	*Measure item count:* Person. *Attribution*: Enrollment. • *Benefits:* Medical. • *Continuous enrollment:* 180 days prior to the measurement period through the last day of the measurement period. • *Allowable gap:* No more than one gap of ≤45 days during the continuous enrollment period. No gaps on the last day of the measurement period. *Ages:* 12 years of age and older as of 180 days prior to the measurement period. *Event:* None.

Denominator exclusions	**Persons with a date of death.** Death in the measurement period, identified using data sources determined by the organization. Method and data sources are subject to review during the HEDIS audit. **Persons in hospice or using hospice services.** Persons who use hospice services (Hospice Encounter Value Set; Hospice Intervention Value Set) or elect to use a hospice benefit any time during the measurement period. Organizations that use the Monthly Membership Detail Data File to identify these persons must use only the run date of the file. **Persons receiving palliative care.** Persons receiving palliative care (Palliative Care Assessment Value Set; Palliative Care Encounter; Palliative Care Intervention Value Set) or who had an encounter for palliative care (ICD-10-CM code Z51.5*) any time during the measurement period. **Coding Guidance** *Do not include laboratory claims (claims with POS code 81).
Denominator	**Denominator 1:** The initial population minus denominator exclusions. **Denominator 2:** Persons from numerator 1 who were identified as a positive tobacco user between January 1 and December 1 of the measurement period.
Numerator	**Numerator 1—Tobacco use screening.** Persons who were screened for tobacco use and identified as either a positive or negative tobacco user (see Definitions above) during the measurement period. **Numerator 2—Cessation intervention.** Persons who received tobacco cessation intervention during the measurement period or 180 days prior to the measurement period. The following meet criteria: • Persons 12–17 years of age as of 180 days prior to the measurement period who received tobacco cessation counseling (Tobacco Use Cessation Counseling Value Set; ICD-10-CM code Z71.6*) during the measurement period or in the 180 days prior to the measurement period. • Persons 18 years of age and older as of 180 days prior to the measurement period who received tobacco cessation counseling (Tobacco Use Cessation Counseling Value Set; ICD-10-CM code Z71.6*) or dispensed pharmacotherapy intervention (Tobacco Use Cessation Medications List) during the measurement period or 180 days prior to the measurement period. **Coding Guidance** *Do not include laboratory claims (claims with POS code 81).
Summary of changes	• This is a first-year measure.

<table>
<tr><td>HEDIS for QRS-specific guidance</td><td>• This measure was proposed to be added to the QRS measure set in the Draft 2026 Call Letter. Refer to the Final 2026 Call Letter and 2027 QRS and QHP Enrollee Survey Technical Guidance for guidance on reporting this measure.</td></tr>
<tr><td>Data element tables</td><td>Organizations that submit HEDIS data to NCQA must provide the following data elements.

Table TSC-E-4: Data Elements for Tobacco Use Screening and Cessation Intervention
<table>
<tr><th>Metric</th><th>Age</th><th>Data Element</th><th>Reporting Instructions</th></tr>
<tr><td>TobaccoUse</td><td>12-17</td><td>InitialPopulation</td><td>For each Stratification, repeat per metric</td></tr>
<tr><td>Cessation</td><td>18-64</td><td>Exclusions</td><td>Only for Tobacco Use Metric and each Stratification</td></tr>
<tr><td></td><td>65+</td><td>Denominator</td><td>For each Metric and Stratification</td></tr>
<tr><td></td><td>Total</td><td>Numerator</td><td>For each Metric and Stratification</td></tr>
<tr><td></td><td></td><td>Rate</td><td>(Percent)</td></tr>
</table></td></tr>
</table>

Appendix 1

Glossary

Appendix 1

Glossary

access	A patient's ability to obtain medical care. Ease of access is determined by components such as availability of medical services and their acceptability to the patient, location of health care facilities, transportation, hours of operation and affordability of care.
Accreditation	An official authorization or designation to an organization determined by compliance with a set of industry-derived standards.
accuracy	The extent to which recorded data (on medical records, forms and computer databases) are error-free and reflect defining events.
acute care	Treatment of a short-term or episodic illness; treatment of an exacerbated chronic condition.
administrative database	Automated data, including claims and encounter systems used by an organization to manage delivery of health services to members.
Administrative Method	An organization must identify a measure's denominator and numerator, using transaction data or other administrative databases. The denominator comprises all eligible members. *See* initial population. The organization reports a rate based on all members who meet the denominator criteria and who are found through administrative data to have received a particular service.
algorithm	A method used to create a calculated result. For example, algorithms are used to combine medical record results with administrative results to produce a measure's rate.
ambulatory care	Outpatient health care services that do not require hospitalization, such as those delivered at a physician's office, clinic, medical or surgical center or outpatient facility.
attestation	A statement ensuring the validity of a report or document (e.g., practitioner attestation).
attribution basis	Health plan enrollment requirements for members to be included in a measure's initial population. Includes continuous enrollment and allowable gaps criteria.
audit	A systemic investigation of procedures and operations that determine conformity with prescribed criteria.
audit results	Designations that are assigned by the HEDIS Compliance Auditor indicating the report status of each measure.
benchmark	National, state and regional averages among organizations submitting data to NCQA. Benchmark data come from accredited and nonaccredited organizations and consist of reporting measures publicly and privately.

bias (degree of bias)	Degree of error. HEDIS rate measures are reported using a 95% confidence interval. A greater than 5% error in the reported rate is considered materially biased and receives a Biased Rate (BR) designation. For non-rate based measures, the error is greater than 10% for material bias and BR designation.
bundling	The organization accepts a single code as representative of several services or encounters. For example, prenatal care visits are bundled with delivery, or all hospital services may be under the revenue code for room and board.
CAHPS	Consumer Assessment of Healthcare Providers and Systems. The CAHPS Program is overseen by the Agency for Healthcare Research and Quality (AHRQ) and includes a number of survey products designed to capture consumer experience across different levels of the health care system. NCQA uses adult and child versions of the CAHPS Health Plan Survey for HEDIS and refers to them as the *CAHPS Health Plan Survey, Adult Version* and *CAHPS Health Plan Survey, Child Version.*
capitation	A set amount of money received or paid and based on membership rather than services delivered. Generally refers to a negotiated, per capita rate to be paid periodically (usually monthly) by an organization to a provider.
carve out	An organization sponsor (e.g., employer or purchaser) contracts for a service or function (e.g., mental health or laboratory) to be performed by an entity other than the organization.
chronic care	A general description of a medical condition from which a person may suffer periodically or continuously, as opposed to a condition that can be healed with treatment.
claim audit/ error rate	A rate that indicates the reliability of a claims processing system. Most organizations review a sample of processed claims to compute an error rate, usually expressed as financial and nonfinancial.
claim-dependent denominator	To determine the denominator through claims data (e.g., diabetic members are identified by claims showing diagnoses for diabetes or dispensing insulin).
concurrent audit	Evaluation of methods and data during the data collection period. HEDIS Compliance Audits take place during data collection, allowing organizations to correct errors before data are reported.
confidence level	The degree of confidence, expressed as a percentage, that a reported number's true value is between the lower and upper range specified.
continuous enrollment	The minimum amount of time, including allowed gaps, that a member must be enrolled in an organization to be eligible for a measure.
copayment	A fixed payment paid by a patient at each visit to an organization clinician or when receiving covered services in a health plan.
corrective action	An activity an organization completes between the onsite visit and data submission to correct problems that may result in a Biased Rate (BR) designation.
CPM	Committee on Performance Measurement. This committee decides the measures included in HEDIS and content or changes to these measures.

