California Quality Collaborative

CalHIVE BHI

Technical Specifications Manual

July 2023

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Purchaser Business Group on Health
1611 Telegraph Avenue #210
Oakland, CA 94612

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Overview

This document includes the technical specifications for use in collecting data for CalHIVE BHI.

The CalHIVE BHI specifications are based primarily on HEDIS measures and are consistent with IHA's Align. Measure. Perform. (AMP) program but have been adapted to support collection at the clinician-practice-product line level for the purposes of supporting quality improvement. Differences between the HEDIS specifications and the CalHIVE BHI specifications are clearly noted under each measure's "*Modifications From HEDIS"* section. All measures are collected using administrative data systems, including claims/encounter or billing data, electronic health records, registries, and other clinical databases. Your full patient population should be included. Hybrid Methodology or medical chart review *is not* permitted.

The CalHIVE BHI measure set includes the following measures:

Measure	Required	Electronic Clinical Data Systems (ECDS)	Non-HEDIS	Differs From HEDIS
Enrollment	✓		✓	
Depression Screening and Follow-Up for Adolescents and Adults	✓	✓		
Depression Remission or Response for Adolescents and Adults	✓	✓		
Unhealthy Alcohol Use Screening and Follow-Up	✓	✓		
Diabetes Care – HbA1c Poor Control (>9%)	✓			
Emergency Department Visits	✓			

To obtain the **Guidelines for Measures Reported Using Electronic Clinical Data Systems (ECDS)** and **Value Sets** for programming the digital quality measures, please contact Jose Ordonez at jordonez@pbgh.org:

- Depression Screening and Follow-Up for Adolescents and Adults
- Depression Remission or Response for Adolescents and Adults
- Unhealthy Alcohol Use Screening and Follow-Up

The **Value Sets** for programing Diabetes Care HbA1c Poor Control (>9%) and Emergency Department Visits (IHA A.M.P. measures) are available electronically at no charge. To access

visit the NCQA store to create an account or login and download them here: https://store.ncqa.org/my-2023-align-measure-perform-amp-product-bundle.html

Some of the information in the Data Collection section (pages 17-30) of the General Guidelines in the Integrated Healthcare Association (IHA) Align. Measure. Perform. (AMP) Program's manual may be helpful, and are available for your reference: https://iha.org/wp-content/uploads/2022/12/AMP-MY23-Tech-Specs-Draft-Oct22.pdf

Please Note:
Provider organizations (PO) are required to report on **ALL** required measures each reporting cycle.

Attribution of Member to Clinicians

- Every member should be assigned to a PCP.
  - PCP types include Family Medicine, General Medicine, Internal Medicine, and Obstetrics/ Gynecology (see "Data Fields" tab in the Enrollment File Template).
  - You can use health plan assignment for managed care members.
  - You may also use an algorithm, like "most frequent, most recent."
- Report **ALL** required measures for all clinicians.
- There will be double counting of some members—this is ok!

Measure Codes and Validations

Below is the list of CalHIVE BHI measures, including all of the sub-measures and measure identifiers. The measure identifiers must be used in the CalHIVE BHI measurement file exactly as shown below, including case and underscores (_).

Files will undergo two levels of validations:

1. Files will be checked for naming conventions and formatting. Files that contain measure identifiers different than below will be returned for correction before moving to the second level of validation.

2. The "Edit checks" from the table below will be implemented on the applicable measure results. Any results that don't meet the edit checks will be flagged for your PO to review and correct as appropriate.

Measure	Measure ID	Description	Edit Checks
1	ENR	Enrollment as of last day of measurement period	Only report the denominator. Numerator should be left blank.
Behavioral Health Digital Quality Measures			
2	DSF1	Depression Screening and Follow-Up for Adolescents and Adults: Depression Screening	The numerator should never be higher than the denominator.
	DSF2	Depression Screening and Follow-Up for Adolescents and Adults: Follow-Up on Positive Screen	The numerator should never be higher than the denominator. The denominator for DSF2 should never be higher than the denominator of DSF1
3	DRR1	Depression Remission or Response for Adolescents and Adults: Follow-Up PHQ-9	The numerator should never be higher than the denominator.
	DRR2	Depression Remission or Response for Adolescents and Adults: Depression Remission	The numerator should never be higher than the denominator.
	DRR3	Depression Remission or Response for Adolescents and Adults: Depression Response	The numerator should never be higher than the denominator.
4	ASF1	Unhealthy Alcohol Use Screening and Follow-Up: Unhealthy Alcohol Use Screening	The numerator should never be higher than the denominator.
	ASF2	Unhealthy Alcohol Use Screening and Follow-Up: Follow-Up Care on Positive Screen	The numerator should never be higher than the denominator. The denominator for ASF2 should never be higher than the denominator of ASF1.

Clinical Measure			
5	HPC	Diabetes Care: HbA1c Poor Control > 9.0%	The numerator should never be higher than the denominator.
Utilization Measure			
6	EDV	Emergency Department Visits (Per Thousand Members Years)	The denominators for EDV should be close or like the ENR measure denominator. Denominator for EDV should be member years (not member months) The numerator is allowed to be larger than the denominator.

Products

Below are the product descriptions and codes that can be used when reporting results. Based on the products that your PO has decided they will include in CalHIVE BHI, you will report on each product as follows:

- You should include a separate row in the CalHIVE BHI Measurement File for each clinician-practice-product combination. In each product field, there should be one product code which indicates the specific product included in that result.

  For example, if a clinician at a practice serves Managed Medi-Cal and Commercial HMO patients, then there would be two rows for each measure.
  - One row for Commercial HMO reporting the product with the code “HMOPOS”.
  - One row for Managed Medi-Cal reporting the product with the code “MC”.

