Health Insurance Exchange

2026 Quality Rating System Measure Technical Specifications

March 2025

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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 2026 (Measurement Year 2025).

Website Links

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

- National Committee for Quality Assurance (NCQA) Healthcare Effectiveness Data and Information Set (HEDIS®)[1] Compliance Audit™ website: 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:
    - NCQA for the HEDIS measures: via the Policy Clarification Support (PCS) system available at https://my.ncqa.org/
    - Pharmacy Quality Alliance (PQA) for the PQA measures: https://www.pqaalliance.org/QRS

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

- For questions regarding QRS survey measures, the 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 Initiative (MQI)-QRS."

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

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1. Introduction

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Introduction

Document Purpose

This document includes the measure specifications and guidelines for data collection for the 2026 Quality Rating System (QRS) measure set. QHP issuers will need to reference this document in order to collect and submit QRS measure data to the Centers for Medicare & Medicaid Services (CMS) in accordance with the QRS 2026 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" (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 2026 QRS measure set (i.e., any measures proposed for addition and removal in the *Draft 2025 Call Letter for the QRS and QHP Enrollee Survey*).[2]

In the fall of 2025, CMS intends to publish the *Quality Rating System and Qualified Health Plan Enrollee Experience Survey: Technical Guidance for 2026* (2026 QRS and QHP Enrollee Survey Technical Guidance), reflecting applicable finalized changes announced in the *Final 2025 QRS and QHP Enrollee Survey Call Letter*. The 2026 QRS and QHP Enrollee Survey Technical Guidance will announce which measures eligible QHP issuers are required to collect and submit to CMS for the 2026 QRS ratings year.

Background

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

[2] The Draft 2025 Call Letter for the QRS and QHP Enrollee Survey is available at: https://www.cms.gov/Medicare/Quality/Health-Insurance-Marketplace-Initiatives
[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 2026 as proposed in the *Draft 2025 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 2026 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 2026 QRS data collection but will not be included in 2026 QRS scoring. The measures collected using the ECDS reporting method are noted with a euro sign (€). CMS will communicate final changes to the 2026 QRS measure set in the *Final 2025 Call Letter for the QRS and QHP Enrollee Survey*, which CMS anticipates publishing in late spring 2025.

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

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

For the 2026 ratings year and beyond, CMS is discontinuing the collection of race and ethnicity stratification (RES) data for select QRS measures in alignment with agency priorities. For the QRS, beginning with the 2025 ratings year, QHP issuers will not be required to collect and report RES measure data and CMS will not receive any RES measure data submitted by QHP issuers via the NCQA Interactive Data Submission System (IDSS). As a result, CMS will not share confidential QRS RES Proof Sheets with QHP issuers and Exchange administrators for the 2025 ratings year and beyond.

Exhibit 1. Proposed 2026 QRS Measures

Measure Title	Measure Steward	Consensus-Based Entity (CBE) ID[6]
QRS Clinical Measures		
Adult Immunization Status (AIS-E)€	NCQA	3620
~~Annual Monitoring for Persons on Long-term Opioid Therapy~~	~~PQA~~	~~3541~~
~~Antidepressant Medication Management~~	~~NCQA~~	~~0105~~
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	0061
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

[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/.

Measure Title	Measure Steward	Consensus-Based Entity (CBE) ID[6]
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%[8]	NCQA	0575
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
~~International Normalized Ratio Monitoring for Individuals on Warfarin~~	~~PQA~~	~~0555~~
Kidney Health Evaluation for Patients with Diabetes	NCQA	N/A
Oral Evaluation, Dental Services	NCQA	2517
Plan All-Cause Readmissions	NCQA	1768
Prenatal and Postpartum Care	NCQA	1517
Proportion of Days Covered	PQA	0541
~~Social Need Screening and Intervention (SNS-E)€~~	~~NCQA~~	~~N/A~~
Use of Imaging Studies for Low Back Pain	NCQA	0052
Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents	NCQA	0024
Well-Child Visits in the First 30 Months of Life	NCQA	1392
QRS Survey Measures		
Access to Care	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[9]	N/A
Medical Assistance with Smoking and Tobacco Use Cessation	NCQA	0027
Plan Administration	AHRQ, CMS[10]	0006
Rating of All Health Care	AHRQ	0006[7]
Rating of Health Plan	AHRQ	0006[7]
Rating of Personal Doctor	AHRQ	0006[7]
Rating of Specialist	AHRQ	0006[7]

[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.
[8] Previously referred to as the Hemoglobin A1c (HbA1c) Control for Patient with Diabetes: HbA1c poor control (>9.0%) measure.
[9] Measure consists of survey item developed for the purposes of the QHP Enrollee Survey.
[10] 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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Measurement Year 2025 (MY 2025) HEDIS® General Guidelines for the QRS Measure Technical Specifications

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

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Overview

HEDIS MY 2025

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 perform when providing or facilitating the use of important health services to 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 2025 (MY 2025). MY 2025 refers to the 2025 calendar year data that is reported on June 15, 2026.

Please note that this publication includes the specifications for measures and/or measure rates that are proposed for inclusion in the 2026 QRS measure set in the *Draft 2025 Call Letter for the Quality Rating System (QRS) and Qualified Health Plan (QHP) Enrollee Experience Survey* (Draft 2025 Call Letter). Refer to the *Final 2025 Call Letter for the QRS and QHP Enrollee Experience Survey* (Final 2025 Call Letter), anticipated June/July 2025, for finalized changes.

The *Quality Rating System and Qualified Health Plan Enrollee Experience Survey: Technical Guidance for 2026* (*2026 QRS and QHP Enrollee Survey Technical Guidance*) will announce which measures eligible QHP issuers are required to collect and submit to CMS for the 2026 ratings year.

New measures

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

Removed measures

- Antidepressant Medication Management (AMM).
- Cervical Cancer Screening (CCS)*.
- Childhood Immunization Status (CIS)*.
- Immunizations for Adolescents (IMA)*.
- ****Only the CCS-E, CIS-E and IMA-E measures will be reported. The CCS, CIS and IMA measures reported via the traditional method (i.e., administrative or hybrid) are retired.***

Revised measures

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

- The Breast Cancer Screening (BCS-E) measure was revised to include members ages 40–49 in alignment with updated guidelines released by the U.S. Preventive Services Task Force (USPSTF).
- The Adult Immunization Status (AIS-E) measure was revised to include an additional indicator to assess hepatitis B vaccination for adults ages 19–59 in an effort to drive improvement in vaccination rates.

Additional Resources

QRS and QHP Enrollee Survey Technical Guidance

Technical specification updates. The Centers for Medicare & Medicaid Services (CMS) publishes guidance for Qualified Health Plans (QHP) in the Exchanges to specify requirements for participating in the Quality Rating System (QRS), including the clinical and survey measures that must be reported. The *2026 QRS and QHP Enrollee Survey Technical Guidance* will be posted to the CMS Marketplace Quality Initiatives (MQI) website in the fall of 2025 (https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityInitiativesGenInfo/ACA-MQI/ACA-MQI-Landing-Page).

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 2026 QRS Measure Technical Specifications for MY 2025 will be posted to the CMS Marketplace Quality Initiatives (MQI) website in the fall of 2025 (https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityInitiativesGenInfo/ACA-MQI/ACA-MQI-Landing-Page).

NCQA will freeze the specifications for MY 2025 with the QRS Measure Technical Specifications release (March/April 2025).

The following are available for free order in the NCQA Store. Once ordered, they will be made available in the My Downloads section of My NCQA.

- **MY 2025 Quality Rating System (QRS) HEDIS Value Set Directory:** https://store.ncqa.org/my-2025-quality-rating-system-qrs-hedis-value-set-directory.html (anticipated release March/April 2025).
- **HEDIS MY 2025 Medication List Directory:** https://store.ncqa.org/hedis-my-2025-medication-list-directory.html (released March 31, 2025).
- **HEDIS MY 2025 Risk Adjustment Tables:** https://store.ncqa.org/hedis-my-2025-risk-adjustment-tables.html (released March 31, 2025).
- **MY 2025 QRS Random Number (RAND) Table:** https://store.ncqa.org/qrs-my-2025-rand.html (anticipated release by October 31, 2025).

Referring to HEDIS Measures and Rates

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

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

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

If You Have Questions About the Specifications

Policy Clarification Support

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

FAQs and Policy Updates

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

Reporting Hotline for Fraud and Misconduct

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

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

How to Report

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

Reporting Data Errors to NCQA

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

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

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

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

General Guidelines for Data Collection and Reporting

General Guidelines for Data Collection and Reporting

These MY 2025 HEDIS for QRS General Guidelines for the *2026 Quality Rating System Measure Technical Specifications* are unique to the issuers offering plans on the Exchanges and participating in the CMS Quality Rating System (QRS).[1,2]

SUMMARY OF CHANGES TO MY 2025 HEDIS FOR QRS

- Removed the data source reporting requirement from *General Guideline:* Race and Ethnicity Stratification.
- Revised *General Guideline:* Collecting Data for Measures With Multiple Numerator Events.
- Revised *General Guideline*: Mapping Proprietary or Other Codes.

HEDIS FOR QRS SPECIFIC GUIDANCE

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

MY 2025 HEDIS for QRS Data Collection

General Guideline: Exchange Product Line

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

General Guideline: Reporting Units (Product)

Organizations must collect HEDIS for QRS measure data for each product (EPO, HMO, POS, PPO) offered through an Exchange in 2026 that had more than 500 enrollees as of July 1 in the prior year (July 1, 2025) and continues to have more than 500 enrollees as of January 1 of the ratings year (January 1, 2026). Reporting units that are decertified or discontinued before June 15 of the ratings year (June 15, 2026) 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.

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

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

Definitions

EPO Exclusive provider organization. A type of health insurance product that usually limits coverage to care from providers, or groups of providers, who have contracts with the health insurance issuer to be part of a network of participating providers. EPO enrollees 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 financing and delivering 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, enrollees 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 enrollee uses in-network or out-of-network services. Common uses of "POS" include references to products that enroll each enrollee 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 2026 that had more than 500 enrollees as of July 1, 2025, and continues to have more than 500 enrollees as of January 1 of the ratings year (2026).

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.

General Guideline: Audit Preparation

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

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

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

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

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, 2025, 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 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 Benefit*. The organization did not offer the health benefit required by the measure (e.g., mental health, chemical dependency). Benefits are assessed at the global level, not the service level (refer to *General Guideline 16: Required Benefits*).