CQL	Clinical Quality Language. A Health Level Seven International® (HL7®) domain-specific language focused on clinical quality and targeted at measure authors. The CQL specification describes a machine-readable canonical representation, ELM, that is designed to enable sharing of clinical knowledge.
database	Data collected and organized in a computer file for ease of expansion, updating and retrieval.
data collection method	Data collection methods used in HEDIS are the Administrative Method (A), which includes claims and encounter data; the Hybrid Method (H), which combines claims/encounter data and chart (medical record) review data; Electronic Clinical Data Systems (ECDS), which includes data from electronic databases; and survey data collected through the CAHPS survey.
data completeness	Determination or evaluation of missing data. Data-completeness issues must be quantified and Biased Rate (BR) designations must be supported by determination of material bias.
data completeness assessment	An assessment of the effect of claim lag and encounter data submission rates on organization data completeness.
data consolidation	A combination of data from multiple sources, such as multiple electronic sources or electronic and medical record sources.
data extraction	Collecting data from medical records or from electronic and automated systems.
data integration	Combining data from multiple sources, with additional steps to ensure that duplicate data are removed and the remaining data are refined.
data integrity	Data that have not been altered or destroyed.
data reliability	A measure of data consistency based on reproducibility and an estimation of measurement error.
deductible	A fixed amount a patient must pay each year before an insurer will begin covering any part of the cost of care.
delegation	An organization gives another entity the authority to perform certain functions on its behalf, such as providing mental health care and laboratory and vision services. Delegation may also include service functions such as claims processing and call center functions. Although the organization may delegate the authority to perform a function, it may not delegate the responsibility for ensuring that the function is performed appropriately. Delegates of NCQA-Accredited health plans may also perform credentialing, utilization management and quality improvement activities.
direct pay	Premium payments made by members directly to the organization rather than through an intermediary such as an employer or state or federal program.
direct reference code	A single code that meets criteria for a service or condition. Listed in the measure specification; also included in the Direct Reference Codes spreadsheet of the VSD (as are direct reference codes used for measures reported using ECDS). **Note:** Value sets that contain only one code will be phased out (and turned into direct reference codes) as measures are digitalized.

discharges	The number of people released from a hospital.
disenrollment	Termination of participation in an organization.
ECDS	Electronic clinical data systems. A HEDIS reporting standard for health plans that collect and submit quality measures to NCQA. This reporting standard defines the data sources and types of electronic data acceptable for use in a HEDIS measure report. Data systems that may be eligible for ECDS reporting include, but are not limited to, administrative claims, clinical registries, health information exchanges, immunization information systems, disease/case management systems and electronic health records.
ELM	Expression Logical Model. A Unified Modeling Language™ specification for representing measure logic independent of syntax and special-purpose constructs introduced at the syntactic level. It is intended to enable distribution and sharing of computable quality logic.
EPO	Exclusive provider organization. A type of health insurance product that usually limits coverage to care from providers, or groups of providers, who have contracts with the health insurance issuer to be part of a network of participating providers. EPO members are generally not reimbursed, nor do they receive benefits for out-of-network services; however, some EPOs provide partial reimbursement for emergency situations.
external data	Automated data supplied by contracted practitioners, vendors or public agencies (e.g., pharmacies, labs, hospitals, schools, state public health agencies). External data can also come from electronic medical records (EMR). An EMR system is typically developed and maintained at a hospital or a physician's office and may be integrated (or linked) to the organization's system. External data files may be standard or nonstandard.
FAQ	Frequently asked questions posted to the NCQA website on the 15th of each month.
fee-for-service	A method of charging for medical services. A physician charges a fee for each service provided and the insurer or patient pays all or part of the fee.
FHIR®	Fast Healthcare Interoperability Resources. A specification standard for exchanging health care information electronically that supports exchange of structured and standardized data. Resources are defined and represented in common ways, and are built from data types that define common, reusable patterns of elements and share a common set of metadata.
HEDIS repository	A database or file system that stores HEDIS information, including practitioners, claims and membership, and which may be updated during the data collection period.
HIPAA	Health Insurance Portability and Accountability Act. Federal government standards regarding privacy regulation that set specific and explicit rights individuals have to access, make changes to and restrict the use of their protected health information. *See* PHI.

HMO	Health maintenance organization. An organized health care system that is accountable for both the financing and delivery of a broad range of comprehensive health services to an enrolled population, and for assessing access and ensuring quality and appropriate care. In this type of organization, members must obtain all services from practitioners affiliated with the HMO, and must usually comply with a predefined authorization system in order to receive reimbursement.
hybrid measure	A measure that requires identification of a numerator using administrative and medical record data. The denominator is a systematic sample of members drawn from the administrative denominator.
in-network	A predesignated set of providers in an organization is referred to as a *network of providers.* Members usually receive a higher rate of coverage when they see an in-network provider for care.
inclusiveness	The extent to which an entire population or defined group is intentionally included in a database.
indicator	HEDIS measures consist of one-to-many indicators, each corresponding to a specific rate. For measures with multiple metrics and/or stratifications, each indicator corresponds to a unique combination of metric and stratifications. For example, the Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents measure has three metrics, each with two age stratifications and a Total, resulting in nine indicators.
initial population	The initial population includes all persons who satisfy attribution criteria, including age, continuous enrollment, allowable gap, benefit, and event criteria.
inpatient	Procedures performed or services rendered to patients during a hospital stay.
internal data	Any automated data file created by the organization, which supplements the claim/encounter data in the HEDIS repository. The data can come from internal systems such as DM programs. Internal files are nonstandard.
interrater reliability	A methodology for quality control and evaluation of the medical record review process. Organizations use this method to compare a record reviewer's results to those of another reviewer.
LOS	Length of stay. Number of hospital days from admission to discharge.
LTI flag	Long Term Institutional flag. Identifies members who are long-term residents in an institution. This flag is populated in CMS's Monthly Membership Detail Data File.
measurement period	The period of time during which a measure is calculated.
measurement year	The year that an organization evaluates HEDIS measures.

medication list	Some measures require the use of clinical pharmacy data or pharmacy claims data to identify dispensed medications. The specifications reference medication lists that must be used for HEDIS reporting for each pharmacy-dependent measure. In the specifications, medication list references are underlined (e.g., Diabetes Medications List). Medication lists used for HEDIS reporting are included in the Medication List Directory. A medication list includes the National Drug Codes (NDC) and RxNorm codes that may be used for reporting along with the generic name, the brand name (if applicable), the strength/ dose and the route for each code.
member	An individual (and the individual's eligible dependents) who pays premiums to the organization as a member of the organization's enrollment population. Members usually receive specified health care services from a defined network for a specified time.
metric	Metrics are used in HEDIS submission and result XML files to group data elements and optional stratification values within a measure. For single-metric measures, the metric describes the subject of the measure. For multi-metric measures, the metrics describe the various concepts evaluated in the measure (e.g., BMIPercentile, PhysicalActivityCounseling and NutritionCounseling for the Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents measure).
network	Doctors, clinics, health centers, medical group practices, hospitals and other providers that an organization selects and contracts with to care for its members.
outpatient visits	Visits to providers that do not require hospital admission.
PHI	Protected health information. Information that can identify a specific person. Person-identified information is associated with names, social security numbers, alphanumeric codes or other unique individual information.
POS	Point of service. An HMO with an opt-out option. In this type of organization, members may choose to receive services either within the organization's health care system (e.g., an in-network practitioner) or outside the organization's health care delivery system (e.g., an out-of-network practitioner). The level of benefits or reimbursement is generally determined by whether the member uses in-network or out-of-network services. Common uses of "POS" include references to products that enroll each member in both an HMO (or HMO-like) system and in an indemnity product. A POS product is also referred to as an "HMO swing-out organization," an "out-of-organization benefits rider to an HMO" or an "open-ended HMO."
positive numerator event	Evidence of a measure-required service/events/diagnoses in either the administrative data or the medical record.
positive numerator hit	A person who satisfies the numerator requirements of a measure and who may be counted in the numerator. Some measures have multiple numerator requirements; for example, in the Childhood Immunization Status measure, the DTaP numerator requires four separate immunizations for a member to be a positive numerator hit.

PPO	Preferred provider organization. PPOs are responsible for providing health benefits-related services to covered individuals and for managing a practitioner network. They may administer health benefits programs for employers by assuming insurance risk or by providing only administrative services.
product	An organized health care system that is accountable for financing and delivering a broad range of comprehensive health services to an enrolled population (HMO, POS, PPO, EPO).
product line	Commercial, Medicaid, Medicare, Exchange.
provider	An institution or organization that provides services for the organization's members. Examples of providers include hospitals and home health agencies. NCQA uses the term *practitioner* to refer to professionals who provide health care services; however, it recognizes that a *provider directory* generally includes both providers and practitioners, and that the inclusive definition is the more common usage.
quality assurance	Activities that safeguard or improve quality of medical care.
rater-to-standard	A methodology for evaluating the medical record review process. Organizations using this method compare their medical record reviewers' results to a supervisor or lead reviewer's results and strive for consistency of reviewer results.
required benefit	HEDIS measures evaluate performance and hold organizations accountable for services provided in their members' benefits package. Measure specifications include benefits (i.e., medical, pharmacy, mental health, chemical dependency) required during the continuous enrollment period.
RES	Race and Ethnicity Stratification. NCQA requires reporting race and ethnicity as defined by the Office of Management and Budget (OMB) Standards for Maintaining, Collecting, and Presenting Federal Data on Race and Ethnicity.
retrospective audit	Evaluation of methods and data after the data collection period has ended. With this type of audit, organizations are not given a chance to correct errors before data are reported. HEDIS Compliance Audits are conducted using a *concurrent audit.*
risk adjustment	A statistical adjustment that controls for factors beyond the control of an organization so that results can be validly compared with those of other organizations.
scoring	Indicates how the calculation is performed for the measure, including proportion, ratio, continuous-variable, and cohort. The value set is extensible, allowing additional measure scoring types to be represented.
supplemental data	Data other than claims and encounters used by the organization to collect information about its members and about delivery of health services to its members.
systematic sample	The methodology that NCQA requires the organization to use to create a subset of members from the administrative denominator. This subset or sample is used for reporting hybrid measures.

telehealth	Synchronous telehealth requires real-time interactive audio and video telecommunications. Asynchronous telehealth, sometimes referred to as an "e-visit" or "virtual check-in," is not in real-time, but still requires two-way interaction between the member and provider. For example, asynchronous telehealth can occur through a patient portal, secure text messaging or email.
type	Indicates whether the measure is used to examine a process, an outcome over time, a patient-reported outcome, or a structure measure such as utilization.
validity	The extent to which data correspond to an actual event or documentation that supports a measure.
value sets	A value set contains two or more codes that meet criteria for a service or condition that is being measured. In the specifications, value set references are capitalized and underlined (e.g., Essential Hypertension Value Set). Organizations refer to the Value Set Directory (VSD) for codes in the value sets.