Code	Name	Notes
HMOPOS	Commercial HMO and POS	includes marketplace HMO
PPO	Commercial PPO	includes marketplace PPO
MA	Medicare Advantage	
MAFFS	Medicare FFS	
MC	Managed Medi-Cal	
MCFFS	Medi-Cal FFS	
DUAL	Medi-Medi	
UNINS	Uninsured	
VA	Military	
OTHER	Other or unknown	e.g., Medicare Supplement

Rolling 12-Month Measurement Periods

The CalHIVE BHI program includes the collection and analysis of performance measure data to understand the impact of participants' quality improvement (QI) efforts. PBGH utilizes a moving average (rolling average) approach to collect performance measure data by applying a rolling 12-month measurement period. After establishing a performance baseline, progress is monitored with each new rolling 12-month measurement period, dropping the earliest month of the previous period and adding a new one. Examples of a rolling 12-month measurement period are provided below:

- January 1, 2022 to December 31, 2022
- February 1, 2022 to January 31, 2023
- March 1, 2022 to February 28, 2023

There are several advantages to utilizing a moving average to understand performance trends:

- Reflective of how patient care is delivered longitudinally.
- Stability in how your performance rates are trended overtime, instead of showing large fluctuations which can be difficult to interpret.
- Flexibility to make time-sensitive changes along the way (allowing you to track quality improvement activities) rather than giving you only one opportunity annually (it can reduce the number of care gaps to close by the end of the year).

Continuous Enrollment and Allowable Gaps

Continuous enrollment specifies the minimum amount of time 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 in the benefit specified for each measure (e.g., pharmacy or mental health) accounting for any allowable gaps.

A **gap** is the time when a member is not covered by the organization (i.e., the time between disenrollment and re-enrollment). For example, if a member disenrolls on June 30 and re-enrolls on July 1, there is no gap because the member was covered on both June 30 and July 1. If the member disenrolls on June 30 and re-enrolls on July 2, there is a one-day gap because the member was not covered on July 1.

An **allowable gap** can occur at 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 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).

Medi-Cal Managed Care Continuous Enrollment

If the organization applies a full-month eligibility criterion to Medi-Cal Managed Care beneficiaries and verifies enrollment prospectively in monthly intervals (in 1-month increments), the one gap in enrollment during the continuous enrollment period may not exceed 45 days. For example, a member whose coverage lapses for 2 months (60 days) is not considered continuously enrolled.

If the organization is notified of prospective member enrollment, use the actual date of enrollment to calculate continuous enrollment, not the notification date.

Retroactive eligibility	The elapsed time between the actual date when the organization became financially responsible for the Medi-Cal Managed Care member and the date when it received notification of the new member. For measures with a continuous enrollment requirement, members may be excluded if the retroactive eligibility period exceeds the allowable gap requirement. This guideline must be used consistently across all measures.

Continuous Enrollment Over Multiple Years

Unless otherwise specified, for measures spanning more than 1 year, members are allowed one gap in enrollment of up to 45 days during each year of continuous enrollment. A gap in enrollment that extends over multiple years of a continuous enrollment period may exceed 45 days.

For example, in the Colorectal Cancer Screening measure (which requires 2 years of continuous enrollment), a member who disenrolls on November 30 of the year prior to the measurement year and re-enrolls on February 1 of the measurement year is considered continuously enrolled as long as there are no other gaps in enrollment during either year. The member has one gap of 31 days (December 1– 31) in the year prior to the measurement year and one gap of 31 days (January 1–31) in the measurement year.

Anchor Dates

If a measure requires a member to be enrolled and to have a benefit on a specific date, the allowable gap must not include that date; the member must also have the benefit on that date. For example, a 55-year-old with only one gap in enrollment from November 30 of the measurement year through the remainder of the year is not eligible for the Colorectal Cancer Screening measure. Although the member meets the continuous enrollment criterion, the

member does not meet the anchor date criterion, which requires enrollment as of December 31 of the measurement year.

Members in Hospice for Digital Measures

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

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

The exclusion of members in hospice is subject to auditor review.

Note

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

Members in Hospice for IHA A.M.P. Measures

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

For PQA measure reporting, use the Hospice Encounter Value Set or Hospice Intervention Value Set to identify members in hospice for Commercial HMO, Commercial ACO, and Medi-Cal Managed Care reporting. For Medicare Advantage reporting, health plans must use the Hospice flag in the Monthly Membership Detail Data File to identify members in hospice. POs reporting PQA measures for Medicare Advantage have the option of using the Monthly Membership Detail Data File or the Hospice Encounter Value Set or Hospice Intervention Value Set to identify members in hospice.

The exclusion of members in hospice is subject to auditor review.

Note

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

Deceased Members for IHA A.M.P. Measures

Exclude members who die any time during the measurement year. These members may be identified using various methods that may include, but are not limited to, enrollment data, claims/encounter data, or supplemental data for this required exclusion. Organizations should attempt to remove these members prior to determining a measure's eligible population.

Deceased members may not be excluded from the PQA owned Clinical measures (PDC, SUPD and COB), Data Quality measures (ENRST, ENFMT and ENLAG) and Utilization measures (AMB, IPU, OSU and GRX).

Exclusion of deceased members is subject to auditor review.

Note

- For the Data Quality measures, GRX, and OSU specifically, deceased members are not excluded if the member had 1+ months of both medical and pharmacy coverage. Organizations may exclude deceased members from the Data Quality measures, GRX, and OSU only if the member had < 1 month of medical and pharmacy coverage.
- IHA does not require the health plan/PO to develop databases or other methods to identify deceased members.
- Supplemental data can be used for excluding deceased members for all applicable measures, including measures that say "supplemental data may not be used for the measure" (e.g., AAB).
- This is a member-level exclusion. For episode-based measures, if one event does not meet numerator criteria, remove all member events/episodes from the measure.