Rate/Result	Comment
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*.

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 [HMO, POS, PPO, EPO] 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 eligible population, starting on the official date of the merger or acquisition. For example, if the merger or acquisition occurred on March 1 of the measurement year, the surviving organization excludes members acquired from the non-surviving entity from the eligible population for January and February.

This guideline must be used consistently across all measures.

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 for QRS report. If a measure allows a gap at the end of the continuous enrollment period, report members in the product and product line-specific HEDIS report in which they were enrolled as of the last enrollment segment. The organization must use claims data from all products/ product lines, even when there is a gap in enrollment.

Measures without a continuous enrollment requirement. Members who enrolled in different products or product lines are reported in the product and product line-specific HEDIS report in which they were enrolled on the date of service (visits) or date of discharge requirement (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 re-enrollment). For example, if a member disenrolls on June 30 and re-enrolls on July 1, there is no gap, because the member is covered by the organization on both June 30 and July 1. If the member disenrolls on June 30 and re-enrolls on July 2, there is a 1-day gap because the member is without coverage on July 1.

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

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 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.

General Guideline: Anchor Dates

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

General Guideline: Required Benefits

HEDIS for QRS measures evaluate performance and hold organizations accountable for services provided in their members' benefits package. Measure specifications include benefits (medical, pharmacy, mental health, chemical dependency) required during the continuous enrollment period. HEDIS for QRS measures do not define benefits at the service or metal level (e.g., if the organization offers a pharmacy benefit but does not cover a specific medication class, the member has a pharmacy benefit and is included in the applicable measures requiring this benefit; similarly, if the member has partial coverage of mental health services (either by service or by diagnosis), they are included as having a mental health benefit). Organizations must assess benefits first at the organization level and then at the individual member level using continuous enrollment data.

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

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

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

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

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

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

This guideline must be used consistently across all measures.

General Guideline: Accessing Medical Records Prior to Enrollment

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

HEDIS for QRS Data Submission and Reporting to NCQA

General Guideline: HEDIS for QRS Reporting Date

For MY 2025 HEDIS for QRS, all organizations reporting data to NCQA through the IDSS must submit audited data to NCQA on or before **June 15, 2026.**

Note: *Organizations must submit and "plan-lock" audited HEDIS for QRS data to allow auditors sufficient time to review, approve and audit lock all submissions by the June 15 deadline. For MY 2025 HEDIS for QRS reporting, organizations are required to "plan-lock" audited HEDIS for QRS data no later than* ***June 1, 2026.***

Data Collection Methods and Data Sources

General Guideline: Data Collection Methods

HEDIS for QRS 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 eligible population and numerator. The reported rate is based on all members who meet the eligible population criteria and who are found through administrative data to have received the service required for the numerator.

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

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

ECDS Method: Refer to the *Guidelines for Measures Reported Using Electronic Clinical Data Systems* for additional information for this data collection method.

Note

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

General Guideline: Supplemental Data

Supplemental data uses. Organizations may find information about services for their members in administrative data, medical records and other data sources. When evidence to support the measure is found in multiple data sources, a hierarchy is applied. Supplemental data are considered last as long as the specifications are followed as written (e.g., if the organization uses a combination of data sources to identify the 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.
- Members in hospice and members who have died.

- Eligible population-required exclusions that are labeled as required exclusions in the specification.

Supplemental data may not be used for:

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

Supplemental Data Definitions

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

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

Audit requirements. Standard supplemental 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 year's 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 for QRS reporting.

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

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

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

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

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

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

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 primary source verification [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 to the reporting entity and what the entity does to the data. This is completed by the health plan; no documentation is required from the DAV entity, which has already been validated.
  - If the reporting entity processes the validated CCD in any way after receipt, the auditor may perform secondary source validation (SSV): examining 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.
  - 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 that indicates the validated data cases and clusters and the date when they were validated.

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 member-reported services (date and place of service, procedure, prescription, test result or finding, practitioner type). When using supplemental data derived from medical records to meet administrative specifications, documentation must be clinically synonymous with the codes included in the measure's value sets. Refer to General Guideline: *Member-Reported Services and Biometric Values*.

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

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

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

Supplemental Data Timeline

Supplemental data may be collected during the measurement year and into the beginning of the reporting year. Supplemental data collection and use must adhere to all applicable deadlines in the Audit Timeline posted on NCQA's website on March 31, 2025.

Identifying and Validating Supplemental Data

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

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

- 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 for QRS rates. Organizations may wait to load supplemental data until primary source verification is complete and the source is approved.

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

General Guideline: Obtaining Information for the Systematic Sample

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

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

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

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

Data refresh for the systematic sample. Because 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.

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

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

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

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

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

- If recent data contradict numerator compliance, those data must be used.
- If recent data exclude a member, those data must be used and the oversample must provide a substitute member.

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

General Guideline: Race and Ethnicity Stratification

This guideline provides instructions on how organizations categorize 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) Standards for Maintaining, Collecting, and Presenting Federal Data on Race and Ethnicity.[3,4,5]

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

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

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

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

Determining race reporting category

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

- *American Indian or Alaska Native*: Identification with any of the original peoples of North and South America (including Central America) and who maintain tribal affiliation or community attachment. It includes people who identify as "American Indian" or "Alaska Native" and includes groups such as Navajo Nation, Blackfeet Tribe, Mayan, Aztec, Native Village of Barrow Inupiat Traditional Government and Nome Eskimo Community.
- *Asian*: Identification with one or more nationalities or ethnic groups originating in the Far East, Southeast Asia or the Indian subcontinent. Examples of these groups include, but are not limited to, Chinese, Filipino, Asian Indian,

[1] Office of Management and Budget Revisions to the Standards for the Classification of Federal Data on Race and Ethnicity. https://www.govinfo.gov/content/pkg/FR-1997-10-30/pdf/97-28653.pdf
[2] 2020 Census Questions: Race. https://www.census.gov/programs-surveys/decennial-census/decade/2020/planning-management/release/faqs-race-ethnicity.html
[3] 2020 Census Questions: Hispanic Origin. https://www.census.gov/data/tables/2020/demo/hispanic-origin/2020-cps.html

Vietnamese, Korean and Japanese. The category also includes groups such as Pakistani, Cambodian, Hmong, Thai, Bengali or 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 and Somali. The category also includes groups such as Ghanaian, South African, Barbadian, Kenyan, Liberian and Bahamian.
- *Native Hawaiian or Other Pacific Islander*: Identification with one or more nationalities or ethnic groups originating in Hawaii, Guam, Samoa, or other Pacific Islands. Examples of these groups include, but are not limited to, Native Hawaiian, Samoan, Chamorro, Tongan, Fijian and Marshallese. The category also includes groups such as Palauan, Tahitian, Chuukese, Pohnpeian, Saipanese or Yapese.
- *White*: Identification with one or more nationalities or ethnic groups originating in Europe, the Middle East or North Africa. Examples of these groups include, but are not limited to, German, Irish, English, Italian, Lebanese, Egyptian, Polish, French, Iranian, Slavic, Cajun and Chaldean.
- *Some Other* Race: People whose race information has been collected but does not fit into any of the other seven race categories. This category includes people who may be Mulatto, Creole and Mestizo or another race not specified in the Census "Race" categories.
- *Two or More Races*: People with any combination of races, including "Some Other Race."
- *Asked But No Answer:* People who the organization asked to identify race but who declined to provide a response.
- *Unknown:* People for whom the organization did not obtain race information and for whom the organization did not receive a declined response (i.e., "Asked But No Answer").
- *Total:* Total of all categories above.

Determining ethnicity reporting category

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

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

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 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 includes any source for which the member self-identified race or ethnicity. This includes member self-reported data collected directly from members under 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.
- Electronic health records (EHR).
- 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 assigning 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 The reported value for race or for ethnicity is known, but the source is unknown (i.e., the organization has race or ethnicity value on file from a legacy system, but does not know the source).

No data 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 specific 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 eligible population and denominator after hybrid sampling.

Reporting Reporting of the race and ethnicity stratification follows the parameters for denominator size outlined in General Guideline: *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
White	White	Unknown
Hispanic	Unknown	Hispanic or Latino
Other	Some Other Race	Unknown
Unknown	Unknown	Unknown
(No equivalent category)	Native Hawaiian or Other Pacific Islander	Unknown
(No equivalent category)	Two or more races	Unknown

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

Race/Ethnicity Combined Category	HEDIS/OMB Race	HEDIS/OMB Ethnicity
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
Native Hawaiian and Other Pacific Islander	Native Hawaiian or Other Pacific Islander	Not Hispanic or Latino
White	White	Not Hispanic or Latino
Hispanic/Latino/Black	Black	Hispanic or Latino
Hispanic/Latino/White	White	Hispanic or Latino
Other	Some Other Race	Unknown
Multiple races marked	Two or More Races	Unknown
Unknown	Unknown	Unknown

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

HEDIS/OMB Race	CDCREC OMB Category Direct Reference Code*	CDCREC Detailed Category Value Set
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
Native Hawaiian or Other Pacific Islander	2076-8	Native Hawaiian or Other Pacific Islander Detailed Race Value Set
White	2106-3	White Detailed Race Value Set
Some Other Race	OTH**	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 LOINC codes, but are not.

**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 is a social construct, not biological; stratifying HEDIS measures by race and ethnicity is intended to be used to further understanding of racial and ethnic disparities in care and to hold health plans accountable to address such disparities, with the goal of achieving equitable health care and outcomes. Data are not to be used to further bias in health care or suggest that race and ethnicity are biological determinants of health.*
- *When multiple sources of data are used for race and ethnicity, there may be disagreements in the data collected. When this happens, data sources should be prioritized based on evaluation of anticipated accuracy. This includes use of specific categories over nonspecific categories, most frequent or consistently reported category and selection of data with clear provenance (source, method of collection) over data without clear provenance. 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, indirect, 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 the provider ordered the test), a collection date (the date when the specimen was drawn), a result/reported date (the date when results were calculated and reported), a claim date (the date of service on the claim) and a documented date (the date the provider documented the result in the medical record).

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

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

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

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

- If a member had an HbA1c sample collected on December 28 of the measurement year and an HbA1c result on January 2 of the year after the measurement year, the dates are within 7 days and

may be considered the same test. The result is present and the collection date is eligible for use in reporting.