Practitioner Types

clinical pharmacist	A pharmacist with extensive education in the biomedical, pharmaceutical, sociobehavioral and clinical sciences. Clinical pharmacists are experts in the therapeutic use of medications and are a primary source of scientifically valid information and advice regarding the safe, appropriate and cost-effective use of medications. Most clinical pharmacists have a Doctor of Pharmacy (PharmD) degree, and many have completed one or more years of post-graduate training (e.g., a general and/or specialty pharmacy residency). In some states, clinical pharmacists have prescriptive authority.
mental health provider	A provider who delivers mental health services and meets any of the following criteria: • An MD or doctor of osteopathy (DO) who is certified as a psychiatrist or child psychiatrist by the American Medical Specialties Board of Psychiatry and Neurology or by the American Osteopathic Board of Neurology and Psychiatry; or, if not certified, who successfully completed an accredited program of graduate medical or osteopathic education in psychiatry or child psychiatry and is licensed to practice patient care psychiatry or child psychiatry, if required by the state of practice. • An individual who is licensed as a psychologist in their state of practice, if required by the state of practice. • An individual who is certified in clinical social work by the American Board of Examiners; who is listed on the National Association of Social Worker's Clinical Register; or who has a master's degree in social work and is licensed or certified to practice as a social worker, if required by the state of practice.

- A registered nurse (RN) who is certified by the American Nurses Credentialing Center (a subsidiary of the American Nurses Association) as a psychiatric nurse or mental health clinical nurse specialist, or who has a master's degree in nursing with a specialization in psychiatric/ mental health and 2 years of supervised clinical experience, and is licensed to practice as a psychiatric or mental health nurse if required by the state of practice.
- An individual (normally with a master's or a doctoral degree in marital and family therapy and at least 2 years of supervised clinical experience) who practices as a marital and family therapist, and is licensed as a certified counselor by the state of practice, or, if licensure or certification is not required by the state of practice, who is eligible for clinical membership in the American Association for Marriage and Family Therapy.
- An individual (normally with a master's or doctoral degree in counseling and at least 2 years of supervised clinical experience) who practices as a professional counselor, and is licensed or certified to do so by the state of practice, or, if licensure or certification is not required by the state of practice, is a National Certified Counselor with a Specialty Certification in Clinical Mental Health Counseling from the National Board for Certified Counselors.
- A physician assistant who is certified to practice psychiatry by the National Commission on Certification of Physician Assistants.
- A certified community mental health center (CMHC), or the comparable term (e.g., behavioral health organization, mental health agency, behavioral health agency) used in the state of location, or a Certified Community Behavioral Health Clinic (CCBHC).

  Only authorized CMHCs are considered mental health providers. To be authorized as a CMHC, an entity must meet one of the following criteria:

  – The entity has been certified by CMS to meet the conditions of participation (CoPs) that community mental health centers (CMHCs) must meet in order to participate in the Medicare program, as defined in the Code of Federal Regulations Title 42. CMS defines a CMHC as an entity that meets applicable licensing or certification requirements for CMHCs in the State in which it is located and provides the set of services specified in section 1913(c)(1) of the Public Health Service Act (PHS Act).
  – The entity has been licensed, operated, authorized, or otherwise recognized as a CMHC by a state or county in which it is located.

  Only authorized CCBHCs are considered mental health providers. To be authorized as a CCBHC, an entity must meet one of the following criteria:

  – Has been certified by a State Medicaid agency as meeting criteria established by the Secretary for participation in the Medicaid CCBHC demonstration program pursuant to Protecting Access to Medicare Act.
  – § 223(a) (42 U.S.C. § 1396a note); or as meeting criteria within the State's Medicaid Plan to be considered a CCBHC.

	– Has been recognized by the Substance Abuse and Mental Health Services Administration, through the award of grant funds or otherwise, as a CCBHC that meets certification criteria of a CCBHC.
OB/GYN and other prenatal care practitioner	Includes: • Physicians certified as obstetricians or gynecologists by the American Medical Specialties Board of Obstetrics or Gynecology or the American Osteopathic Association; or, if not certified, who successfully completed an accredited program of graduate medical or osteopathic education in obstetrics and gynecology. • Certified nurse midwives, nurse practitioners or physician assistants who deliver prenatal care services in a specialty setting (under the direction of an OB/GYN certified or accredited provider). • Direct entry midwives who deliver prenatal and postpartum services, in a specialty setting (under the direction of an OB/GYN certified or accredited provider) and are licensed in their state of practice.
ongoing care provider	A practitioner who assumes responsibility for the member's care.
PCP	Primary care practitioner. A physician or nonphysician (e.g., nurse practitioner, physician assistant, certified nurse midwife) who offers primary care medical services. Licensed practical nurses and registered nurses are not considered PCPs. Only certified Federally Qualified Health Centers (FQHC) are considered PCPs. This must be reviewed and approved by an auditor. To be certified as an FQHC, an entity must meet any one of the following criteria: • Is receiving a grant under Section 330 of the Public Health Service (PHS) Act (42 United States Code Section 254a) or is receiving funding from such a grant and meets other requirements. • Is not receiving a grant under Section 330 of the PHS Act but is determined by the Secretary of the Department of Health & Human Services (HHS) to meet the requirements for receiving such a grant (qualifies as a "FQHC look-alike") based on the recommendation of the Health Resources and Services Administration. • Was treated by the Secretary of HHS for purposes of Medicare Part B as a comprehensive federally funded health center as of January 1, 1990. • Is operating as an outpatient health program or facility of a tribe or tribal organization under the Indian Self Determination Act or as an urban Indian organization receiving funds under Title V of the Indian Health Care Improvement Act as of October 1991. • For certification as an FQHC, the entity must meet all of the following criteria (in addition to one of the criteria above): – Provide comprehensive services and have an ongoing quality assurance program. – Meet other health and safety requirements. – Not be concurrently approved as a Rural Health Clinic (RHC).

	▪ Only certified RHCs are considered PCPs. This must be reviewed and approved by an auditor. To be certified as an RHC, the entity must meet CMS requirements to qualify for payment via an all-inclusive rate (AIR) for medically-necessary primary health services and qualified preventive health services furnished by an RHC practitioner.
practitioner	A professional who provides health care services. Practitioners must usually be licensed as defined by law.
prescribing practitioner	A practitioner with prescribing privileges, including nurse practitioners, physician assistants and other non-MDs who have the authority to prescribe medications.
provider	An institution or organization that provides services for the organization's members. Examples of providers include hospitals and home health agencies. NCQA uses the term *practitioner* to refer to professionals who provide health care services, recognizing that a provider directory generally includes both providers and practitioners, and that the inclusive definition is the more common usage.

Appendix 2

Data Element Definitions

Appendix 2

Data Element Definitions

Organizations that submit audited HEDIS data to NCQA report the data elements identified in each measure specification. Data elements are standard for hybrid, administrative, digital and ECDS reported measures.

Table 1: Data Element Definitions for Reporting

Data Element	Description	Admin	Hybrid	ECDS	Meaning
CollectionMethod	Data collection methodology	✓	✓	✓	Method used to collect HEDIS data. The Administrative Method is from transactional data for the denominator and the Hybrid Method is from medical record or electronic medical record and transactional data for the sample. Only reported for measures allowing both the Administrative and the Hybrid Method. ECDS uses electronic method for data collection.
Benefit	Benefit	✓	✓	✓	For measures requiring a benefit other than Medical, the Benefit flag is reported in the Metadata section of the submission XML.
InitialPopulation	Initial population	✓	✓	✓	Number of members in the initial population.
Exclusions	Number of required exclusions	✓	✓	✓	Number of members excluded from the initial population based on transaction data because they did meet the required exclusion criteria.
NumeratorByAdminDenom	Number of numerator events by administrative data in the administrative denominator		✓		The number of members in the administrative denominator who met the numerator criteria. *This may or may not include supplemental data, it depends on when an organization loads its supplemental data for reporting.*
CYAR	Current year's administrative rate		✓		This is a calculated field in IDSS. NumeratorByAdminDenom / (InitialPopulation – Exclusions) *This rate may or may not include numerator events by supplemental data.*
MinReqSampleSize	Minimum required sample size (MRSS)		✓		When selecting the sample, this is the required number of members in the sample. Organizations can reduce their samples using Tables 2 in the sampling guidelines.
OversampleRate	Oversampling rate		✓		The percentage of additional records used only to replace exclusions and valid data errors in the denominator reported as a proportion. Organizations that need more than a 20% oversample must contact NCQA. The oversample rate should reflect the true percentage that an organization needs to maintain the MRSS and should not result in an amount larger than the administrative denominator.