Enrollment (ENR)

All POs must submit ENR for data validation purposes.

MODIFICATIONS FROM HEDIS

This is not a HEDIS measure.

Description

The number of members enrolled as of the last day of the measurement period. This is a point-in-time number.

Eligible Population

Stratification	All product line(s) agreed during data onboarding calls (page 8). Report each product line separately.
Ages	All ages.
Continuous enrollment	The measurement year in the PO.
Anchor date	Enrolled in the PO and attributed to the clinician/practice on the last day of the measurement period.
Benefit	Medical.
Measurement Period	Rolling 12-Months: • E.g., January 1, 2022 – December 31, 2022 • E.g., February 1, 2022 – January 31, 2023

Administrative Specification

Denominator	The eligible population.
Numerator	Leave blank.

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

***Adapted with financial support from the Centers for Medicare & Medicaid Services (CMS).**

MODIFICATIONS FROM HEDIS

Refer to the Technical Release Notes file in the Digital Measures Package for a comprehensive list of changes.

Revised the "Other" criteria in the Nonclinical Components table under *Rules for Allowable Adjustments of HEDIS*

Description

The percentage of members 12 years of age and older who were screened for clinical depression using a standardized instrument and, if screened positive, received follow-up care.

- ***Depression Screening.*** The percentage of members who were screened for clinical depression using a standardized instrument.
- ***Follow-Up on Positive Screen.*** The percentage of members who received follow-up care within 30 days of a positive depression screen finding.

Measurement Period

Rolling 12-Months:

- E.g., January 1, 2022 – December 31, 2022
- E.g., February 1, 2022 – January 31, 2023

Clinical Recommendation Statement

The U.S. Preventive Services Task Force (USPSTF) recommends screening for depression among adolescents 12–18 years and the general adult population, including pregnant and postpartum women. (B recommendation)

The USPSTF also recommends that screening be implemented with adequate systems in place to ensure accurate diagnosis, effective treatment and appropriate follow-up. (B recommendation)

Citations

U.S. Preventive Services Task Force. 2016. "Screening for Depression in Children and Adolescents: U.S. Preventive Services Task Force Recommendation Statement." *Annals of Internal Medicine* 164:360–6.

U.S. Preventive Services Task Force. 2016. "Screening for Major Depressive Disorder in Adults: US Preventive Services Task Force Recommendation Statement." *Journal of the American Medical Association* 315(4):380–7.

Characteristics

Scoring	Proportion.
Type	Process.
Stratification	Depression Screening. • All product line(s) agreed during data onboarding calls (page 8). Report each product line separately. Follow-Up on Positive Screen. • All product line(s) agreed during data onboarding calls (page 8). Report each product line separately.
Risk Adjustment	None
Improvement Notation	A higher rate indicates better performance.
Guidance	**Allocation:** The member was enrolled with a medical benefit throughout the participation period. When identifying members in hospice, the requirements described in "Members in Hospice for Digital Measures" for identification of hospice members using the monthly membership detail data files are not included in the measure calculation logic and need to be programmed manually.

Requirements:

- This measure requires the use of an age-appropriate screening instrument. The member's age is used to select the appropriate depression screening instrument.
- Depression screening captured in health risk assessments or other types of health assessments are allowed if the questions align with a specific instrument that is validated for depression screening. For example, if a health risk assessment includes questions from the PHQ-2, it counts as screening if the member answered the questions and a total score is calculated.

Reporting:
Product line stratifications are not included in the measure calculation logic and need to be programmed manually.

Definitions

Participation

The identifiers and descriptors for each organization's coverage used to define members' eligibility for measure reporting. Allocation for HEDIS reporting is based on eligibility during the participation period.

Participation Period

The measurement period.

Depression Screening Instrument

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

Instruments for Adolescents (≤17 years)	Positive Finding
Patient Health Questionnaire (PHQ-9)®	Total score ≥10
Patient Health Questionnaire Modified for Teens (PHQ-9M)®	Total score ≥10
Patient Health Questionnaire-2 (PHQ-2)®[1]	Total score ≥3
Beck Depression Inventory-Fast Screen (BDI-FS)®[1,2]	Total score ≥8
Center for Epidemiologic Studies Depression Scale—Revised (CESD-R)	Total score ≥17
Edinburgh Postnatal Depression Scale (EPDS)	Total score ≥10

Instruments for Adolescents (≤17 years)	Positive Finding
PROMIS Depression	Total score (T Score) ≥60

[1]Brief screening instrument. All other instruments are full-length.
[2]Proprietary; may be cost or licensing requirement associated with use.

Instruments for Adults (18+ years)	Positive Finding
Patient Health Questionnaire (PHQ-9)®	Total score ≥10
Patient Health Questionnaire-2 (PHQ-2)®[1]	Total score ≥3
Beck Depression Inventory-Fast Screen (BDI-FS)®[1,2]	Total score ≥8
Beck Depression Inventory (BDI-II)	Total score ≥20
Center for Epidemiologic Studies Depression Scale-Revised (CESD-R) Duke Anxiety-Depression Scale (DUKE-AD)®[2]	Total score ≥17 Total score ≥30
Geriatric Depression Scale Short Form (GDS)[1]	Total score ≥5
Geriatric Depression Scale Long Form (GDS)	Total score ≥10
Edinburgh Postnatal Depression Scale (EPDS)	Total score ≥10
My Mood Monitor (M-3)®	Total score ≥5
PROMIS Depression	Total score (T Score) ≥60
Clinically Useful Depression Outcome Scale (CUDOS)	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

Initial population 1
Members 12 years of age and older at the start of the measurement period who also meet criteria for participation.