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

General Guideline: Date Specificity

HEDIS for QRS requires that a date be specific enough to determine that an event occurred during the time frame established in the measure. For example, in the Childhood Immunization Status measure, members must receive three hepatitis B vaccines. For HEDIS MY 2025, assume a member was born on February 5, 2023. Documentation that the first hepatitis B vaccine was given "at birth" is specific enough to determine that it was given prior to the deadline for this measure (the child's second birthday), but if the documentation states that the third hepatitis B vaccine was given in February 2025, the organization cannot count the immunization, because the date is not specific enough to confirm that it occurred prior to the member's second birthday.

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

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

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: Measures That Use Medication Lists

Some measures require the use of clinical pharmacy data or pharmacy claims data to identify dispensed medications. The specifications reference medication lists that must be used for HEDIS for QRS

reporting for each pharmacy-dependent measure. In the specifications, medication list references are underlined (e.g., Diabetes Medications List). Medication lists used for HEDIS for QRS reporting are included in the Medication List Directory. A medication list includes the National Drug Codes (NDC) and RxNorm codes that may be used for reporting along with the generic name, the brand name (if applicable), the strength/dose and the route for each code.

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

General Guideline: Member-Collected Samples

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

General Guideline: Member-Reported Services and Biometric Values

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

HEDIS Coding Conventions

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 for QRS. Generally, a **principal diagnosis** (or primary diagnosis) is the diagnosis given at discharge and the one listed first on a claim

form. A diagnosis listed on a claim or encounter form that is not classified as the principal diagnosis is a **secondary diagnosis**. A claim form can contain several secondary diagnoses. Organizations follow the measure specifications to determine whether a diagnosis must be principal or can be secondary. If the specification does not specify that the principal diagnosis must be used, any applicable diagnosis is used.

Some measures require a specific principal diagnosis for eligibility; other measures allow any diagnosis (principal or secondary). For example, the Asthma Medication Ratio (AMR) measure specifies in certain bullets in the Event/diagnosis criteria that only a primary diagnosis of asthma is eligible. If a member's claim lists the principal diagnosis as "severe cough," but asthma is listed as a secondary diagnosis on the same claim form, the member is not included in the Asthma Medication Ratio measure.

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

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 for QRS appears in the organization's database with any modifier, the code may be counted in the HEDIS for QRS measure.

General Guideline: SNOMED Codes

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

General Guideline: Uniform Bill Code Specificity

HEDIS for QRS 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 for QRS 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 only 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 only 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 member'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 for QRS measures. Obsolete codes are deleted from the HEDIS for QRS specifications after the look-back period has passed.

For example, since the Asthma Medication Ratio measure counts a principal diagnosis of asthma in the measurement year or the year prior to the measurement year, asthma codes, for this measure, have a 2-year look-back period. A code that is designated obsolete effective January 1, 2024, is deleted from the specifications in HEDIS MY 2025 after the 2-year look-back period (2024, 2025) has passed.

HEDIS for QRS 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 specified otherwise in the measure specifications.
- For administrative-only measures, all data elements must be reported.

Coding

Example Data Elements for Reporting Table

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

HEDIS for QRS measures consist of one-to-many indicators for reporting. Each indicator corresponds to a unique combination of a metric and any stratifications (if applicable). For example, a measure with 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

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Guidelines for Calculations and Sampling

Guidelines for Calculations and Sampling

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

SUMMARY OF CHANGES TO MY 2025 HEDIS FOR QRS

- Removed references to the Childhood Immunization Status, Immunizations for Adolescents, Cervical Cancer Screening and Eye Exam for Patients With Diabetes measures from the Guidelines for Calculations and Sampling because these measures no longer include the Hybrid reporting method.
- Updated Table 1: Sample Size Information for Hybrid Measures.
- Updated the HEDIS MY 2025 RAND Table for Measures Using the Hybrid Method.
- Revised the Systematic Sampling Methodology.

How to Use the Administrative Method

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

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

Step 3 Calculate the rate.

Guidelines for the Hybrid Method

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

- Measures that can be collected using the Hybrid Method are listed in Table 1. Each hybrid measure can be classified into one of the following categories:
- *Membership-dependent denominator*—Defined by membership data only (e.g., members between 3 and 24 years of age, for *Child and Adolescent Well-Care Visits)* ***or***
- *Claim-dependent denominator*—Defined by membership and claims data (e.g., members diagnosed with hypertension, for *Controlling High Blood Pressure*).

Drawing the sample prior to the reporting year

Organizations are strongly encouraged to draw samples no earlier than January 2026 for the 2025 measurement year. This increases the accuracy and completeness of the eligible population from which the sample is drawn.

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

Claim-dependent denominators

The eligible population for the following measures is determined through membership data and claims data. Organizations may draw the sample for these measures as early as December 1 of the measurement year. If an organization draws the sample on or between December 1 and December 31 of the measurement year, it must perform the tasks included in the "Membership-

dependent denominators" section above (i.e., oversample as necessary and verify that members remain eligible on or after December 31 of the measurement year):

- 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 eligible population. Use Table 1 to determine the appropriate sample size for measures. For hybrid measures reported in the prior year, use the last column of Table 1 to determine whether the prior year's audited result can be used to reduce the current year's sample size. 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 commercial product line for a new measure and decides to implement the Hybrid Method.

Instead of using a sample size of 411, the organization reduces the sample size for this measure for its Exchange product line by using the 77% administrative rate and Table 2. According to Table 2, the minimum required sample size is 296. The sample size can be reduced even when the original eligible member (EM) population is less than 411.

Organization responsibility for chart review

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

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

Statistical assumptions for sample size

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

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

Table 1: Sample Size Information for Hybrid Measures

HEDIS for QRS Measure	Sample Size	Prior Year's Rate May Be Used to Reduce MY 2025 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] If the same sample is used for the two diabetes measures, the organization must first take the inverse of the Glycemic Status>9.0% rate (100 minus the Glycemic Status >9.0% rate) and then reduce using the lowest rate among all the reported indicators of the diabetes measures (the Glycemic Status 9.0% indicator of the GSD measure and the EED measure). If separate samples are used for these measures, organizations may reduce the sample based on the product line-specific current measurement year's administrative rate or the prior year's audited, product line-specific rate for the measure.

[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

If the Current Year's Administrative Rate or the Prior Year's Reported Rate Is…	…the Minimum Sample Size Is:
≤51%	411
52%	410
53%	410
54%	409
66%	371
67%	366
68%	360
69%	354
70%	348
71%	342
72%	335
73%	328
74%	321
75%	313
76%	305
77%	296
89%	172
90%	159
91%	147
92%	134
93%	120
94%	106
≥95%	100

Note

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

Systematic Sampling Methodology

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

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

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

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

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

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

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

Step 4 If EM ≤MRSS, all eligible members are included in the sample. The MRSS must be reported as the EM.

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

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

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

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

For example, for MY 2025 HEDIS for QRS, sort the list of EMs from Z to A. For HEDIS MY 2026, sort the list from A to Z.

Note: *Sort order applies to all components. For HEDIS MY 2025, sort all fields by descending order (i.e., last name descending, first name descending, date of birth descending, event descending).*

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

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

N = EM/(MRSS + all oversample records)

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

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

Use the Random Number (RAND) table for the appropriate measurement year that lists a value between 0 and 1 for each measure where the Hybrid Method is applicable. Refer to this table to determine the RAND to be used when determining START. The RAND for each measure is used to calculate the starting point from which to draw the final sample.

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

START = (RAND x N)

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

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

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

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

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

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

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

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

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

Oversample requests to NCQA

Any oversampling rate larger than 20% must be approved by NCQA annually. Organizations submit a formal request with the rationale to NCQA through PCS via My NCQA.

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

Oversampling methodology

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

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

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

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

The recommended methodology for substitution is:

- Replace the member's chart with that of the first member in the oversample list.
- Continue replacing each ineligible member with the next consecutive member of the oversample list.
- If the initial oversample was underestimated and all oversample members have been exhausted without satisfying the MRSS, the organization must contact NCQA through PCS via My NCQA to determine next steps.

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

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

Example 1

The eligible population 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 for QRS submission, which was 77%. Based on experience, estimate a 5% oversample rate. Follow the systematic sampling scheme.

Step 1 EM = 9,000.

Step 2 From Table 2, the MRSS is 296.

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

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

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

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

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

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

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

Example 2

The eligible member population for 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 EM = 389.

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

Step 3 *Skip this step.*

Step 4 Include all 389 members in your primary list.

Example 3

The eligible member population for 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 EM = 436.

Step 2 From Table 1, the MRSS is 411.

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

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

Step 5 *Skip this step.*

Step 6 *Skip this step.*

Step 7 *Skip this step.*

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

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

Example 4

The eligible member population for Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents is 400. Reduce the minimum required sample size using the rate from the prior year's HEDIS for QRS submission, which was 62%. Based on experience, estimate a 5% oversample rate. Follow the systematic sampling methodology.

Step 1 EM = 400.

Step 2 From Table 2, the MRSS is 388.

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

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

Step 5 *Skip this step.*

Step 6 *Skip this step.*

Step 7 *Skip this step.*

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

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

Complex Probability Sampling

Organization responsibility

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

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

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

Substituting Medical Records

Acceptable circumstances for substitution:

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

from the sample or substituted, except under the three circumstances described below.

1. Errors in sampling data

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

- A member selected for the Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents sample is found to be 18 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*. Employee and employee dependents are not excluded from administrative reporting and should not be removed before the sample is drawn.

References

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

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

Guidelines for Effectiveness of Care Measures

Guidelines for Effectiveness of Care Measures

SUMMARY OF CHANGES TO MY 2025 HEDIS FOR QRS

- No changes to these guidelines.

HEDIS FOR QRS SPECIFIC GUIDANCE

These guidelines apply to the following measures:

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

Guidelines

Which services count?

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

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

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

Note

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

  - *Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis.*
  - *Use of Imaging Studies for Low Back Pain.*
- *Organizations must include all claims (paid, suspended, pending and denied) for required exclusions in all the measures listed above.*

Measure format

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

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

Eligible population criteria

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

1. **Product line** (Exchange) applicable to the measure.
2. **Age** group and gender requirements.
3. **Continuous enrollment** criteria for the measure.
4. **Allowable gap** in benefits during the continuous enrollment period.
5. **Anchor date** specifies the required enrollment date for the eligible population.
6. **Benefit** a member must have during the continuous enrollment period to be included in the eligible population.
7. **Event/diagnosis** specifies the medical event or diagnosis requirements for the eligible population.