Data Element	Description	Admin	Hybrid	ECDS	Meaning
OversampleRecordsNumber	Number of oversample records		✓		This is a calculated field in IDSS. MinReqSampleSize * OversampleRate (rounded up to next whole number) *Oversample records should be used only to replace cases taken out of the sample because of valid data errors, false positives, etc., otherwise, not all records will be reported in the final denominator.*
ExclusionValidDataErrors	Number of original sample records excluded because of valid data errors		✓		If medical record review shows that the member does not meet the criteria outlined in the administrative denominator, that member is considered a valid data error. If an administrative exclusion is found during data refresh, the member is also considered a valid data error.
ExclusionEmployeeOrDep	Number of employee/ dependent medical records excluded		✓		Number of records in the sample excluded because the member was an organization employee or a dependent of an organization employee. *Employees/dependents are only excluded from the sample, they are not removed from the initial population.*
OversampleRecsAdded	Records added from the oversample list		✓		Replacement records for members in the sample who had an exclusion or valid data error. *This number should not exceed the number of oversample records and should be accounted for in the exclusion categories above.*
Denominator	Denominator	✓	✓	✓	For the Administrative Method and ECDS, the initial population minus exclusions. For the Hybrid Method the final sample size: MRSS – exclusions + members added from the oversample list.
NumeratorByAdmin	Numerator events by administrative data	✓	✓		The number of members in the denominator who met numerator criteria using transactional data.
NumeratorBySupplemental	Numerator events by supplemental data	✓	✓		The number of members in the denominator who met numerator criteria using supplemental data (includes standard and nonstandard data). This data element is collected for only EOC and EOC-like measures.
NumeratorByMedicalRecords	Numerator events by medical records		✓		The number of members in the denominator who met numerator criteria using medical record data.
Numerator	Numerator	✓	✓	✓	The number of members in the denominator who met numerator criteria as an aggregate across all data sources. This is reported in the ECDS and Race Ethnicity Stratification Tables.
Rate	Reported rate	✓	✓	✓	This is a calculated field in IDSS. *Administrative Method:* NumeratorByAdmin ÷ Denominator. *Hybrid Method*: (NumeratorByAdmin + NumeratorByMedicalRecords) ÷ Denominator.

Data Element	Description	Admin	Hybrid	ECDS	Meaning
					ECDS Method: Numerator ÷ Denominator Measures that collect numerator events by supplemental data: *Administrative:* (NumeratorByAdmin + NumeratorBySupplemental) ÷ Denominator. *Hybrid:* (NumeratorByAdmin + NumeratorBySupplemental + NumeratorByMedicalRecords) ÷ Denominator.

Reporting Instruction Explanations

Reporting Instructions	Explanation
Metadata	For Measures requiring a benefit other than Medical, the Benefit flag is reported in the Metadata section of the submission XML.
For each Metric	Report independent values for each metric.
For each Stratification*	Report independent values for each stratification.
For each Metric and Stratification*	Report independent values for each metric and stratification.
Report once	For single Indicator measures.
Repeat per Metric	The same value is repeated across all Metrics. Used e.g., when the same Denominator is used for the calculation of multiple rates within a measure (e.g., CIS, IMA).
Repeat per Stratification*	The same value is repeated across all Stratifications. This is common for measures using the Hybrid collection method where a single sample is drawn for all stratifications. The sample corresponds to the Total stratification but plans only report the individual stratifications. Therefore, plans must repeat the sample data elements for all stratifications.
Repeat per Metric and Stratification*	The same value is repeated across all Metrics and Stratifications. For example, the Hybrid sample data elements for WCC and TRC when reporting using the Hybrid collection method.
For each Stratification, repeat per Metric*	Report independent values for each stratification but repeat these for the same stratifications over multiple metrics.
For each Metric, repeat per Stratification*	Report independent values for each Metric but repeat these for all stratifications within each Metric (e.g., CollectionMethod).
Only for Total	Only used for CYAR in stratified measures. Plans report NumeratorByAdminDenom (Number of numerator events by administrative data in the administrative denominator) for each stratification, but IDSS calculates the CYAR (Current year's administrative rate), only at the total stratification. Only this total CYAR can be used to reduce the minimum required sample size for measures where this is allowed. Refer to the *Guidelines for Calculations and Sampling* for more information.

*For measures with multiple stratifications, the reporting instructions apply to all stratification combinations.

3. QRS Clinical Measure Specifications

3.1 NCQA Measure Specifications

3.2 PQA Measure Specifications

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3.2 PQA Measure Specifications

Overview

Pharmacy Quality Alliance (PQA, Inc.)

PQA is a consensus-based, multi-stakeholder membership organization committed to optimizing health by advancing the quality of medication use. Established in 2006, PQA is a 501(c)3 designated non-profit alliance with over 240 member organizations.

PQA Measure Development Process

PQA uses a systematic, transparent, consensus-based process to conceptualize, specify, test, endorse, and maintain measures of medication use quality. PQA's measure life cycle centers on standard criteria for evaluating measures, which include importance, scientific acceptability, feasibility, and usability, ensuring that PQA measures are evidence-based, precisely specified, valid, reliable, feasible, and usable measure while advancing national quality goals.

Measure Conceptualization:

The goal of the measure conceptualization phase is to generate and prioritize a list of measure concepts for potential development. This prioritization process ensures that PQA devotes resources to developing measures that are high-impact and address areas of need. The measure conceptualization phase includes the following activities:

1. Environmental scan
2. Measure Concept Advisory Group input
3. Public comment Period

Measure Specification:

The goal of the measure specification phase is to create and refine specifications to produce a measure concept that is ready to be tested. The measure specification phase includes the following activities:

1. Draft specification and feasibility testing
2. Technical Expert Panel input

Measure Testing:

Measure testing occurs both for new measure concepts as well as PQA-endorsed measures undergoing maintenance. The primary goal of measure testing is to apply the measure (or measure concept) draft specifications to test data representative of the intended population to determine the measure's scientific acceptability. During testing, PQA evaluates whether the measure meets (or continues to meet) the criteria of reliability (the measure consistently captures true differences in performance on the construct, as opposed to differences due to chance variation) and validity (the measure truly captures the intended concept of the construct).

Beyond scientific acceptability, measure testing also evaluates the existence of performance gaps and may inform outstanding specification questions, such as the appropriateness of exclusions given their frequency in test data. The answers to these questions may result in additional refinement of the draft measure specifications.

The measure testing phase includes the following activities:

1. Alpha testing
2. Testing plan development
3. Initial Quality Metrics Expert Panel (QMEP) Review
4. Beta testing
5. Face validity assessment
6. Final QMEP Review

Measure Endorsement:

After QMEP approval, the measure concept is considered by PQA's membership for an endorsement vote. By the time a measure concept is approved by the QMEP to move forward for endorsement consideration, it has gone through PQA's consensus-based development process and is found to meet PQA's measure criteria. The measure endorsement process consists of the following activities:

1. Public comment period and Measure Endorsement and Retirement meeting
2. Membership vote

Measure Implementation and Maintenance:

The measure life cycle does not end when a measure is endorsed. In addition to PQA's role as a measure developer, PQA is a measure steward, which entails promoting measure implementation with outreach and education, supporting measure use with technical assistance, and performing continuous evaluation to ensure that PQA measures remain current, appropriate and impactful in light of new treatments coming to the market or the emergence of new clinical evidence or standards. Measure Implementation.

The measure implementation and maintenance phase includes the following activities:

1. Measure implementation and use
2. Technical assistance
3. Continuous evaluation of measures
4. Measure retirement

Updated: 2/23/2026

General Guidelines for the *Proportion of Days Covered: Renin Angiotensin System Antagonists, Proportion of Days Covered: Statins,* and *Proportion of Days Covered: Diabetes All Class* Measure Data Collection.

Refer to the General Guidelines for Data Collection and Reporting in Section 3.1, Measurement Year 2026 (MY 2026) HEDIS® General Guidelines for the QRS Measure Technical Specifications, for details that will inform appropriate data collection for the *Proportion of Days Covered: Renin Angiotensin System Antagonists* (PDC-RASA), *Proportion of Days Covered: Statins* (PDC-STA), and *Proportion of Days Covered: Diabetes All Class* (PDC-DR) measures. All general guidelines apply, except for the following items specified below.