Initial population 2
Same as the initial population 1.

Exclusion

Exclusions 1

- Members with a history of bipolar disorder any time during the member's history through the end of the year prior to the measurement period.
- Members with depression that starts during the year prior to the measurement period.
- Members in hospice or using hospice services any time during the measurement period.

Exclusions 2
Same as exclusions 1.

Denominator

Denominator 1
The initial population, minus exclusions.

Denominator 2
All members from numerator 1 with a positive depression screen finding between the first date of the first month and the first date of last month of the measurement period.

Numerator

Numerator 1—Depression Screening
Members with a documented result for depression screening, using an age-appropriate standardized instrument, performed between the first date of the first month and the first date of last month of the measurement period.
Example:

- January 1, 2022 – December 1, 2022
- February 1, 2022 – January 1, 2023

Numerator 2—Follow-Up on Positive Screen
Members who received follow-up care on or up to 30 days after the date of the first positive screen (31 total days).

Any of the following on or up to 30 days after the first positive screen:

- An outpatient, telephone, e-visit or virtual check-in follow-up visit with a diagnosis of depression or other behavioral health condition.
- A depression case management encounter that documents assessment for symptoms of depression or a diagnosis of depression or other behavioral health condition.

- A behavioral health encounter, including assessment, therapy, collaborative care or medication management.
- A dispensed antidepressant medication.

OR

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

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

Data Criteria (element level)

Digital Measures Value Sets:

- Reach out to Jose Ordonez to obtain the value sets.

Direct reference codes and codesystems:

- **DSFE_HEDIS_MY2023-2.1.0**

- codesystem "LOINC": 'http://loinc.org'
- code "Beck Depression Inventory Fast Screen total score [BDI]": '89208-3' from "LOINC" display 'Beck Depression Inventory Fast Screen total score [BDI]'
- code "Beck Depression Inventory II total score [BDI]": '89209-1' from "LOINC" display 'Beck Depression Inventory II total score [BDI]'
- code "Center for Epidemiologic Studies Depression Scale-Revised total score [CESD-R]": '89205-9' from "LOINC" display 'Center for Epidemiologic Studies Depression Scale-Revised total score [CESD-R]'
- code "Edinburgh Postnatal Depression Scale [EPDS]": '71354-5' from "LOINC" display 'Edinburgh Postnatal Depression Scale [EPDS]'
- code "Final score [DUKE-AD]": '90853-3' from "LOINC" display 'Final score [DUKE-AD]'
- code "Geriatric depression scale (GDS) short version total": '48545-8' from "LOINC" display 'Geriatric depression scale (GDS) short version total'
- code "Geriatric depression scale (GDS) total": '48544-1' from "LOINC" display 'Geriatric depression scale (GDS) total'
- code "Patient Health Questionnaire 2 item (PHQ-2) total score [Reported]": '55758-7' from "LOINC" display 'Patient Health Questionnaire 2 item (PHQ-2) total score [Reported]'
- code "Patient Health Questionnaire 9 item (PHQ-9) total score [Reported]": '44261-6' from "LOINC" display 'Patient Health Questionnaire 9 item (PHQ-9) total score [Reported]'

- code "Patient Health Questionnaire-9: Modified for Teens total score [Reported.PHQ.Teen]": '89204-2' from "LOINC" display 'Patient Health Questionnaire-9: Modified for Teens total score [Reported.PHQ.Teen]'
- code "PROMIS-29 Depression score T-score": '71965-8' from "LOINC" display 'PROMIS-29 Depression score T-score'
- code "Total score [CUDOS]": '90221-3' from "LOINC" display 'Total score [CUDOS]'
- code "Total score [M3]": '71777-7' from "LOINC" display 'Total score [M3]'

• **NCQA_Screening-1.1.0**

- codesystem "ICD-10-CM": 'https://terminology.hl7.org/2.0.0/CodeSystem-icd10CM.html'
- code "Exercise counseling": 'Z71.82' from "ICD-10-CM" display 'Exercise counseling'

• **NCQA_Terminology-2.1.0**

- codesystem "ActCode": 'https://terminology.hl7.org/5.1.0/CodeSystem-v3-ActCode.html'
- codesystem "ConditionClinicalStatusCodes": 'http://terminology.hl7.org/CodeSystem/condition-clinical'
- code "active": 'active' from "ConditionClinicalStatusCodes"
- code "managed care policy": 'MCPOL' from "ActCode"
- code "retiree health program": 'RETIRE' from "ActCode"
- code "subsidized health program": 'SUBSIDIZ' from "ActCode"

Depression Remission or Response for Adolescents and Adults (DRR-E)*

***Adapted with financial support from the Agency for Healthcare Research and Quality (AHRQ) and the Centers for Medicare & Medicaid Services (CMS) under the CHIPRA Pediatric Quality Measures Program Centers of Excellence grant number U18HS020503, and with permission from the measure developer, Minnesota Community Measurement.**

MODIFICATIONS FROM HEDIS

Refer to the Technical Release Notes file in the Digital Measures Package for a comprehensive list of changes.

Revised the "Other" criteria in the Nonclinical Components table under *Rules for Allowable Adjustments of HEDIS*

Description

The percentage of members 12 years of age and older with a diagnosis of depression and an elevated PHQ-9 score, who had evidence of response or remission within 4–8 months of the elevated score.

- ***Follow-Up PHQ-9.*** The percentage of members who have a follow-up PHQ-9 score documented within 4–8 months after the initial elevated PHQ-9 score.
- ***Depression Remission.*** The percentage of members who achieved remission within 4–8 months after the initial elevated PHQ-9 score.
- ***Depression Response.*** The percentage of members who showed response within 4–8 months after the initial elevated PHQ-9 score.