Administrative Specification

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

Hybrid Specification

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

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Guidelines for Access/Availability of Care Measures

Guidelines for Access/Availability of Care Measures

SUMMARY OF CHANGES TO MY 2025 HEDIS FOR QRS

- No changes to the guidelines.

HEDIS FOR QRS SPECIFIC GUIDANCE

These guidelines apply to the following measures:

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

Continuous Enrollment

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

Which Services Count?

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

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

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

Hybrid Methodology

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

Guidelines for Risk Adjusted Utilization Measures

Guidelines for Risk Adjusted Utilization Measures

SUMMARY OF CHANGES TO MY 2025 HEDIS FOR QRS

- No changes to these guidelines.

HEDIS FOR QRS SPECIFIC GUIDANCE

These guidelines apply to the following measure:

- Plan All-Cause Readmissions (PCR).

Guidelines

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

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

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

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

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

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

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

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

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

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

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

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

Risk Adjustment Comorbidity Category Determination

Step 1 Identify all diagnoses for encounters during the classification period for each denominator unit of the measure (i.e., denominator event or member). 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 during the classification period.
- Acute and nonacute inpatient discharges (Inpatient Stay Value Set) with a discharge date during the classification period.

Exclude the principal discharge diagnosis on the IHS.

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

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

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

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

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

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

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

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

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

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

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

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

Example: Table HCC—Rank

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

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

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

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

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

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

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

Example: Table HCC—Comb

Comorbid HCC 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

MY 2025 HEDIS for QRS Measure Technical Specifications

(Alphabetical Order)

Appropriate Treatment for Upper Respiratory Infection (URI)

SUMMARY OF CHANGES TO MY 2025 HEDIS FOR QRS

- No changes to this measure.

Description

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

Calculation

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

Definitions

Intake period July 1 of the year prior to the measurement year to June 30 of the measurement year. The intake period captures eligible episodes of treatment.

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.

Negative medication history To qualify for negative medication history, the following criteria must be met:

- A period of 30 days prior to the episode date when the member had no pharmacy claims for either new or refill prescriptions for a listed antibiotic drug.
- No prescriptions dispensed more than 30 days prior to the episode date that are active on the episode date.

A prescription is considered active if the "days supply" indicated on the date when the member was dispensed the prescription is the number of days or more between that date and the relevant service date. The 30-day look-back period for pharmacy data includes the 30 days prior to the intake period.

Negative comorbid condition history A period of 365 days prior to and including the episode date when the member had no claims/encounters with any diagnosis for a comorbid condition (366 days total).

Negative competing diagnosis The episode date and 3 days following the episode date when the member had no claims/encounters with a competing diagnosis.

Eligible Population

Product line Exchange.

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

Report three age stratifications and a total rate:

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

The total is the sum of the age stratifications.

Continuous enrollment	30 days prior to the episode date through 3 days after the episode date (34 total days).
Allowable gap	None.
Anchor date	None.
Benefits	Medical and pharmacy.
Event/diagnosis	Follow the steps below to identify the eligible population:
Step 1	Identify all members who had an outpatient visit, 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 member 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 member 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. Do not include laboratory claims (claims with POS code 81).
Step 4	Test for negative medication history. Remove episode dates where a new or refill prescription for an antibiotic medication (AAB Antibiotic Medications List) was dispensed 30 days prior to the episode date or was active on the episode date.
Step 5	Test for negative competing diagnosis. Remove episode dates where the member had a claim/encounter with a competing diagnosis on or three days after the episode date. Either of the following meets criteria for a competing diagnosis. Do not include laboratory claims (claims with POS code 81). • Pharyngitis Value Set. • Competing Diagnosis Value Set.
Step 6	Calculate continuous enrollment. The member must be continuously enrolled without a gap in coverage from 30 days prior to the episode date through 3 days after the episode date (34 days total).
Step 7	Deduplicate eligible episodes. If a member has more than one eligible episode in a 31-day period, include only the first eligible episode. For example, if a member has an eligible episode on January 1, include the January 1 visit and do not include eligible episodes that occur on or between January 2 and January 31; then, if applicable, include the next eligible episode that occurs on or after February 1. Identify visits chronologically, including only one per 31-day period. ***Note:*** *The denominator for this measure is based on episodes, not on members. All eligible episodes that were not removed or deduplicated remain in the denominator.*
Required exclusions	Exclude members who meet either of the following criteria: • Members who use hospice services (Hospice Encounter Value Set; Hospice Intervention Value Set) or elect to use a hospice benefit any time during the measurement year. Organizations that use the Monthly Membership Detail Data File to identify these members must use only the run date of the file to

determine if the member elected to use a hospice benefit during the measurement year.

- Members who die any time during the measurement year.

Administrative Specification

Denominator The eligible population.

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

AAB Antibiotic Medications

Description	Prescription		
Aminoglycosides	• Amikacin • Gentamicin	• Streptomycin • Tobramycin	
Aminopenicillins	• Amoxicillin	• Ampicillin	
Beta-lactamase inhibitors	• Amoxicillin-clavulanate	• Ampicillin-sulbactam	• Piperacillin-tazobactam
First-generation cephalosporins	• Cefadroxil	• Cefazolin	• Cephalexin
Fourth-generation cephalosporins	• Cefepime		
Lincomycin derivatives	• Clindamycin	• Lincomycin	
Macrolides	• Azithromycin	• Clarithromycin	• Erythromycin
Miscellaneous antibiotics	• Aztreonam • Chloramphenicol • Dalfopristin-quinupristin	• Daptomycin • Linezolid • Metronidazole	• Vancomycin
Natural penicillins	• Penicillin G benzathine-procaine • Penicillin G potassium	• Penicillin G procaine • Penicillin G sodium	• Penicillin V potassium • Penicillin G benzathine
Penicillinase resistant penicillins	• Dicloxacillin	• Nafcillin	• Oxacillin
Quinolones	• Ciprofloxacin • Gemifloxacin	• Levofloxacin • Moxifloxacin	• Ofloxacin
Rifamycin derivatives	• Rifampin		
Second-generation cephalosporin	• Cefaclor • Cefotetan	• Cefoxitin • Cefprozil	• Cefuroxime
Sulfonamides	• Sulfadiazine	• Sulfamethoxazole-trimethoprim	
Tetracyclines	• Doxycycline	• Minocycline	• Tetracycline
Third-generation cephalosporins	• Cefdinir • Cefixime	• Cefotaxime • Cefpodoxime	• Ceftazidime • Ceftriaxone
Urinary anti-infectives	• Fosfomycin • Nitrofurantoin	• Nitrofurantoin macrocrystals-monohydrate • Trimethoprim	

Note

- *Although denied claims are not included when assessing the numerator, all claims (paid, suspended, pending and denied) must be included when identifying the eligible population.*

- *Supplemental data may not be used for this measure, except for required exclusions.*

Data Elements for Reporting

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

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

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

Asthma Medication Ratio (AMR)

SUMMARY OF CHANGES TO MY 2025 HEDIS FOR QRS

- Clarified in the *Note* to not use RxNorm codes when identifying required exclusions.
- Removed the data source reporting requirement from the race and ethnicity stratification.

HEDIS FOR QRS SPECIFIC GUIDANCE

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

Description

The percentage of members 5–64 years of age who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater during the measurement year.

Definitions

Oral medication dispensing event

One prescription of an amount lasting 30 days or less. To calculate dispensing events for prescriptions longer than 30 days, divide the days supply by 30 and round down to convert. For example, a 100-day prescription is equal to three dispensing events (100/30 = 3.33, rounded down to 3). Allocate the dispensing events to the appropriate year based on the date when the prescription is dispensed.

Multiple prescriptions for different medications dispensed on the same day are counted as separate dispensing events. If multiple prescriptions for the same medication are dispensed on the same day, sum the days supply and divide by 30.

Use the medication lists to determine if drugs are the same or different. Drugs in different medication lists are considered different drugs.

Inhaler dispensing event

When identifying the eligible population, use the definition below to count inhaler dispensing events.

All inhalers (i.e., canisters) of the same medication dispensed on the same day count as one dispensing event. Different inhaler medications dispensed on the same day are counted as different dispensing events. For example, if a member received three canisters of Medication A and two canisters of Medication B on the same date, it would count as two dispensing events.

Allocate the dispensing events to the appropriate year based on the date when the prescription was dispensed.

Use the medication lists to determine if drugs are the same or different. Drugs in different medication lists are considered different drugs.

Injection dispensing event

Each injection counts as one dispensing event. Multiple dispensed injections of the same or different medications count as separate dispensing events. For example, if a member received two injections of Medication A and one injection of Medication B on the same date, it would count as three dispensing events.

Use the medication lists to determine if drugs are the same or different. Drugs in different medication lists are considered different drugs. Allocate the dispensing events to the appropriate year based on the date when the prescription was dispensed.

Units of medication

When identifying medication units for the numerator, count each individual medication, defined as an amount lasting 30 days or less, as one medication unit. One medication unit equals one inhaler canister, one injection, one infusion or a 30 days or less supply of an oral medication. For example, two inhaler canisters of the same medication dispensed on the same day count as two medication units and only one dispensing event.

Use the package size and units columns in the medication lists to determine the number of canisters or injections. Divide the dispensed amount by the package size to determine the number of canisters or injections dispensed. For example, if the package size for an inhaled medication is 10 g and pharmacy data indicate the dispensed amount is 30 g, three inhaler canisters were dispensed.

Eligible Population

Product line

Exchange.

Stratifications

Report the following stratifications by race and total, and stratifications by ethnicity and total:

- Race:
  - American Indian or Alaska Native.
  - Asian.
  - Black or African American.
  - Native Hawaiian or Other Pacific Islander.
  - White.
  - Some Other Race.
  - Two or More Races.
  - Asked But No Answer.
  - Unknown.
  - Total.
- Ethnicity:
  - Hispanic or Latino.
  - Not Hispanic or Latino.
  - Asked But No Answer.
  - Unknown.
  - Total.

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

Ages

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

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

The total is the sum of the age stratifications.

Continuous enrollment

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

Allowable gap

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

Anchor date

December 31 of the measurement year.

Benefits

Medical. Pharmacy during the measurement year.