PQA Posting of the Value Sets

The Value Sets for PQA measures will be available by request from PQA. Please refer to the PQA website in order to obtain the Value Sets, including National Drug Code (NDC) lists, at https://www.pqaalliance.org/QRS.

The final Value Sets, including NDC lists, for 2027 are available as of March 31, 2026. The NDC lists includes current NDCs from January 1, 2025 through December 31, 2025, and NDCs with obsolete dates of July 1, 2024 or after.

Required Data Elements for PQA Measures

The reporting tables in the measure specifications outline the data elements required for reporting. For more information, refer to *General Guideline: Reporting Tables* in the General Guidelines for Data Collection and Reporting section.

Proportion of Days Covered: Renin Angiotensin System Antagonists (PDC-RASA)

Measure title	Proportion of Days Covered: Renin Angiotensin System Antagonists	**Measure ID**	PDC-RASA
Description	The percentage of members ≥18 years of age who met the proportion of days covered (PDC) threshold of 80 percent for RAS antagonists during the measurement period.		
Measurement period	January 1–December 31.		
Clinical recommendation statement/ rationale	The body of evidence linking adherence to reduced costs and improved outcomes is substantial and consistent, as adherence has been the subject of extensive research over the past several decades. Multiple studies have indicated that adherence to RAS antagonists exceeding the 80% threshold is associated with fewer inpatient, outpatient, and emergency visits, lower all-cause mortality, and lower total healthcare costs. The Centers for Medicare & Medicaid Services (CMS) 2024 Impact Assessment Report found that health care costs avoided due to improved patient medication adherence were estimated at $4.2 billion-$25.9 billion, providing robust evidence of the economic benefits of medication adherence. For RAS antagonists specifically, the CMS 2024 Impact Assessment estimated health care costs avoided due to improved adherence to be $12.4 billion to $15.8 billion (Medicare Part D), and $405.5 million to $515.6 Million (Health Insurance Marketplace).		
Citations	Sokol MC, McGuigan KA, Verbrugge RR, Epstein RS. Impact of medication adherence on hospitalization risk and healthcare cost. Med Care. 2005;43:521-30. PMID: 15908846. Ho PM, Magid DJ, Masoudi FA, et al. Adherence to cardioprotective medications and mortality among patients with diabetes and ischemic heart disease. BMC Cardiovasc Disord. 2006;6:48. PMID: 17173679. Roebuck MC, Liberman JN, Gemmill-Toyama M, et al. Medication adherence leads to lower health care use and costs despite increased drug spending. Health Aff. 2011; 30:91-9. PMID: 21209444. Choudhry NK, Glynn RJ, Avorn J, et al. Untangling the relationship between medication adherence and post-myocardial infarction outcomes: medication adherence and clinical outcomes. Am Heart J. 2014;167:51-58.e5. PMID: 24332142. Roebuck MC, Kaestner RJ, Dougherty JS. Impact of Medication Adherence on Health Services Utilization in Medicaid. Med Care. 2018;56:266-273. PMID: 29309392. Centers for Medicare & Medicaid Services. *2024 National Impact Assessment of the Centers for Medicare & Medicaid Services (CMS) Quality Measures Report*. 2024. Accessed August 12, 2025.		

	https://www.cms.gov/files/document/2024-national-impact-assessment-report.pdf.
Characteristics	
Scoring	Proportion.
Type	TBD.
Product line	Exchange.
Stratifications	None.
Risk adjustment	None.
Improvement notation	Increased score indicates improvement.
Guidance	**Data collection methodology:** Administrative. Refer to *General Guideline: Data Collection Methods* for additional information. **Date specificity:** Date must be specific enough to determine the event occurred in the period being measured. **Which services count?** Only paid, non-reversed prescription claims are included in the data set to calculate the measure. **Supplemental data exceptions:** Supplemental data may not be used for this measure, except for hospice exclusion.
Definitions	
Calculating number of days covered for the numerator	If multiple prescriptions for different target medications (i.e., two or more products within the same therapeutic category, but with different generic ingredients) are dispensed on the same day, count the number of days covered using the prescription with the longest days' supply. If multiple prescriptions for different target medications (i.e., two or more products within the same therapeutic category, but with different generic ingredients) are dispensed on different days with overlapping days' supply, count each day covered by a target medication only once within the treatment period. *For example: if a prescription for aliskiren and a prescription for azilsartan are filled 5 days apart and each has a 30-day supply, then the total days covered is 35.* If multiple prescriptions for the same target medication (i.e., one or more products with the same generic ingredient) are dispensed on the same day or different days where the days' supply overlap, adjust the prescription start date to be the day after the previous fill has ended.

	For example: if three prescriptions for the same target medication are dispensed on the same day, each with a 30-day supply, then a total of 90 days are covered. Overlap adjustment should also occur when there is an overlap of a single target drug product to a combination product containing the single target drug (i.e., same generic ingredient) or when there is an overlap of a combination product to another combination product where at least one of the target drugs (i.e., same generic ingredient) is common. Any days' supply that extends beyond the end of the treatment period are not included when calculating the total number of days covered. The NDC list for each class of medications includes flags for each target medication. The flags will help determine whether the prescription (NDC) includes the same or different target medication.
IPSD	Index prescription start date. The earliest date of service for a target medication during the measurement period.
PDC	Proportion of days covered. The proportion of days in the treatment period "covered" by prescription claims for the same medication or another in its therapeutic category.
PDC threshold	The level of PDC above which the medication has a reasonable likelihood of achieving most of the potential clinical benefit (i.e., 80% for diabetes and cardiovascular drugs, and many chronic conditions).
Renin Angiotensin System (RAS) Antagonists	ACEI/ARB/direct renin inhibitor or ACEI/ARB/direct renin inhibitor combination product. Refer to Renin Angiotensin System (RAS) Antagonists Value Set.
Treatment period	The member's treatment period begins on the IPSD and extends through whichever comes first: the last day of enrollment during the measurement period, death, or the end of the measurement period. The treatment period should be at least 91 days.
Initial population	*Measure item count:* Member. *Attribution basis:* Enrollment. • *Benefits:* Medical and Pharmacy. • *Continuous enrollment:* The treatment period. • *Allowable gap:* Exclude members with more than one 1-day gap in enrollment during the treatment period. *Note: This allows only a single 1-day gap to compensate for discrepancies in the enrollment data. For example, a member who was eligible from January 1–April 1 and April 3–April December 31 would still be continuously enrolled despite the 1-day gap in eligibility on April 2.* *Ages:* ≥18 years of age as of the first day of the measurement period.

	Event: **Members with ≥2 prescription claims for any RAS antagonist (Renin Angiotensin System (RAS) Antagonists Value Set) on different dates of service in the treatment period.** **Step 1.** Identify members ≥18 years of age as of the first day of the measurement period. **Step 2.** Identify members with ≥2 prescription claims on different dates of service for any RAS antagonist (Renin Angiotensin System (RAS) Antagonists Value Set) during the measurement period. The prescription claims can be for the same or different medications. **Step 3.** Determine each member's treatment period. **Step 4.** Identify members with a treatment period that is ≥91 days during the measurement period. **Step 5**. Identify members meeting the continuous enrollment requirement during the treatment period.
Denominator exclusions	**Members in hospice or using hospice services.** Members who use hospice services (Hospice Encounter Value Set; Hospice Intervention Value Set) or elect to use a hospice benefit any time during the measurement period. Organizations that use the Monthly Membership Detail Data File to identify these members must use only the run date of the file. **Members with end-stage renal disease (ESRD) diagnosis.** Members with a diagnosis of ESRD (ESRD Exclusion Value Set*) any time during the measurement period. An ESRD diagnosis is defined as having ≥1 claim with ESRD in the primary diagnosis or any other diagnosis fields during the measurement period. **Members with sacubitril/valsartan medication.** Members with ≥1 prescription claims for the medication sacubitril/valsartan (Sacubitril/Valsartan Exclusion Value Set) during the treatment period. **Coding Guidance** *Do not include laboratory claims (claims with POS code 81).
Denominator	Initial population minus denominator exclusions.
Numerator	**Members who met the PDC threshold during the measurement period.** Follow the steps below for each member to determine whether the member meets the PDC threshold. **Step 1.** Determine the treatment period. **Step 2.** Within the treatment period, count the days the member was covered by at least one RAS antagonist medication (Renin Angiotensin System [RAS] Antagonists Value Set) based on the date of service and days' supply on the prescription claims. If the days' supply for prescription claims with the same target drug (generic ingredient) overlap, then adjust the prescription claim's start date to be the day after the last days' supply for the previous prescription claim. Adjustment of overlap should also occur when there is overlap of a single drug product to a combination product containing the single target drug or when

<table>
<tr><td></td><td>there is an overlap of a combination product to another combination product where at least one of the target drugs is common.