Measurement Period

Rolling 12-Months:

- E.g., January 1, 2022 – December 31, 2022
- E.g., February 1, 2022 – January 31, 2023

Clinical Recommendation Statement

The Institute for Clinical Systems Improvement recommends that clinicians establish and maintain follow-up with adult patients who have depression. Appropriate, reliable follow-up is highly correlated with improved response and remission scores (Kessler, 2016).

The American Academy of Pediatrics recommends that adolescents with depression be assessed for treatment response and remission of symptoms using a depression assessment tool such as the PHQ-9 Modified for Teens (Cheung, 2018).

Citations

Cheung A. H., R. A. Zuckerbrot, P. S. Jensen, K. Ghalib, D. Laraque, and R.E.K. Stein. "Guidelines for Adolescent Depression in Primary Care (GLAD-PC): II. Treatment and Ongoing Management." **Pediatrics** 120, no. 5 (January 2007). https://doi.org/10.1542/peds.2006-1395.

Trangle, M., J. Gursky, R. Haight, J. Hardwig, T. Hinnenkamp, D. Kessler, N. Mack, M. Myszkowski. Institute for Clinical Systems Improvement. **Adult Depression in Primary Care**. Updated March 2013.

Characteristics

Scoring	Proportion.
Type	Outcome
Stratification	Depression Follow-Up. • All product line(s) agreed during data onboarding calls (page 8). Report each product line separately. Depression Remission. • All product line(s) agreed during data onboarding calls (page 8). Report each product line separately. Depression Response. • All product line(s) agreed during data onboarding calls (page 8). Report each product line separately.
Risk Adjustment	None
Improvement Notation	A higher rate indicates better performance.

Guidance	**Allocation:** The member was enrolled with a medical benefit throughout the participation period. A gap in enrollment is allowed only in the measurement period. No gaps in enrollment are allowed in calendar year measurement periods from May 1 of the year prior to the measurement period through December 31 of the year prior to the measurement period (8 months). No gaps in enrollment logic should apply to rolling 12-months measurement periods like calendar years (e.g., For a rolling 12-months measurement period from 2/1/2022 to 1/31/2023, no gaps in enrollment are allowed from June 1 of the year prior to the measurement period through January 31 of the year prior to the measurement period). When identifying members in hospice, the requirements described in "Members in Hospice for Digital Measures" for identification of hospice members using the monthly membership detail data files are not included in the measure calculation logic and need to be programmed manually. **Requirements:** The measure allows two PHQ-9 assessments. Selection of the appropriate assessment should be based on the member's age. • *PHQ-9:* 12 years of age and older. • *PHQ-9 Modified for Teens:* 12–17 years of age. The PHQ-9 assessment does not need to occur during a face-to-face encounter; it may be completed over the telephone or through a web-based portal. **Reporting:** Product line stratifications are not included in the measure calculation logic and need to be programmed manually.
Definitions	
Participation	The identifiers and descriptors for each organization's coverage used to define members' eligibility for measure reporting. Allocation for reporting is based on eligibility during the participation period.

Participation Period	For a calendar year measurement period (1/1/2022 to 12/31/2022) the participation period starts on May 1 of the year prior to the measurement period through December 31 of the measurement period (20 months) Adjust participation period for rolling 12-months measurement periods. (e.g., For a rolling 12-months measurement period from 2/1/2022 to 1/31/2023, the participation period would be from June 1 of the year prior to the measurement period through January 31 of the measurement period).
Intake period	For a calendar year measurement period (1/1/2022 to 12/31/2022) the participation period starts on May 1 of the year prior to the measurement period through April 30 of the measurement period (12 months). Adjust intake period for rolling 12-months measurement periods. (e.g., For a rolling 12-months measurement period from 2/1/2022 to 1/31/2023, the intake period would be from June 1 of the year prior to the measurement period through May 31 of the measurement period).
Depression follow-up period	The 120–240-day period after the IESD.
IESD	Index episode start date. The earliest date during the intake period where a member has a PHQ-9 total score >9 documented within a 31-day period including and around (15 days before and 15 days after) an interactive outpatient encounter with a diagnosis of major depression or dysthymia.
Interactive outpatient encounter	A bidirectional communication that is face-to-face, phone based, an e-visit or virtual check-in, or via secure electronic messaging. This does not include communications for scheduling appointments.
Initial population	**Initial population 1** Members 12 years and older as of the start of the intake period who meet **both** of the following criteria: • The depression encounter and PHQ-9 total score requirements as described by the IESD. • Participation. **Initial population 2** Same as the initial population 1. **Initial population 3** Same as the initial population 1.

Exclusion

Exclusions 1
Members with any of the following any time during the member's history through the end of the measurement period:

- Bipolar disorder.
- Personality disorder.
- Psychotic disorder.
- Pervasive developmental disorder.

OR

- Members in hospice or using hospice services any time during the measurement period.

Exclusions 2
Same as exclusions 1.

Exclusions 3
Same as exclusions 1.

Denominator

Denominator 1
Initial population, minus exclusions.

Denominator 2
Same as denominator 1.

Denominator 3
Same as denominator 1.

Numerator

Numerator 1—Depression Follow-Up
A PHQ-9 total score in the member's record during the depression follow-up period.

Numerator 2—Depression Remission
Members who achieve remission of depression symptoms, as demonstrated by the most recent PHQ-9 score of <5 during the depression follow-up period.