Event/diagnosis

Follow the steps below to identify the eligible population.

Step 1

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

- At least one ED visit or acute inpatient encounter (ED and Acute Inpatient Value Set), with a principal diagnosis of asthma (Asthma Value Set).
- At least one acute inpatient discharge with a principal diagnosis of asthma (Asthma Value Set) on the discharge claim. To identify an acute inpatient discharge:
  1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
  2. Exclude nonacute inpatient stays (Nonacute Inpatient Stay Value Set).
  3. Identify the discharge date for the stay.
- At least four outpatient visits, telephone visits or e-visits or virtual check-ins (Outpatient and Telehealth Value Set), on different dates of service, with any diagnosis of asthma (Asthma Value Set) ***and*** at least two asthma medication dispensing events for any controller or reliever medication. Visit type need not be the same for the four visits. Use all the medication lists in the tables below to identify asthma controller and reliever medications.
- At least four asthma medication dispensing events for any controller or reliever medication. Use all the medication lists in the tables below to identify asthma controller and reliever medications.

Step 2

A member identified as having persistent asthma because of at least four asthma medication dispensing events, where leukotriene modifiers or antibody inhibitors were the sole asthma medication dispensed in that year, must also have at least one diagnosis of asthma (Asthma Value Set), in any setting, in the same year as the leukotriene modifier or antibody inhibitor (the measurement year or the year prior to the measurement year). Do not include laboratory claims (claims with POS code 81).

Required exclusions

Exclude members who met any of the following criteria:

- Members who had any diagnosis that requires a different treatment approach than members with asthma (Respiratory Diseases With Different Treatment Approaches Than Asthma Value Set) any time during the member's history

through December 31 of the measurement year. Do not include laboratory claims (claims with POS code 81).

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

Administrative Specification

Denominator The eligible population.

Numerator The number of members who have a medication ratio of ≥0.50 during the measurement year. Follow the steps below to calculate the ratio.

Use all the medication lists in the Asthma Controller Medications table below to identify asthma controller medications. Use all the medication lists in the Asthma Reliever Medications table below to identify asthma reliever medications.

Step 1 For each member, count the units of asthma controller medications dispensed during the measurement year. Refer to the definition of *Units of medications*.

Step 2 For each member, count the units of asthma reliever medications dispensed during the measurement year. Refer to the definition of *Units of medications*.

Step 3 For each member, sum the units calculated in step 1 and step 2 to determine units of total asthma medications.

Step 4 For each member, calculate the ratio of controller medications to total asthma medications using the following formula. Round (using the 0.5 rule) to the nearest whole number.

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

Step 5 Sum the total number of members who have a ratio of ≥0.50 in step 4.

Asthma Controller Medications

Description	Prescriptions	Medication Lists	Route
Antibody inhibitors	• Omalizumab	Omalizumab Medications List	Injection
Anti-interleukin-4	• Dupilumab	Dupilumab Medications List	Injection
Anti-interleukin-5	• Benralizumab	Benralizumab Medications List	Injection
Anti-interleukin-5	• Mepolizumab	Mepolizumab Medications List	Injection
Anti-interleukin-5	• Reslizumab	Reslizumab Medications List	Injection
Inhaled steroid combinations	• Budesonide-formoterol	Budesonide Formoterol Medications List	Inhalation

Description	Prescriptions	Medication Lists	Route
Inhaled steroid combinations	• Fluticasone-salmeterol	Fluticasone Salmeterol Medications List	Inhalation
Inhaled steroid combinations	• Fluticasone-vilanterol	Fluticasone Vilanterol Medications List	Inhalation
Inhaled steroid combinations	• Formoterol-mometasone	Formoterol Mometasone Medications List	Inhalation
Inhaled corticosteroids	• Beclomethasone	Beclomethasone Medications List	Inhalation
Inhaled corticosteroids	• Budesonide	Budesonide Medications List	Inhalation
Inhaled corticosteroids	• Ciclesonide	Ciclesonide Medications List	Inhalation
Inhaled corticosteroids	• Flunisolide	Flunisolide Medications List	Inhalation
Inhaled corticosteroids	• Fluticasone	Fluticasone Medications List	Inhalation
Inhaled corticosteroids	• Mometasone	Mometasone Medications List	Inhalation
Leukotriene modifiers	• Montelukast	Montelukast Medications List	Oral
Leukotriene modifiers	• Zafirlukast	Zafirlukast Medications List	Oral
Leukotriene modifiers	• Zileuton	Zileuton Medications List	Oral
Methylxanthines	• Theophylline	Theophylline Medications List	Oral

Asthma Reliever Medications

Description	Prescriptions	Medication Lists	Route
Short-acting, inhaled beta-2 agonists	Albuterol	Albuterol Medications List	Inhalation
Short-acting, inhaled beta-2 agonists	Levalbuterol	Levalbuterol Medications List	Inhalation

Note

- *Do not use RxNorm codes when identifying required exclusions or assessing the numerator.*
- *When mapping NDC codes, medications described as "injection," "prefilled syringe," "subcutaneous," "intramuscular" or "auto-injector" are considered "injections" (route).*
- *When mapping NDC codes, medications described as "metered dose inhaler," "dry powder inhaler" or "inhalation powder" are considered "inhalation" (route) medications.*
- *Do not map medications described as "nasal spray" to "inhalation" medications.*

Data Elements for Reporting

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

Table AMR-A-4: Data Elements for Asthma Medication Ratio

Metric	Age	Data Element	Reporting Instructions
AsthmaMedicationRatio	5-11	Benefit	Metadata
	12-18	EligiblePopulation	For each Stratification
	19-50	ExclusionAdminRequired	For each Stratification
	51-64	NumeratorByAdmin	For each Stratification
	Total	NumeratorBySupplemental	For each Stratification
		Rate	(Percent)

Table AMR-B-4: Data Elements for Asthma Medication Ratio: Stratifications by Race

Metric	Race	Data Element	Reporting Instructions
AsthmaMedicationRatio	AmericanIndianOrAlaskaNative	EligiblePopulation	For each Stratification
	Asian	Numerator	For each Stratification
	BlackOrAfricanAmerican	Rate	(Percent)
	NativeHawaiianOrOtherPacificIslander		
	White		
	SomeOtherRace		
	TwoOrMoreRaces		
	AskedButNoAnswer		
	Unknown		

Table AMR-C-4: Data Elements for Asthma Medication Ratio: Stratifications by Ethnicity

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

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

SUMMARY OF CHANGES TO MY 2025 HEDIS FOR QRS

- No changes to this measure.

Description

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

Calculation

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

Definitions

Intake period July 1 of the year prior to the measurement year to June 30 of the measurement year. The intake period captures eligible episodes of treatment.

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.

Negative medication history To qualify for negative medication history, the following criteria must be met:

- A period of 30 days prior to the episode date, when the member had no pharmacy claims for either new or refill prescriptions for a listed antibiotic drug.
- No prescriptions that were dispensed more than 30 days prior to the episode date and are active on the episode date.

A prescription is considered active if the “days supply” indicated on the date when the member was dispensed the prescription is the number of days or more between that date and the relevant service date. The 30-day look-back period for pharmacy data includes the 30 days prior to the intake period.

Negative comorbid condition history A period of 365 days prior to and including the episode date when the member had no claims/encounters with any diagnosis for a comorbid condition (366 days total).

Negative competing diagnosis The episode date and 3 days following the episode date when the member had no claims/encounters with any competing diagnosis.

Eligible Population

Product line Exchange.

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

Report three age stratifications and a total rate:

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

	The total is the sum of the age stratifications.
Continuous enrollment	30 days prior to the episode date through 3 days after the episode date (34 total days).
Allowable gap	None.
Anchor date	None.
Benefits	Medical and pharmacy.
Event/diagnosis	Follow the steps below to identify the eligible population:
Step 1	Identify all members who had an outpatient visit, ED visit, telephone visit, e-visit or virtual check-in (Outpatient, ED and Telehealth Value Set) during the intake period, with a diagnosis of acute bronchitis/bronchiolitis (Acute Bronchitis Value Set).
Step 2	Determine all acute bronchitis/bronchiolitis episode dates. For each member identified in step 1, determine all outpatient, telephone or ED visits, e-visits and virtual check-ins with a diagnosis of acute bronchitis/bronchiolitis. Exclude visits that result in an inpatient stay (Inpatient Stay Value Set).
Step 3	Test for negative comorbid condition history. Remove episode dates where the member had a claim/encounter with any diagnosis for a comorbid condition (Comorbid Conditions Value Set) during the 365 days prior to or on the episode date. Do not include laboratory claims (claims with POS code 81).
Step 4	Test for negative medication history. Remove episode dates where a new or refill prescription for an antibiotic medication (AAB Antibiotic Medications List) was dispensed 30 days prior to the episode date or was active on the episode date.
Step 5	Test for Negative Competing Diagnosis. Remove episode dates where the member had a claim/encounter with a competing diagnosis on or 3 days after the episode date. Either of the following meets criteria for a competing diagnosis. Do not include laboratory claims (claims with POS code 81). • Pharyngitis Value Set. • Competing Diagnosis Value Set.
Step 6	Calculate continuous enrollment. The member must be continuously enrolled without a gap in coverage from 30 days prior to the episode date through 3 days after the episode date (34 total days).
Step 7	Deduplicate eligible episodes. If a member has more than one eligible episode in a 31-day period, include only the first eligible episode. For example, if a member has an eligible episode on January 1, include the January 1 visit and do not include eligible episodes that occur on or between January 2 and January 31; then, if applicable, include the next eligible episode that occurs on or after February 1. Identify visits chronologically, including only one per 31-day period. ***Note:*** *The denominator for this measure is based on episodes, not on members. All eligible episodes that were not excluded or deduplicated remain in the denominator.*

Required exclusions

Exclude members who meet either of the following criteria:

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

Administrative Specification

Denominator The eligible population.