Step 3. Divide the number of covered days found in step 2 by the number of days found in step 1. Multiply this number by 100 to obtain the PDC (as a percentage) for each member. Then round the PDC to the nearest hundredth (e.g., 79.996% is rounded to 80.00%, 79.992% is rounded to 79.99%).

Step 4. Count the number of members who had a PDC of ≥80.00% and then divide by the total number of eligible members.</td></tr>
<tr><td>Summary of changes</td><td>• This measure resulted from the separation of indicators in the Proportion of Days Covered.
• Added definition for Renin Angiotensin System (RAS) Antagonists.
• Removed definition for Prescription Claims, as this information is now in the Guidance section.</td></tr>
<tr><td>Data element tables</td><td>Organizations that submit data to NCQA must provide the following data elements.

Table PDC-RASA-4: Data Elements for Proportion of Days Covered: Renin Angiotensin System Antagonists
<table>
<tr><th>Metric</th><th>Data Element</th><th>Reporting Instructions</th></tr>
<tr><td>RASAntagonists</td><td>Benefit</td><td>Metadata</td></tr>
<tr><td></td><td>InitialPopulation</td><td>Report once</td></tr>
<tr><td></td><td>Exclusions</td><td>Report once</td></tr>
<tr><td></td><td>Denominator</td><td>Report once</td></tr>
<tr><td></td><td>NumeratorByAdmin</td><td>Report once</td></tr>
<tr><td></td><td>Rate</td><td>(Percent)</td></tr>
</table></td></tr>
</table>

Proportion of Days Covered: Statins (PDC-STA)

Measure title	Proportion of Days Covered: Statins	**Measure ID**	PDC-STA
Description	The percentage of members ≥18 years of age who met the proportion of days covered (PDC) threshold of 80 percent for statins during the measurement period.		
Measurement period	January 1–December 31.		
Clinical recommendation statement/ rationale	The body of evidence linking adherence to reduced costs and improved outcomes is substantial and consistent, as adherence has been the subject of extensive research over the past several decades. Multiple studies have indicated that adherence to statins exceeding the 80% threshold is associated with fewer inpatient, outpatient, and emergency visits, lower all-cause mortality, and lower total health care costs. The Centers for Medicare & Medicaid Services (CMS) 2024 Impact Assessment Report found that health care costs avoided due to improved patient medication adherence were estimated at $4.2 billion-$25.9 billion, providing robust evidence of the economic benefits of medication adherence. For statins specifically, the CMS 2024 Impact Assessment estimated health care costs avoided due to improved adherence to be $11.6 Billion (Medicare Part D) and $732.5 Million (Health Insurance Marketplace).		
Citations	Wei L, Wang J, Thompson P, et al. Adherence to statin treatment and readmission of patients after myocardial infarction: a six year follow up study. Heart. 2002;88:229-33. PMID: 12181210. Sokol MC, McGuigan KA, Verbrugge RR, Epstein RS. Impact of medication adherence on hospitalization risk and healthcare cost. Med Care. 2005;43:521-30. PMID: 15908846. Ho PM, Magid DJ, Masoudi FA, et al. Adherence to cardioprotective medications and mortality among patients with diabetes and ischemic heart disease. BMC Cardiovasc Disord. 2006;6:48. PMID: 17173679. Roebuck MC, Liberman JN, Gemmill-Toyama M, et al. Medication adherence leads to lower health care use and costs despite increased drug spending. Health Aff. 2011; 30:91-9. PMID: 21209444. Choudhry NK, Glynn RJ, Avorn J, et al. Untangling the relationship between medication adherence and post-myocardial infarction outcomes: medication adherence and clinical outcomes. Am Heart J. 2014;167:51-58.e5. PMID: 24332142. Korhonen MJ, Ruokoniemi P, Ilomäki J, et al. Adherence to statin therapy and the incidence of ischemic stroke in patients with diabetes. Pharmacoepidemiol Drug Saf. 2016;25:161-9. PMID: 26687512. Chinthammit C, Axon D, Anderson S, et al. A retrospective database analysis evaluating the association between Pharmacy Quality Alliance cholesterol medication adherence measure and economic outcomes for commercially		

	insured patients. J Manag Care Spec Pharm. 2019;25:3-a Suppl, I17. PMID: 30854912. Centers for Medicare & Medicaid Services. *2024 National Impact Assessment of the Centers for Medicare & Medicaid Services (CMS) Quality Measures Report*. 2024. Accessed August 12, 2025. https://www.cms.gov/files/document/2024-national-impact-assessment-report.pdf.
Characteristics	
Scoring	Proportion.
Type	TBD.
Product line	Exchange.
Stratifications	None.
Risk adjustment	None.
Improvement notation	Increased score indicates improvement.
Guidance	**Data collection methodology:** Administrative. Refer to *General Guideline: Data Collection Methods* for additional information. **Date specificity:** Date must be specific enough to determine the event occurred in the period being measured. **Which services count?** Only paid, non-reversed prescription claims are included in the data set to calculate the measure. **Supplemental data exceptions:** Supplemental data may not be used for this measure, except for hospice exclusion.
Definitions	
Calculating number of days covered for the numerator	If multiple prescriptions for different target medications (i.e., two or more products within the same therapeutic category, but with different generic ingredients) are dispensed on the same day, count the number of days covered using the prescription with the longest days' supply. If multiple prescriptions for different target medications (i.e., two or more products within the same therapeutic category, but with different generic ingredients) are dispensed on different days with overlapping days' supply, count each day covered by a target medication only once within the treatment period. *For example: if a prescription for simvastatin and a prescription for atorvastatin are filled 5 days apart and each has a 30-day supply, then the total days covered is 35.* If multiple prescriptions for the same target medication (i.e., one or more products with the same generic ingredient) are dispensed on the same day or different days where the days' supply overlap, adjust the prescription start date to be the day after the previous fill has ended.

	For example: if three prescriptions for the same target medication are dispensed on the same day, each with a 30-day supply, then a total of 90 days are covered. Overlap adjustment should also occur when there is an overlap of a single target drug product to a combination product containing the single target drug (i.e., same generic ingredient) or when there is an overlap of a combination product to another combination product where at least one of the target drugs (i.e., same generic ingredient) is common. Any days' supply that extends beyond the end of the treatment period are not included when calculating the total number of days covered. The NDC list for each class of medications includes flags for each target medication. The flags will help determine whether the prescription (NDC) includes the same or different target medication.
IPSD	Index prescription start date. The earliest date of service for a target medication during the measurement period.
PDC	Proportion of days covered. The proportion of days in the treatment period "covered" by prescription claims for the same medication or another in its therapeutic category.
PDC threshold	The level of PDC above which the medication has a reasonable likelihood of achieving most of the potential clinical benefit (i.e., 80% for diabetes and cardiovascular drugs, and many chronic conditions).
Statin medications	Statin or statin combination products. See Statins Value Set.
Treatment period	The member's treatment period begins on the IPSD and extends through whichever comes first: the last day of enrollment during the measurement period, death, or the end of the measurement period. The treatment period should be at least 91 days.
Initial population	*Measure item count:* Member. *Attribution basis:* Enrollment. • *Benefits:* Medical and Pharmacy. • *Continuous enrollment:* The treatment period. • *Allowable gap:* Exclude members with more than one 1-day gap in enrollment during the treatment period. *Note: This allows only a single 1-day gap to compensate for discrepancies in the enrollment data. For example, a member who was eligible from January 1–April 1 and April 3–April December 31 would still be continuously enrolled despite the 1-day gap in eligibility on April 2.* *Ages:* ≥18 years of age as of the first day of the measurement period. *Event:* **Members with ≥2 prescription claims for any statin (Statins Value Set) on different dates of service in the treatment period.** **Step 1.** Identify members ≥18 years of age as of the first day of the measurement period.