Numerator 3—Depression Response
Members who indicate a response to treatment for depression, as demonstrated by the most recent PHQ-9 total score being at least 50 percent lower than the PHQ-9 score associated with the IESD, documented during the depression follow-up period.

Data Criteria (element level)

Digital Measures Value Sets:

- Reach out to Jose Ordonez to obtain the value sets.

Direct reference codes and codesystems:

- **DRRE_HEDIS_MY2023-2.2.0**

- codesystem "LOINC": 'http://loinc.org'
- code "Patient Health Questionnaire 9 item (PHQ-9) total score [Reported]": '44261-6' from "LOINC" display 'Patient Health Questionnaire 9 item (PHQ-9) total score [Reported]'
- code "Patient Health Questionnaire-9: Modified for Teens total score [Reported.PHQ.Teen]": '89204-2' from "LOINC" display 'Patient Health Questionnaire-9: Modified for Teens total score [Reported.PHQ.Teen]'

- **NCQA_Terminology-2.1.0**

- codesystem "ActCode": 'http://terminology.hl7.org/CodeSystem/v3-ActCode'
- codesystem "ConditionClinicalStatusCodes": 'http://terminology.hl7.org/CodeSystem/condition-clinical'
- code "active": 'active' from "ConditionClinicalStatusCodes"
- code "managed care policy": 'MCPOL' from "ActCode"
- code "retiree health program": 'RETIRE' from "ActCode"
- code "subsidized health program": 'SUBSIDIZ' from "ActCode"

Unhealthy Alcohol Use Screening and Follow-Up (ASF-E)*

***Adapted with financial support from the Substance Abuse and Mental Health Services Administration (SAMHSA) and with permission from the measure developer, the American Medical Association (AMA).**

MODIFICATIONS FROM HEDIS

Refer to the Technical Release Notes file in the Digital Measures Package for a comprehensive list of changes.

Revised the "Other" criteria in the Nonclinical Components table under *Rules for Allowable Adjustments of HEDIS*

Description

The percentage of members 18 years of age and older who were screened for unhealthy alcohol use using a standardized instrument and, if screened positive, received appropriate follow-up care.

- ***Unhealthy Alcohol Use Screening.*** The percentage of members who had a systematic screening for unhealthy alcohol use.
- ***Follow-Up Care on Positive Screen.*** The percentage of members receiving brief counseling or other follow-up care within 2 months of screening positive for unhealthy alcohol use.

Measurement Period

Rolling 12-Months:

- E.g., January 1, 2022 – December 31, 2022
- E.g., February 1, 2022 – January 31, 2023

Clinical Recommendation Statement

The U.S. Preventive Services Task Force recommends that clinicians screen adults aged 18 years or older for alcohol misuse and provide brief behavioral counseling interventions to those who misuse alcohol. (B recommendation)

Citations

U.S. Preventive Services Task Force. 2018. "Unhealthy Alcohol Use in Adolescents and Adults: Screening and Behavioral Counseling Interventions." JAMA 320(18):1899–1909. DOI:10.1001/jama.2018.16789.

Characteristics

Scoring	Proportion.
Type	Process.
Stratification	Unhealthy Alcohol Use Screening. • All product line(s) agreed during data onboarding calls (page 8). Report each product line separately. Follow-Up on Care Positive Screen. • All product line(s) agreed during data onboarding calls (page 8). Report each product line separately.
Risk Adjustment	None
Improvement Notation	A higher rate indicates better performance.
Guidance	**Allocation:** The member was enrolled with a medical benefit throughout the participation period. When identifying members in hospice, the requirements described in "Members in Hospice for Digital Measures" for identification of hospice members using the monthly membership detail data files are not included in the measure calculation logic and need to be programmed manually.

Reporting:
Product line stratifications are not included in the measure calculation logic and need to be programmed manually.

Definitions

Participation

The identifiers and descriptors for each organization's coverage used to define members' eligibility for measure reporting. Allocation for reporting is based on eligibility during the participation period.

Participation Period

The measurement period.

Unhealthy Alcohol Use Screening

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

Screening Instrument	Positive Finding
Alcohol Use Disorders Identification Test (AUDIT) screening instrument	Total score ≥8
Alcohol Use Disorders Identification Test Consumption (AUDIT-C) screening instrument	Total score ≥4 for men Total score ≥3 for women
Single-question screen: "How many times in the past year have you had 5 (for men) or 4 (for women and all adults older than 65 years) or more drinks in a day?"	Total score ≥1

Alcohol Counseling or Other Follow-Up Care

Any of the following on or up to 60 days after the first positive screen:

- Feedback on alcohol use and harms.
- Identification of high-risk situations for drinking and coping strategies.
- Increase the motivation to reduce drinking.
- Development of a personal plan to reduce drinking.
- Documentation of receiving alcohol misuse treatment.

Initial population	**Initial population 1** Members 18 years of age and older at the start of the measurement period who also meet criteria for participation. **Initial population 2** Same as the initial population 1.
Exclusion	**Exclusions 1** • Members with alcohol use disorder that starts during the year prior to the measurement period. • Members with history of dementia any time during the member's history through the end of the measurement period. • Members in hospice or using hospice services any time during the measurement period. **Exclusions 2** Same as exclusions 1.
Denominator	**Denominator 1** The initial population, minus exclusions. **Denominator 2** All members in numerator 1 with a positive finding for unhealthy alcohol use screening between first date of the first month and the first date of the second to last month of the measurement period (January 1 to November 1).
Numerator	**Numerator 1—Unhealthy Alcohol Use Screening** Members with a documented result for unhealthy alcohol use screening performed between first date of the first month and the first date of the second to last month of the measurement period (January 1 to November 1). **Numerator 2—Follow-Up Care on Positive Screen** Members receiving alcohol counseling or other follow-up care on or up to 60 days after the date of the first positive screen (61 days total).