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

AAB Antibiotic Medications

Description	Prescription		
Aminoglycosides	• Amikacin • Gentamicin	• Streptomycin • Tobramycin	
Aminopenicillins	• Amoxicillin	• Ampicillin	
Beta-lactamase inhibitors	• Amoxicillin-clavulanate	• Ampicillin-sulbactam	• Piperacillin-tazobactam
First-generation cephalosporins	• Cefadroxil	• Cefazolin	• Cephalexin
Fourth-generation cephalosporins	• Cefepime		
Lincomycin derivatives	• Clindamycin	• Lincomycin	
Macrolides	• Azithromycin	• Clarithromycin	• Erythromycin
Miscellaneous antibiotics	• Aztreonam • Chloramphenicol • Dalfopristin-quinupristin	• Daptomycin • Linezolid • Metronidazole	• Vancomycin
Natural penicillins	• Penicillin G benzathine-procaine • Penicillin G potassium • Penicillin G procaine	• Penicillin G sodium • Penicillin V potassium	• Penicillin G benzathine
Penicillinase resistant penicillins	• Dicloxacillin	• Nafcillin	• Oxacillin
Quinolones	• Ciprofloxacin • Gemifloxacin	• Levofloxacin • Moxifloxacin	• Ofloxacin
Rifamycin derivatives	• Rifampin		
Second-generation cephalosporin	• Cefaclor • Cefotetan	• Cefoxitin • Cefprozil	• Cefuroxime
Sulfonamides	• Sulfadiazine	• Sulfamethoxazole-trimethoprim	
Tetracyclines	• Doxycycline	• Minocycline	• Tetracycline
Third-generation cephalosporins	• Cefdinir • Cefixime	• Cefotaxime • Cefpodoxime	• Ceftazidime • Ceftriaxone
Urinary anti-infectives	• Fosfomycin • Nitrofurantoin	• Nitrofurantoin macrocrystals-monohydrate • Trimethoprim	

Note

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

Data Elements for Reporting

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

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

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

Child and Adolescent Well-Care Visits (WCV)

SUMMARY OF CHANGES TO MY 2025 HEDIS FOR QRS

- Removed telehealth well visits from the numerator.
- Removed the data source reporting requirement from the race and ethnicity stratification.

HEDIS FOR QRS SPECIFIC GUIDANCE

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

Description

The percentage of members 3–21 years of age who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year.

Note: *This measure has the same structure as measures in the Effectiveness of Care domain. The organization must follow the* Guidelines for Effectiveness of Care Measures *when calculating this measure.*

Eligible Population

Product line

Exchange.

Stratifications

Report the following stratifications by race and total, and stratifications by ethnicity and total:

- Race:
  - American Indian or Alaska Native.
  - Asian.
  - Black or African American.
  - Native Hawaiian or Other Pacific Islander.
  - White.
  - Some Other Race.
  - Two or More Races.
  - Asked But No Answer.
  - Unknown.
  - Total.
- Ethnicity:
  - Hispanic or Latino.
  - Not Hispanic or Latino.
  - Asked But No Answer.
  - Unknown.
  - Total.

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

Ages

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

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

The total is the sum of the age stratifications.

Continuous enrollment The measurement year.

Allowable gap No more than one gap in enrollment of up to 45 days during the continuous enrollment period.

Anchor date December 31 of the measurement year.

Benefit Medical.

Event/diagnosis None.

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

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

Administrative Specification

Denominator The eligible population.

Numerator One or more well-care visits during the measurement year. Either of the following meet the criteria:

- A well-care visit (Well-Care Value Set).
- An encounter for well-care (Encounter for Well Care Value Set). Do not include laboratory claims (claims with POS code 81).

Do not include telehealth visits (visits billed with a code that indicates telehealth: Telehealth POS Value Set; Online Assessments Value Set; Telephone Visits Value Set).

The well-care visit must occur with a PCP or an OB/GYN practitioner, but the practitioner does not have to be the practitioner assigned to the member.

Note

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

Data Elements for Reporting

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

Table WCV-A-4: Data Elements for Child and Adolescent Well-Care Visits

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

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

Metric	Race	Data Element	Reporting Instructions
ChildAdolescentWellVisits	AmericanIndianOrAlaskaNative	EligiblePopulation	For each Stratification
	Asian	Numerator	For each Stratification
	BlackOrAfricanAmerican	Rate	(Percent)
	NativeHawaiianOrOtherPacificIslander		
	White		
	SomeOtherRace		
	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	EligiblePopulation	For each Stratification
	NotHispanicOrLatino	Numerator	For each Stratification
	AskedButNoAnswer	Rate	(Percent)
	Unknown		

Chlamydia Screening (CHL)

SUMMARY OF CHANGES TO MY 2025 HEDIS FOR QRS

- Updated the measure title from *Chlamydia Screening in Women* to *Chlamydia Screening*.
- Replaced references to "women" with "members recommended for routine chlamydia screening."
- Added criteria for "members recommended for routine chlamydia screening" to the eligible population.
- Added an exclusion for members who were assigned male at birth.
- Added a note to clarify that supplemental data can be used to identify members recommended for routine chlamydia screening.

Description

The percentage of members 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 year.

Eligible Population

Product line	Exchange.
Ages	Members 16–24 years as of December 31 of the measurement year. Report two age stratifications and a total rate: • 16–20 years. • 21–24 years. • Total. The total is the sum of the age stratifications.
Continuous enrollment	The measurement year.
Allowable gap	No more than one gap in enrollment of up to 45 days during the measurement year.
Anchor date	December 31 of the measurement year.
Benefit	Medical.
Members recommended for routine chlamydia screening	Include members recommended for routine chlamydia screening with any of the following criteria: • Administrative Gender: Female (AdministrativeGender code female) any time in the member's history. • Sex Assigned at Birth: (LOINC code 76689-9) Female (LOINC code LA3-6) any time in the member's history. • Sex Parameter for Clinical Use of Female (SexParameterForClinicalUse code female-typical) during the measurement year.
Event/diagnosis	Follow the steps below to identify the eligible population.
Step 1	Identify members who were recommended for routine chlamydia screening and are sexually active. Two methods identify sexually active members: pharmacy

data and claim/encounter data. The organization must use both methods to identify the eligible population, but a member only needs to be identified in one method to be eligible for the measure.

Claim/encounter data. Members who had a claim or encounter indicating sexual activity during the measurement year. Any of the following meets criteria.

- Diagnoses Indicating Sexual Activity Value Set. Do not include laboratory claims (claims with POS code 81).
- Procedures Indicating Sexual Activity Value Set.
- Pregnancy Tests Value Set.

Pharmacy data. At least one contraceptive medication dispensing event during the measurement year (Contraceptive Medications List).

Contraceptive Medications

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

Step 2

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

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

Retinoid Medications

Description	Prescription
Retinoid	Isotretinoin

Required exclusions

Exclude members who meet either of the following criteria:

- Sex Assigned at Birth: (LOINC code 76689-9) Male (LOINC code LA2-8) any time in the member's history.
- Members who use hospice services (Hospice Encounter Value Set; Hospice Intervention Value Set) or elect to use a hospice benefit any time during the measurement year. Organizations that use the Monthly Membership Detail

Data File to identify these members must use only the run date of the file to determine if the member elected to use a hospice benefit during the measurement year.

- Members who die any time during the measurement year.

Administrative Specification

Denominator The eligible population.

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

Note

- *Do not include supplemental data when identifying the eligible population, except when identifying members recommended for routine chlamydia screening criteria and required exclusions.*

Data Elements for Reporting

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

Table CHL-4: Data Elements for Chlamydia Screening

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

Controlling High Blood Pressure (CBP)

SUMMARY OF CHANGES TO MY 2025 HEDIS FOR QRS

- Removed the data source reporting requirement from the race and ethnicity stratification.
- Revised the required exclusions.

HEDIS FOR QRS SPECIFIC GUIDANCE

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

Description

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

Definitions

Adequate control Both a representative systolic BP <140 mm Hg and a representative diastolic BP of <90 mm Hg.

Representative BP The most recent BP reading during the measurement year on or after the second diagnosis of hypertension. If multiple BP measurements occur on the same date, or are noted in the chart on the same date, use the lowest systolic and lowest diastolic BP reading. If no BP is recorded during the measurement year, assume that the member is "not controlled."

Eligible Population

Product line Exchange.

Stratifications Report the following stratifications by race and total, and stratifications by ethnicity and total:

- Race:
  - American Indian or Alaska Native.
  - Asian.
  - Black or African American.
  - Native Hawaiian or Other Pacific Islander.
  - White.
  - Some Other Race.
  - Two or More Races.
  - Asked But No Answer.
  - Unknown.
  - Total.
- Ethnicity:
  - Hispanic or Latino.
  - Not Hispanic or Latino.
  - Asked But No Answer.
  - Unknown.

– Total.

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

Ages 18–85 years as of December 31 of the measurement year.

Continuous enrollment The measurement year.

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

Anchor date December 31 of the measurement year.

Benefit Medical.

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

Step 1 Identify members who had at least two 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 year and June 30 of the measurement year.

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

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

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

- Members who use hospice services (Hospice Encounter Value Set; Hospice Intervention Value Set) or elect to use a hospice benefit any time during the measurement year. Organizations that use the Monthly Membership Detail Data File to identify these members must use only the run date of the file to determine if the member elected to use a hospice benefit during the measurement year.
- Members who die any time during the measurement year.
- Members receiving palliative care (Palliative Care Assessment Value Set; Palliative Care Encounter Value Set; Palliative Care Intervention Value Set) during the measurement year.
- Members who had an encounter for palliative care (ICD-10-CM code Z51.5) any time during the measurement year. Do not include laboratory claims (claims with POS code 81).
- Members with a diagnosis that indicates end-stage renal disease (ESRD) (ESRD Diagnosis Value Set; History of Nephrectomy or Kidney Transplant Value Set), any time during the member's history on or prior to December 31 of the measurement year. Do not include laboratory claims (claims with POS code 81).
- Members with a procedure that indicates ESRD: dialysis (Dialysis Procedure Value Set), nephrectomy (Total Nephrectomy Value Set; Partial Nephrectomy

Value Set) or kidney transplant (Kidney Transplant Value Set) any time during the member's history on or prior to December 31 of the measurement year.