	Step 2. Identify members with ≥2 prescription claims on different dates of service for any statin medication (Statins Value Set) during the measurement period. The prescription claims can be for the same or different medications. **Step 3.** Determine each member's treatment period. **Step 4.** Identify members with a treatment period that is ≥91 days during the measurement period. **Step 5.** Identify members meeting the continuous enrollment requirement during the treatment period.
Denominator exclusions	**Members in hospice or using hospice services.** Members who use hospice services (Hospice Encounter Value Set; Hospice Intervention Value Set) or elect to use a hospice benefit any time during the measurement period. Organizations that use the Monthly Membership Detail Data File to identify these members must use only the run date of the file. **Members with end-stage renal disease (ESRD) diagnosis.** Members with a diagnosis of ESRD (ESRD Exclusion Value Set*) any time during the measurement period. An ESRD diagnosis is defined as having ≥1 claim with ESRD in the primary diagnosis or any other diagnosis fields during the measurement period. **Coding Guidance** *Do not include laboratory claims (claims with POS code 81).
Denominator	Initial population minus denominator exclusions.
Numerator	**Members who met the PDC threshold during the measurement period.** Follow the steps below for each member to determine whether the member meets the PDC threshold. **Step 1.** Determine the treatment period. **Step 2.** Within the treatment period, count the days the member was covered by at least one statin medication (Statins Value Set) based on the date of service and days' supply on the prescription claims. If the days' supply for prescription claims with the same target drug (generic ingredient) overlap, then adjust the prescription claim's start date to be the day after the last days' supply for the previous prescription claim. Adjustment of overlap should also occur when there is overlap of a single drug product to a combination product containing the single target drug or when there is an overlap of a combination product to another combination product where at least one of the target drugs is common. **Step 3.** Divide the number of covered days found in step 2 by the number of days found in step 1. Multiply this number by 100 to obtain the PDC (as a percentage) for each member. Then round the PDC to the nearest hundredth (e.g., 79.996% is rounded to 80.00%, 79.992% is rounded to 79.99%). **Step 4.** Count the number of members who had a PDC of ≥80.00% and then divide by the total number of eligible members.
Summary of changes	• This measure resulted from the separation of indicators in the Proportion of Days Covered. • Added definition for statins.

<table>
<tr><td></td><td>• Removed definition for Prescription Claims, as this information is now in the Guidance section.</td></tr>
<tr><td>Data element tables</td><td>Organizations that submit data to NCQA must provide the following data elements.
Table PDC-STA-4: Data Elements for Proportion of Days Covered: Statins
<table>
<tr><th>Metric</th><th>Data Element</th><th>Reporting Instructions</th></tr>
<tr><td>Statins</td><td>Benefit</td><td>Metadata</td></tr>
<tr><td></td><td>InitialPopulation</td><td>Report once</td></tr>
<tr><td></td><td>Exclusions</td><td>Report once</td></tr>
<tr><td></td><td>Denominator</td><td>Report once</td></tr>
<tr><td></td><td>NumeratorByAdmin</td><td>Report once</td></tr>
<tr><td></td><td>Rate</td><td>(Percent)</td></tr>
</table></td></tr>
</table>

Proportion of Days Covered: Diabetes All Class (PDC-DR)

Measure title	Proportion of Days Covered: Diabetes All Class	**Measure ID**	PDC-DR
Description	The percentage of members ≥18 years of age who met the proportion of days covered (PDC) threshold of 80 percent for diabetes medications during the measurement period.		
Measurement period	January 1–December 31.		
Clinical recommendation statement/ rationale	The body of evidence linking adherence to reduced costs and improved outcomes is substantial and consistent, as adherence has been the subject of extensive research over the past several decades. Multiple studies have indicated that adherence to diabetes medications exceeding the 80% threshold is associated with fewer inpatient, outpatient, and emergency visits, lower all-cause mortality, and lower total health care costs. The CMS 2024 Impact Assessment Report found that health care costs avoided based on patient impacts were estimated at $4.2 billion-$25.9 billion, providing robust evidence of the economic benefits of medication adherence. For diabetes medications specifically, the CMS 2024 Impact Assessment estimated health care costs avoided due to improved adherence to be $505.9 Million to $1.8 Billion (Medicare Part D) and $61.4 Million to $214.4 Million (Health Insurance Marketplace).		
Citations	Lau DT, Nau DP. Oral antihyperglycemic medication nonadherence and subsequent hospitalization among individuals with type 2 diabetes. Diabetes Care. 2004;27:2149-53. PMID: 15333476. Sokol MC, McGuigan KA, Verbrugge RR, Epstein RS. Impact of medication adherence on hospitalization risk and healthcare cost. Med Care. 2005;43:521-30. PMID: 15908846. Roebuck MC, Liberman JN, Gemmill-Toyama M, et al. Medication adherence leads to lower health care use and costs despite increased drug spending. Health Aff. 2011; 30:91-9. PMID: 21209444. Boye KS, Curtis SE, Lage MJ, et al. Associations between adherence and outcomes among older, type 2 diabetes patients: evidence from a Medicare Supplemental database. Patient Prefer Adherence. 2016;10:1573-81. PMID: 27574406. Roebuck MC, Kaestner RJ, Dougherty JS. Impact of Medication Adherence on Health Services Utilization in Medicaid. Med Care. 2018;56:266-273. PMID: 29309392. Campbell P, Axon D, Mollon L, et al. A retrospective database analysis evaluating the association between Pharmacy Quality Alliance antidiabetic medication measure adherence, healthcare use, and expenditures among commercially insured patients. J Manag Care Spec Pharm. 2019;25:3-a Suppl, S38. PMID: 30854912.		

	Lloyd JT, Maresh S, Powers CA, Shrank WH, Alley DE. How Much Does Medication Nonadherence Cost the Medicare Fee-for-Service Program? Med Care. 2019;57:218-24. PMID: 30676355. Centers for Medicare & Medicaid Services. *2024 National Impact Assessment of the Centers for Medicare & Medicaid Services (CMS) Quality Measures Report*. 2024. Accessed August 12, 2025. https://www.cms.gov/files/document/2024-national-impact-assessment-report.pdf.
Characteristics	
Scoring	Proportion.
Type	TBD.
Product line	Exchange.
Stratifications	None.
Risk adjustment	None.
Improvement notation	Increased score indicates improvement.
Guidance	**Data collection methodology:** Administrative. Refer to *General Guideline: Data Collection Methods* for additional information. **Date specificity:** Date must be specific enough to determine the event occurred in the period being measured. **Which services count?** Only paid, non-reversed prescription claims are included in the data set to calculate the measure. **Supplemental data exceptions:** Supplemental data may not be used for this measure, except for hospice exclusion.
Definitions	
Calculating Number of Days Covered for the Numerator	If multiple prescriptions for different target medications (i.e., two or more products within the same therapeutic category, but with different generic ingredients) are dispensed on the same day, count the number of days covered using the prescription with the longest days' supply. If multiple prescriptions for different target medications (i.e., two or more products within the same therapeutic category, but with different generic ingredients) are dispensed on different days with overlapping days' supply, count each day covered by a target medication only once within the treatment period. *For example: if a prescription for metformin and a prescription for chlorpropamide are filled 5 days apart and each has a 30-day supply, then the total days covered is 35.*

	If multiple prescriptions for the same target medication (i.e., one or more products with the same generic ingredient) are dispensed on the same day or different days where the days' supply overlap, adjust the prescription start date to be the day after the previous fill has ended. *For example: if three prescriptions for the same target medication are dispensed on the same day, each with a 30-day supply, then a total of 90 days are covered.* Overlap adjustment should also occur when there is an overlap of a single target drug product to a combination product containing the single target drug (i.e., same generic ingredient) or when there is an overlap of a combination product to another combination product where at least one of the target drugs (i.e., same generic ingredient) is common. Any days' supply that extends beyond the end of the treatment period are not included when calculating the total number of days covered. The NDC list for each class of medications includes flags for each target medication. The flags will help determine whether the prescription (NDC) includes the same or different target medication.
Diabetes Medications	Diabetes or diabetes combination products. See the following value sets: • BG: Biguanides Value Set • SFU: Sulfonylureas Value Set • TZD: Thiazolidinediones Value Set • DPP4: DPP-4 Inhibitors Value Set • GIP/GLP1: GIP/GLP-1 Receptor Agonists Value Set • MEG: Meglitinides Value Set • SGLT2: SGLT2 Inhibitors Value Set
IPSD	Index prescription start date. The earliest date of service for a target medication during the measurement period.
PDC	Proportion of days covered. The proportion of days in the treatment period "covered" by prescription claims for the same medication or another in its therapeutic category.
PDC threshold	The level of PDC above which the medication has a reasonable likelihood of achieving most of the potential clinical benefit (i.e., 80% for diabetes and cardiovascular drugs, and many chronic conditions).
Treatment period	The member's treatment period begins on the IPSD and extends through whichever comes first: the last day of enrollment during the measurement period, death, or the end of the measurement period. The treatment period should be at least 91 days.
Initial population	*Measure item count:* Member. *Attribution basis:* Enrollment. • *Benefits:* Medical and Pharmacy. • *Continuous enrollment:* The treatment period.