Data Criteria (element level)

Digital Measures Value Sets:

- Reach out to Jose Ordonez to obtain the value sets.

Direct reference codes and codesystems:

- **ASFE_HEDIS_MY2023-2.1.0**
- codesystem "ICD-10-CM": 'https://terminology.hl7.org/2.0.0/CodeSystem-icd10CM.html'
- codesystem "LOINC": 'http://loinc.org'
- code "Alcohol abuse counseling and surveillance of alcoholic": 'Z71.41' from "ICD-10-CM" display 'Alcohol abuse counseling and surveillance of alcoholic'
- code "How often have you had five or more drinks in one day during the past year [Reported]": '88037-7' from "LOINC" display 'How often have you had five or more drinks in one day during the past year [Reported]'
- code "How often have you had four or more drinks in one day during the past year [Reported]": '75889-6' from "LOINC" display 'How often have you had four or more drinks in one day during the past year [Reported]'
- code "Total score [AUDIT-C]": '75626-2' from "LOINC" display 'Total score [AUDIT-C]'
- code "Total score [AUDIT]": '75624-7' from "LOINC" display 'Total score [AUDIT]'
- **NCQA_Terminology-2.1.0**
- codesystem "ActCode": 'http://terminology.hl7.org/CodeSystem/v3-ActCode'
- codesystem "ConditionClinicalStatusCodes": 'http://terminology.hl7.org/CodeSystem/condition-clinical'
- code "active": 'active' from "ConditionClinicalStatusCodes"
- code "managed care policy": 'MCPOL' from "ActCode"
- code "retiree health program": 'RETIRE' from "ActCode"
- code "subsidized health program": 'SUBSIDIZ' from "ActCode"

Hemoglobin A1c Control for Patients with Diabetes: HbA1c Poor Control (>9.0%) (HPC)

MODIFICATIONS FROM HEDIS

The exclusion for members living long-term in an institution (LTI) is optional for POs that do not have access to the LTI flag in the Monthly Membership Detail Data File.

Description

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

- HbA1c Poor Control (>9.0%)

Eligible Population

Stratification	All product line(s) agreed during data onboarding calls (page 8). Report each product line separately.
Ages	18–75 years as of December 31 of the measurement year.
Continuous enrollment	The measurement year in the PO.
Allowable gap	No more than one gap in enrollment of up to 45 days during the measurement year. To determine continuous enrollment for a Medi-Cal Managed Care beneficiary for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage (e.g., a member whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).
Anchor date	Enrolled in the PO and attributed to the clinician/practice on the last day of the measurement period (December 31).
Benefit	Medical.
Measurement Period	Rolling 12-Months: • e.g., January 1, 2022 – December 31, 2022 • e.g., February 1, 2022 – January 31, 2023

Event/diagnosis

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

Claim/encounter data. Use the following IHA A.M.P. measures' value sets. Members who met any of the following criteria during the measurement year or the year prior to the measurement year (count services that occur over both years):

- At least one acute inpatient encounter (Acute Inpatient Value Set) with a diagnosis of diabetes (Diabetes Value Set) without telehealth (Telehealth Modifier Value Set; Telehealth POS Value Set).

- At least one acute inpatient discharge with a diagnosis of diabetes (Diabetes Value Set) on the discharge claim. To identify an acute inpatient discharge:

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

- At least two outpatient visits (Outpatient Value Set), observation visits (Observation Value Set), telephone visits (Telephone Visits Value Set), e-visits or virtual check-ins (Online Assessments Value Set), ED visits (ED Value Set), nonacute inpatient encounters (Nonacute Inpatient Value Set) or nonacute inpatient discharges (instructions below; the diagnosis must be on the discharge claim), on different dates of service, with a diagnosis of diabetes (Diabetes Value Set). Visit type need not be the same for the two encounters. To identify a nonacute inpatient discharge:

  1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).

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

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

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

Diabetes Medications

Description	Prescription		
Alpha-glucosidase inhibitors	• Acarbose • Miglito		
Amylin analogs	• Pramlintide		
Antidiabetic combinations	• Alogliptin-metformin • Alogliptin-pioglitazone • Canagliflozin-metformin • Dapagliflozin-metformin • Dapagliflozin-saxagliptin • Empagliflozin-linagliptin • Empagliflozin-linagliptin-metformin	• Empagliflozin-metformin • Ertugliflozin-metformin • Ertugliflozin-sitagliptin • Glimepiride-pioglitazone • Glipizide-metformin • Glyburide-metformin	• Linagliptin-metformin • Metformin-pioglitazone • Metformin-repaglinide • Metformin-rosiglitazone • Metformin-saxagliptin • Metformin-sitagliptin

Description	Prescription		
Insulin	• Insulin aspart • Insulin aspart-insulin aspart protamine • Insulin degludec • Insulin degludec-liraglutide • Insulin detemir • Insulin glargine • Insulin glargine-lixisenatide	• Insulin glulisine • Insulin isophane human • Insulin isophane-insulin regular • Insulin lispro • Insulin lispro-insulin lispro protamine • Insulin regular human • Insulin human inhaled	
Meglitinides Glucagon-like peptide-1 (GLP1) agonists	• Nateglinide • Albiglutide • Dulaglutide • Exenatide	• Repaglinide • Liraglutide (excluding Saxenda®) • Lixisenatide • Semaglutide	
Sodium glucose cotransporter 2 (SGLT2) inhibitor	• Canagliflozin • Dapagliflozin (excluding Farxiga®)	• Empagliflozin • Ertugliflozin	
Sulfonylureas	• Chlorpropamide • Glimepiride	• Glipizide • Glyburide	• Tolazamide • Tolbutamide
Thiazolidinediones Dipeptidyl peptidase-4 (DDP-4) inhibitors	• Pioglitazone • Alogliptin • Linagliptin	• Rosiglitazone • Saxagliptin • Sitagliptin	