- Members with a diagnosis of pregnancy (Pregnancy Value Set) any time during the measurement year. Do not include laboratory claims (claims with POS code 81).
- Members 66–80 years of age as of December 31 of the measurement year with frailty ***and*** advanced illness. Members must meet **BOTH** frailty and advanced illness criteria to be excluded:
  1. **Frailty**. At least two indications of frailty (Frailty Device Value Set; Frailty Diagnosis Value Set; Frailty Encounter Value Set; Frailty Symptom Value Set) with different dates of service during the measurement year. Do not include laboratory claims (claims with POS code 81).
  2. **Advanced Illness**. Either of the following during the measurement year or the year prior to the measurement year:
     - Advanced illness (Advanced Illness Value Set) on at least two different dates of service. Do not include laboratory claims (claims with POS code 81).
     - Dispensed dementia medication (Dementia Medications List).
- Members 81 years of age and older as of December 31 of the measurement year with at least two indications of frailty (Frailty Device Value Set; Frailty Diagnosis Value Set; Frailty Symptom Value Set) with different dates of service during the measurement year. Do not include laboratory claims (claims with POS code 81).

Dementia Medications

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

Administrative Specification

Denominator The eligible population.

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

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

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

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

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

Hybrid Specification

Denominator

A systematic sample drawn from the eligible population.

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

Identifying the medical record

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

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

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

Numerator

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

Administrative

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

Medical record

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

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

Do not include BP readings:

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

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

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

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

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

Note

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

Data Elements for Reporting

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

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

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

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

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

Enrollment by Product Line (ENP)

SUMMARY OF CHANGES TO MY 2025 HEDIS FOR QRS

- No changes to this measure.

Description

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

Calculations

Product line 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.

Data Elements for Reporting

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

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)

SUMMARY OF CHANGES TO MY 2025 HEDIS FOR QRS

- Moved bilateral eye enucleation from the numerator to required exclusions.
- Added new criteria for identifying numerator events.
- Removed the Hybrid Data Collection Method.
- Removed the data source reporting requirement from the race and ethnicity stratification.
- Revised the required exclusions and numerator.

HEDIS FOR QRS SPECIFIC GUIDANCE

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

Description

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

Eligible Population

Product line Exchange.

Stratifications Report the following stratifications by race and total, and stratifications by ethnicity and total:

- Race:
  - American Indian or Alaska Native.
  - Asian.
  - Black or African American.
  - Native Hawaiian or Other Pacific Islander.
  - White.
  - Some Other Race.
  - Two or More Races.
  - Asked But No Answer.
  - Unknown.
  - Total.
- Ethnicity:
  - Hispanic or Latino.
  - Not Hispanic or Latino.
  - Asked But No Answer.
  - Unknown.
  - Total.

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

Ages 18–75 years as of December 31 of the measurement year.

Continuous enrollment The measurement year.

Allowable gap No more than one gap in enrollment of up to 45 days during the measurement year.

Anchor date December 31 of the measurement year.

Benefit Medical.

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

Claim/encounter data. Members who had at least two diagnoses of diabetes (Diabetes Value Set) on different dates of service during the measurement year or prior to the measurement year. Do not include laboratory claims (claims with POS code 81).

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) and have at least one diagnosis of diabetes (Diabetes Value Set) during the measurement year or the year prior to the measurement year. Do not include laboratory claims (claims with POS code 81).

Diabetes Medications

Description	Prescription		
Alpha-glucosidase inhibitors	• Acarbose	• Miglitol	
Amylin analogs	• Pramlintide		
Antidiabetic combinations	• Alogliptin-metformin • Alogliptin-pioglitazone • Canagliflozin-metformin • Dapagliflozin-metformin • Dapagliflozin-saxagliptin • Empagliflozin-linagliptin • Empagliflozin-linagliptin metformin	• Empagliflozin-metformin • Ertugliflozin-metformin • Ertugliflozin-sitagliptin • Glimepiride-pioglitazone • Glipizide-metformin • Glyburide-metformin	• Linagliptin-metformin • Metformin-pioglitazone • Metformin-repaglinide • Metformin-rosiglitazone • Metformin-saxagliptin • Metformin-sitagliptin
Insulin	• Insulin aspart • Insulin aspart-insulin aspart protamine • Insulin degludec • Insulin degludec-liraglutide • Insulin detemir	• Insulin glargine • Insulin glargine-lixisenatide • Insulin glulisine • Insulin isophane human • Insulin isophane-insulin regular	• Insulin lispro • Insulin lispro-insulin lispro protamine • Insulin regular human • Insulin human inhaled
Meglitinides	• Nateglinide	• Repaglinide	
Biguanides	• Metformin		

Description	Prescription		
Glucagon-like peptide-1 (GLP1) agonists	• Albiglutide • Dulaglutide • Exenatide • Liraglutide	• Lixisenatide • Semaglutide • Tirzepatide	
Sodium glucose cotransporter 2 (SGLT2) inhibitor	• Canagliflozin	• Dapagliflozin	• Empagliflozin • Ertugliflozin
Sulfonylureas	• Chlorpropamide • Glimepiride	• Glipizide • Glyburide	• Tolazamide • Tolbutamide
Thiazolidinediones	• Pioglitazone	• Rosiglitazone	
Dipeptidyl peptidase-4 (DDP-4) inhibitors	• Alogliptin • Linagliptin	• Saxagliptin • Sitagliptin	

Required exclusions

Exclude members who meet any of the following criteria:

- Bilateral absence of eyes (SNOMED CT code 15665641000119103) anytime during the member's history through December 31 of the measurement year.
- Bilateral eye enucleation any time during the member's history through December 31 of the measurement year:
  - 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. For example, if the service date for the first unilateral eye enucleation was February 1 of the measurement year, the service date for the second unilateral eye enucleation must be on or after February 15.
  - Left unilateral eye enucleation (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.
- Members who use hospice services (Hospice Encounter Value Set; Hospice Intervention Value Set) or elect to use a hospice benefit any time during the measurement year. Organizations that use the Monthly Membership Detail Data File to identify these members must use only the run date of the file to determine if the member elected to use a hospice benefit during the measurement year.
- Members who die any time during the measurement year.
- Members receiving palliative care (Palliative Care Assessment Value Set; Palliative Care Encounter Value Set; Palliative Care Intervention Value Set) any time during the measurement year.

- Members who had an encounter for palliative care (ICD-10-CM code Z51.5) any time during the measurement year. Do not include laboratory claims (claims with POS code 81).
- Members 66 years of age and older as of December 31 of the measurement year with frailty **and** advanced illness. Members must meet **both** frailty and advanced illness criteria to be excluded:
  - **Frailty.** At least two indications of frailty (Frailty Device Value Set; Frailty Diagnosis Value Set; Frailty Encounter Value Set; Frailty Symptom Value Set) with different dates of service during the measurement year. Do not include laboratory claims (claims with POS code 81).
  - **Advanced Illness.** Either of the following during the measurement year or the year prior to the measurement year:
    - Advanced illness (Advanced Illness Value Set) on at least two different dates of service. Do not include laboratory claims (claims with POS code 81).
    - Dispensed dementia medication (Dementia Medications List).

Dementia Medications

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

Administrative Specification

Denominator The eligible population.

Numerator Screening or monitoring for diabetic retinal disease as identified by administrative data. This includes people with diabetes who had either of the following:

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

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 year.
- 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 year, with a diagnosis of diabetes without complications (Diabetes Mellitus Without Complications Value Set).
- Any code in the Eye Exam With Evidence of Retinopathy Value Set, Eye Exam Without Evidence of Retinopathy Value Set billed by any provider type during the measurement year. Do not include codes with a modifier (CPT CAT II Modifier Value Set).
- Retinal imaging with interpretation and reporting by a qualified reading center (Retinal Imaging Value Set) billed by any provider type during the measurement year.

- Autonomous eye exam billed by any provider type during the measurement year. 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 year. Do not include codes with a modifier (CPT CAT II Modifier Value Set).
- Diabetic retinal screening negative in prior year (CPT-CAT-II code 3072F) billed by any provider type during the measurement year. Do not include codes with a modifier (CPT CAT II Modifier Value Set).
- 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:

Left Eye	Right Eye
Retinal exam finding: Any level of retinopathy (LOINC code 71490-7 ***with*** Diabetic Retinopathy Severity Level Value Set) during the measurement year.	Retinal exam finding: Any level of retinopathy (LOINC code 71491-5 ***with*** Diabetic Retinopathy Severity Level Value Set) during the measurement year.
Retinal exam finding: No retinopathy (LOINC code 71490-7 ***with*** LOINC code LA18643-9) in the year prior to the measurement year.	Retinal exam finding: No retinopathy (LOINC code 71491-5 ***with*** LOINC code LA18643-9) in the year prior to the measurement year.
Enucleation: ICD-10-PCS code 08T1XZZ any time during the member's history through December 31 of the measurement year.	Enucleation: ICD-10-PCS code 08T0XZZ any time during the member's history through December 31 of the measurement year.

Note

- *Blindness is not an exclusion for a diabetic eye exam because it is difficult to distinguish between individuals who are legally blind but require a retinal exam and those who are completely blind and therefore do not require an exam.*

Data Elements for Reporting

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

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

Metric	Data Element	Reporting Instructions
EyeExams	EligiblePopulation	Report once
	ExclusionAdminRequired	Report once
	NumeratorByAdmin	Report once
	NumeratorBySupplemental	Report once
	Rate	(Percent)

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

Metric	Race	Data Element	Reporting Instructions
EyeExams	AmericanIndianOrAlaskaNative	EligiblePopulation	For each Stratification
	Asian	Numerator	For each Stratification
	BlackOrAfricanAmerican	Rate	(Percent)
	NativeHawaiinOrOtherPacificIslanders		
	White		
	SomeOtherRace		
	TwoOrMoreRaces		
	AskedButNoAnswer		
	Unknown		

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

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

Follow-Up After Hospitalization for Mental Illness (FUH)

SUMMARY OF CHANGES TO MY 2025 HEDIS FOR QRS

- Modified the denominator criteria to allow intentional self-harm diagnoses to take any position on the acute inpatient discharge claim.
- Added phobia, anxiety and additional intentional self-harm diagnoses to the denominator in the event/ diagnosis.
- Added visits with any diagnosis of a mental health disorder to the numerator.
- Added peer support and residential treatment services to the numerator.
- Deleted the Note regarding billing methods for intensive outpatient encounters and partial hospitalizations.
- Removed the data source reporting requirement from the race and ethnicity stratification.

HEDIS FOR QRS SPECIFIC GUIDANCE

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

Description

The percentage of discharges for members 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 member received follow-up within 30 days after discharge.
2. The percentage of discharges for which the member received follow-up within 7 days after discharge.

Eligible Population

Product line Exchange.