	• *Allowable gap:* Exclude members with more than one 1-day gap in enrollment during the treatment period. *Note: This allows only a single 1-day gap to compensate for discrepancies in the enrollment data. For example, a member who was eligible from January 1–April 1 and April 3–April December 31 would still be continuously enrolled despite the 1-day gap in eligibility on April 2.* *Ages:* ≥18 years of age as of the first day of the measurement period. *Event:* **Members with ≥2 prescription claims for any of the diabetes medications (BG, SFU, TZD, DPP4, GIP/GLP1, MEG, or SGLT2 Value Sets) on different dates of service in the treatment period.** **Step 1.** Identify members ≥18 years of age as of the first day of the measurement period. **Step 2.** Identify members with ≥2 prescription claims on different dates of service for any diabetes medication (BG, SFU, TZD, DPP4, GIP/GLP1, MEG, or SGLT2 Value Sets) during the measurement period. The prescription claims can be for the same or different medications and can be from any of these seven value sets. **Step 3.** Determine each member's treatment period. **Step 4.** Identify members with a treatment period that is ≥91 days during the measurement period. **Step 5.** Identify members meeting the continuous enrollment requirement during the treatment period.
Denominator exclusions	**Members in hospice or using hospice services.** Members who use hospice services (Hospice Encounter Value Set; Hospice Intervention Value Set) or elect to use a hospice benefit any time during the measurement period. Organizations that use the Monthly Membership Detail Data File to identify these members must use only the run date of the file. **Members with end-stage renal disease (ESRD) diagnosis.** Members with a diagnosis of ESRD (ESRD Exclusion Value Set*) any time during the measurement period. An ESRD diagnosis is defined as having ≥1 claim with ESRD in the primary diagnosis or any other diagnosis fields during the measurement period. **Members with insulin medication.** Members with ≥1 prescription claims for the medication insulin (Insulin Exclusion Value Set) during the treatment period. **Coding Guidance** *Do not include laboratory claims (claims with POS code 81).
Denominator	Initial population minus denominator exclusions.
Numerator	**Members who met the PDC threshold during the measurement period.** Follow the steps below for each member to determine whether the member meets the PDC threshold. **Step 1.** Determine the treatment period.

<table>
<tr><td></td><td>Step 2. Within the treatment period, count the days of the member was covered by at least one diabetes medication (BG, SFU, TZD, DPP4, GIP/GLP1, MEG, or SGLT2 Value Sets) based on the date of service and days' supply on the prescription claims. If the days' supply for prescription claims with the same target drug (generic ingredient) overlap, then adjust the prescription claim's start date to be the day after the last days' supply for the previous prescription claim.

Adjustment of overlap should also occur when there is overlap of a single drug product to a combination product containing the single target drug or when there is an overlap of a combination product to another combination product where at least one of the target drugs is common.

Step 3. Divide the number of covered days found in step 2 by the number of days found in step 1. Multiply this number by 100 to obtain the PDC (as a percentage) for each member. Then round the PDC to the nearest hundredth (e.g., 79.996% is rounded to 80.00%, 79.992% is rounded to 79.99%).

Step 4. Count the number of members who had a PDC of ≥80.00% and then divide by the total number of eligible members.</td></tr>
<tr><td>Summary of changes</td><td>• This measure resulted from the separation of indicators in the Proportion of Days Covered.
• Added definition for Diabetes Medications.
• Removed definition for Prescription Claims, as this information is now in the Guidance section.</td></tr>
<tr><td>Data element tables</td><td>Organizations that submit HEDIS data to NCQA must provide the following data elements.

Table PDC-DR-4: Data Elements for Proportion of Days Covered: Diabetes All Class
<table>
<tr><th>Metric</th><th>Data Element</th><th>Reporting Instructions</th></tr>
<tr><td>Diabetes</td><td>Benefit</td><td>Metadata</td></tr>
<tr><td></td><td>InitialPopulation</td><td>Report once</td></tr>
<tr><td></td><td>Exclusions</td><td>Report once</td></tr>
<tr><td></td><td>Denominator</td><td>Report once</td></tr>
<tr><td></td><td>NumeratorByAdmin</td><td>Report once</td></tr>
<tr><td></td><td>Rate</td><td>(Percent)</td></tr>
</table></td></tr>
</table>

4. QRS Survey Measure Specifications

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QRS Survey Measure Descriptions

Overview

This section includes descriptions for the QRS survey measures that will be collected as part of the 2027 QHP Enrollee Survey. The QHP Enrollee Survey is largely based on items from the CAHPS® Surveys. For a crosswalk that maps each QRS survey measure to the relevant 2027 QHP Enrollee Survey item(s), refer to the annual QRS and QHP Enrollee Survey: Technical Guidance.

Additional details related to the 2027 QHP Enrollee Survey and data collection protocols are included on the CMS QHP Enrollee Survey page of the CMS Marketplace Quality Initiatives website at https://www.cms.gov/marketplace/about/health-insurance-quality-initiatives/enrollee-survey.

QRS Survey Measure Descriptions

Access to Care

The *Access to Care* measure includes data from the following four questions from the 2027 QHP Enrollee Survey:

- In the last 6 months, when you **needed care right away**, in an emergency room, doctor's office, or clinic, how often did you get care in person, by telephone, or by video as soon as you needed? *(Question #22)*
- How often did you get an appointment in person, by phone, or by video **for a check-up or routine care** at a doctor's office or clinic as soon as you needed? *(Question #23)*
- How often was it easy to get the care, tests, or treatment you needed in person, by phone, or by video? *(Question #25)*
- How often did you get an in person, phone, or video appointment to see a specialist as soon as you needed? *(Question #45)*

Access to Information

The *Access to Information* measure includes data from the following three questions from the 2027 QHP Enrollee Survey:

- In the last 6 months, how often did written materials or the internet provide the information you needed about how your health plan works? *(Question #3)*
- In the last 6 months, how often were you able to find out from your health plan how much you would have to pay for a health care service or equipment before you got it? *(Question #4)*
- In the last 6 months, how often were you able to find out from your health plan how much you would have to pay for specific prescription medicines? *(Question #5)*

Care Coordination

The *Care Coordination* measure includes data from the following six questions from the 2027 QHP Enrollee Survey:

- When you visited your personal doctor for a scheduled in person, phone, or video appointment, how often did he or she have your medical records or other information about your care? *(Question #35)*
- When your personal doctor ordered a blood test, x-ray, or other test for you, how often did someone from your personal doctor's office follow up to give you those results? *(Question #37)*
- When your personal doctor ordered a blood test, x-ray, or other test for you, how often did you get those results as soon as you needed them? *(Question #38)*
- In the last 6 months, how often did you and your personal doctor talk about all the prescription medicines you were taking? *(Question #39)*
- How often did you **get the help that you needed** from your personal doctor's office to manage your care among these different providers and services?[1] *(Question #42)*
- How often did your personal doctor seem informed and up-to-date about the care you got from specialists? *(Question #47)*

Enrollee Experience with Cost

The *Enrollee Experience with Cost* measure includes data from the following four questions from the 2027 QHP Enrollee Survey:

- In the last 6 months, how often did your health plan **not** pay for care that your doctor said you needed? *(Question #15)*
- In the last 6 months, how often did you have to pay out of your own pocket for care that you thought your health plan would pay for? *(Question #16)*
- In the last 6 months, how often did you delay visiting or **not** visit a doctor because you were worried about the cost? *Do **not** include dental care. (Question #17)*
- In the last 6 months, how often did you delay filling or **not** fill a prescription because you were worried about the cost? *(Question #18)*

Plan Administration

The *Plan Administration* measure includes data from the following five questions from the 2027 QHP Enrollee Survey:

- How often did your health plan's customer service give you the information or help you needed? *(Question #7)*
- How often did your health plan's customer service staff treat you with courtesy and respect? *(Question #8)*
- How often did the time that you waited to talk to your health plan's customer service staff take longer than you expected? *(Question #9)*
- How often were the forms from your health plan easy to fill out? *(Question #11)*
- How often did the health plan explain the purpose of a form before you filled it out? *(Question #12)*

[1] Enrollees must answer affirmatively to the screener question: "Did you need help from anyone in your personal doctor's office to manage your care among these different providers and services?" in order to respond to this question.

Rating of All Health Care

The *Rating of All Health Care* measure includes data from the following question from the 2027 QHP Enrollee Survey:

- Using any number from 0 to 10, where 0 is the worst health care possible and 10 is the best health care possible, what number would you use to rate all your health care in the last 6 months? *(Question #27)*

Rating of Health Plan

The *Rating of Health Plan* measure includes data from the following question from the 2027 QHP Enrollee Survey:

- Using any number from 0 to 10, where 0 is the worst health plan possible and 10 is the best health plan possible, what number would you use to rate your health plan in the last 6 months? *(Question #21)*

Rating of Personal Doctor

The *Rating of Personal Doctor* measure includes data from the following question from the 2027 QHP Enrollee Survey:

- Using any number from 0 to 10, where 0 is the worst personal doctor possible and 10 is the best personal doctor possible, what number would you use to rate your personal doctor? *(Question #43)*

Rating of Specialist

The *Rating of Specialist* measure includes data from the following question from the 2027 QHP Enrollee Survey:

- We want to know your rating of the specialist you saw most often in the last 6 months. Using any number from 0 to 10, where 0 is the worst specialist possible and 10 is the best specialist possible, what number would you use to rate the specialist? *(Question #48)*