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

Required exclusions

Exclude members who meet any of the following criteria (use IHA A.M.P value sets):

- Members who did not have a diagnosis of diabetes (Diabetes Value Set), in any setting, during the measurement year or the year prior to the measurement year **and** who had a diagnosis of polycystic ovarian syndrome, gestational diabetes or steroid-induced diabetes (Diabetes Exclusions Value Set), in any setting, during the measurement year or the year prior to the measurement year.
- Members in hospice or using hospice services any time during the measurement year. Refer to "Members in Hospice for IHA A.M.P. Measures".
- Members who died any time during the measurement year. Refer to Deceased Members for IHA A.M.P.
- Members receiving palliative care (Palliative Care Assessment Value Set; Palliative Care Encounter Value Set; Palliative Care Intervention Value Set; ICD-10-CM code Z51.5) any time during the measurement year.

Exclusions

Exclude members who meet any of the following criteria (use IHA A.M.P value sets):

Note: Supplemental data may not be used for these exclusions.

- Medicare Advantage members 66 years of age and older as of December 31 of the measurement year who meet either of the following:
    - Enrolled in an Institutional SNP (I-SNP) any time during the measurement year.
    - Living long-term in an institution any time during the measurement year as identified by the LTI flag in the Monthly Membership Detail Data File. Use the run date of the file to determine if a member had an LTI flag during the measurement year. *

  *The exclusion for members living long-term in an institution is optional for POs that do not have access to the LTI flag in the Monthly Membership Detail Data File.
- Members 66 years of age and older as of December 31 of the measurement year (all product lines) with frailty **and** advanced illness. Members must meet **BOTH** of the following frailty and advanced illness criteria to be excluded:

1. At least two indications of frailty (Frailty Device Value Set; Frailty Diagnosis Value Set; Frailty Encounter Value Set; Frailty Symptom Value Set) with different dates of service during the measurement year.
2. Any of the following during the measurement year or the year prior to the measurement year (count services that occur over both years):
   - At least two outpatient visits (Outpatient Value Set), observation visits (Observation Value Set), ED visits (ED Value Set), telephone visits (Telephone Visits Value Set), e-visits or virtual check-ins (Online Assessments Value Set), nonacute inpatient encounters (Nonacute Inpatient Value Set) or nonacute inpatient discharges (instructions below; the diagnosis must be on the discharge claim) on different dates of service, with an advanced illness diagnosis (Advanced Illness Value Set). Visit type need not be the same for the two visits. To identify a nonacute inpatient discharge:
     1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
     2. Confirm the stay was for nonacute care based on the presence of a nonacute code (Nonacute Inpatient Stay Value Set) on the claim.
     3. Identify the discharge date for the stay.

   - At least one acute inpatient encounter (Acute Inpatient Value Set) with an advanced illness diagnosis (Advanced Illness Value Set).
   - At least one acute inpatient discharge with an advanced illness diagnosis (Advanced Illness Value Set) on the discharge claim. To identify an acute inpatient discharge:
     1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
     2. Exclude nonacute inpatient stays (Nonacute Inpatient Stay Value Set).
     3. Identify the discharge date for the stay.

   - A dispensed dementia medication (Dementia Medications List)

Dementia Medications

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

Administrative Specification

Denominator

The eligible population.

Numerator
HbA1c Poor Control >9%

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

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

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

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

Note: If a combination of administrative and supplemental data is used, the most recent HbA1c result must be used, regardless of data source.

Emergency Department Visits (EVD)

MODIFICATIONS FROM HEDIS

Adapted to be collected at the clinician-practice-product line level for the purposes of supporting performance improvement.

Description

This measure summarizes the utilization of emergency department (ED) visits. It is reported as the number of ED Visits per 1,000 member years (PTMY).

Eligible Population

Stratification	All product line(s) agreed during data onboarding calls (page 8). Report each product line separately.
Ages	All ages.
Continuous enrollment	The measurement year and the year prior to the measurement year in the PO
Allowable gap	No more than one gap in enrollment of up to 45 days during each year of continuous enrollment.
Anchor date	December 31 of the measurement year for the PO. Adjust for rolling 12-months measurement periods.
Benefit	Medical.
Measurement Period	Rolling 12-Months: • E.g., January 1, 2022 – December 31, 2022 • E.g., February 1, 2022 – January 31, 2023
Member years	Determine the clinician's total member years of enrollment for each practice and product line as the sum of the number of days during the measurement period when each eligible member was enrolled in the PO, divided by 365. If your PO tracks enrollment by month, please divide the number of member

	months by 12. Please carry the decimal out to the thousandths place and do not round member years at any point. For example, if one member was enrolled for four months, the member years would be translated into 4/12 = .333 for that member for that clinician.
Event/diagnosis	None.
Required exclusions	Members in hospice or using hospice services any time during the measurement year. Refer to "Members in Hospice for IHA A.M.P. Measures".

Administrative Specification

Denominator	The eligible population.
Numerator	The number of qualifying ED Visits. Use the following IHA A.M.P measures value sets to identify qualifying ED visits for each clinician-practice-product. • An ED visit (ED Value Set). • An ED procedure code (ED Procedure Code Value Set) with an ED place of service code (ED POS Value Set).

Note: Count each visit to an ED that does not result in an inpatient stay once, regardless of the intensity or duration of the visit. Count multiple ED visits on the same date of service as one visit. Both professional and facility claims are used to identify ED visit.