Stratifications Report the following stratifications by race and total, and stratifications by ethnicity and total:

- Race:
  - American Indian or Alaska Native.
  - Asian.
  - Black or African American.
  - Native Hawaiian or Other Pacific Islander.
  - White.
  - Some Other Race.
  - Two or More Races.
  - Asked But No Answer.
  - Unknown.
  - Total.
- Ethnicity:
  - Hispanic or Latino.

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

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

Ages

6 years and older as of the date of discharge. Report three age stratifications and a total rate:

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

The total is the sum of the age stratifications.

Continuous enrollment

Date of discharge through 30 days after discharge.

Allowable gap

None.

Anchor date

None.

Benefits

Medical and mental health (inpatient and outpatient).

Event/diagnosis

An acute inpatient discharge with a principal diagnosis of mental illness (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 year. To identify acute inpatient discharges:

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

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

Acute readmission or direct transfer

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

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

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

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

Required exclusions

Exclude members who meet either of the following criteria:

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

Administrative Specification

Denominator

The eligible population.

Numerators

30-Day Follow-Up

A follow-up service for mental health within 30 days after discharge. Do not include services that occur on the date of discharge.

7-Day Follow-Up

- A follow-up service for mental health within 7 days after discharge. Do not include services that occur on the date of discharge.

For both indicators, Any of the following meet criteria for a follow-up service:

- 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*** a 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*** a 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).

Note

- *Refer to Appendix 1 for the definition of mental health provider. Organizations must develop their own methods to identify mental health providers. Methods are subject to review by the HEDIS auditor.*

Data Elements for Reporting

Organizations that submit HEDIS for QRS data to NCQA 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	EligiblePopulation	For each Stratification, repeat per Metric
	65+	ExclusionAdminRequired	For each Stratification, repeat per Metric
	Total	NumeratorByAdmin	For each Metric and Stratification
		NumeratorBySupplemental	For each Metric and Stratification
		Rate	(Percent)

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

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

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

Metric	Race	Data Element	Reporting Instructions
FollowUp30Day	HispanicOrLatino	EligiblePopulation	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)

SUMMARY OF CHANGES TO MY 2025 HEDIS FOR QRS

- Removed the data source reporting requirement from the race and ethnicity stratification.

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.

Description

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

- Glycemic Status >9.0%.

Eligible Population

Product line

Exchange.

Stratification

Report the following stratifications by race and total, and stratifications by ethnicity and total:

- Race:
  - American Indian or Alaska Native.
  - Asian.
  - Black or African American.
  - Native Hawaiian or Other Pacific Islander.
  - White.
  - Some Other Race.
  - Two or More Races.
  - Asked But No Answer.
  - Unknown.
  - Total.
- Ethnicity:
  - Hispanic or Latino.
  - Not Hispanic or Latino.
  - Asked But No Answer.
  - Unknown.
  - Total.

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

Ages

18–75 years as of December 31 of the measurement year.

Continuous enrollment

The measurement year.

Allowable gap No more than one gap in enrollment of up to 45 days during the measurement year.

Anchor date December 31 of the measurement year.

Benefit Medical.

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

Claim/encounter data. Members who had at least two diagnoses of diabetes (Diabetes Value Set) on different dates of service during the measurement year or the year prior to the measurement year. Do not include laboratory claims (claims with POS code 81).

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) and have at least one diagnosis of diabetes (Diabetes Value Set) during the measurement year or the year prior to the measurement year. Do not include laboratory claims (claims with POS code 81).

Diabetes Medications

Description	Prescription		
Alpha-glucosidase inhibitors	• Acarbose	• Miglitol	
Amylin analogs	• Pramlintide		
Antidiabetic combinations	• Alogliptin-metformin • Alogliptin-pioglitazone • Canagliflozin-metformin • Dapagliflozin-metformin • Dapagliflozin-saxagliptin • Empagliflozin-linagliptin • Empagliflozin-linagliptin-metformin	• Empagliflozin-metformin • Ertugliflozin-metformin • Ertugliflozin-sitagliptin • Glimepiride-pioglitazone • Glipizide-metformin • Glyburide-metformin	• Linagliptin-metformin • Metformin-pioglitazone • Metformin-repaglinide • Metformin-rosiglitazone • Metformin-saxagliptin • Metformin-sitagliptin
Insulin	• Insulin aspart • Insulin aspart-insulin aspart protamine • Insulin degludec • Insulin degludec-liraglutide • Insulin detemir • Insulin glargine • Insulin glargine-lixisenatide	• Insulin glulisine • Insulin isophane human • Insulin isophane-insulin regular • Insulin lispro • Insulin lispro-insulin lispro protamine • Insulin regular human • Insulin human inhaled	
Meglitinides	• Nateglinide	• Repaglinide	
Biguanides	• Metformin		

Description	Prescription		
Glucagon-like peptide-1 (GLP1) agonists	• Albiglutide • Dulaglutide • Exenatide • Liraglutide	• Lixisenatide • Semaglutide • Tirzepatide	
Sodium glucose cotransporter 2 (SGLT2) inhibitor	• Canagliflozin • Dapagliflozin	• Ertugliflozin • Empagliflozin	
Sulfonylureas	• Chlorpropamide • Glimepiride	• Glipizide • Glyburide	• Tolazamide • Tolbutamide
Thiazolidinediones	• Pioglitazone	• Rosiglitazone	
Dipeptidyl peptidase-4 (DDP-4) inhibitors	• Alogliptin • Linagliptin	• Saxagliptin • Sitagliptin	

Required exclusions

Exclude members who meet any of the following criteria:

- Members who use hospice services (Hospice Encounter Value Set; Hospice Intervention Value Set) or elect to use a hospice benefit any time during the measurement year. Organizations that use the Monthly Membership Detail Data File to identify these members muse use only the run date of the file to determine if the member elected to use a hospice benefit during the measurement year.
- Members who die any time during the measurement year.
- Members receiving palliative care (Palliative Care Assessment Value Set; Palliative Care Encounter Value Set; Palliative Care Intervention Value Set) any time during the measurement year.
- Members who had an encounter for palliative care (ICD-10-CM code Z51.5) any time during the measurement year. Do not include laboratory claims (claims with POS code 81).
- Members 66 years of age and older as of December 31 of the measurement year with frailty **and** advanced illness. Members must meet **both** frailty and advanced illness criteria to be excluded:
  1. **Frailty.** At least two indications of frailty (Frailty Device Value Set; Frailty Diagnosis Value Set; Frailty Encounter Value Set; Frailty Symptom Value Set) with different dates of service during the measurement year. Do not include laboratory claims (claims with POS code 81).
  2. **Advanced Illness.** Either of the following during the measurement year or the year prior to the measurement year:
     - Advanced illness (Advanced Illness Value Set) on at least two different dates of service. Do not include laboratory claims (claims with POS code 81).
     - Dispensed dementia medication (Dementia Medications List).

Dementia Medications

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

Administrative Specification

Denominator The eligible population.

Numerator

Glycemic Status >9% Identify the most recent glycemic status assessment (HbA1c or GMI) (HbA1c Lab Test Value Set; HbA1c Test Result or Finding Value Set; LOINC code 97506-0) during the measurement year. Do not include CPT Category II codes (HbA1c Test Result or Finding Value Set) with a modifier (CPT CAT II Modifier Value Set) or from laboratory claims (claims with POS code 81). The member is numerator compliant if the most recent glycemic status assessment has a result of >9.0% or is missing a result, or if a glycemic status assessment was not done during the measurement year. The member is not numerator compliant if the result of the most recent glycemic status assessment during the measurement year is ≤9.0%. If there are multiple glycemic status assessments on the same date, use the lowest result.

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

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

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

Hybrid Specification

Denominator A systematic sample drawn from the eligible population.

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

Numerator

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

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

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

Medical record

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

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

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

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

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

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

Note

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

Data Elements for Reporting

Organizations that submit HEDIS for QRS data to NCQA 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	Report once	✓
	EligiblePopulation	Report once	✓
	ExclusionAdminRequired	Report once	✓
	NumeratorByAdminElig	Report once	
	CYAR	(Percent)	
	MinReqSampleSize	Report once	
	OversampleRate	Report once	
	OversampleRecordsNumber	(Count)	
	ExclusionValidDataErrors	Report once	
	ExclusionEmployeeOrDep	Report once	
	OversampleRecsAdded	Report once	
	Denominator	Report once	
	NumeratorByAdmin	Report once	✓
	NumeratorByMedicalRecords	Report once	
	NumeratorBySupplemental	Report once	✓
	Rate	(Percent)	✓

Table 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 Stratification	✓
Asian	EligiblePopulation*	For each Stratification	✓
BlackOrAfricanAmerican	Denominator	For each Stratification	
NativeHawaiianOrOtherPacificIslander	Numerator	For Stratification	✓
White	Rate	(Percent)	✓
SomeOtherRace			
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 Stratification	✓
NotHispanicOrLatino	EligiblePopulation	For each Stratification	✓
AskedButNoAnswer	Denominator	For each Stratification	
Unknown	Numerator	For each Stratification	✓
	Rate	(Percent)	✓

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

Initiation and Engagement of Substance Use Disorder Treatment (IET)

SUMMARY OF CHANGES TO MY 2025 HEDIS FOR QRS

- Added a laboratory claim exclusion to a value set for which laboratory claims should not be used.
- Removed the data source reporting requirement from the race and ethnicity stratification.

HEDIS FOR QRS SPECIFIC GUIDANCE

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

Description

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

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

Definitions

Intake period November 15 of the year prior to the measurement year–November 14 of the measurement year. The intake period is used to capture new SUD episodes.

SUD episode An encounter during the intake period with a diagnosis of SUD.

For visits that result in an inpatient stay, the inpatient discharge is the SUD episode (an SUD diagnosis is not required for the inpatient stay; use the diagnosis from the visit that resulted in the inpatient stay to determine the diagnosis cohort).

SUD episode date The date of service for an encounter during the intake period with a diagnosis of SUD.

For a visit (not resulting in an inpatient stay), the SUD episode date is the date of service.

For an inpatient stay or for withdrawal management (i.e., detoxification) that occurred during an inpatient stay, the SUD episode date is the date of discharge.

For withdrawal management (i.e., detoxification), other than those that occurred during an inpatient stay, the SUD episode date is the date of service.

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

Date of service for services billed weekly or monthly For an opioid treatment service that bills monthly or weekly (OUD Weekly Non Drug Service Value Set; OUD Monthly Office Based Treatment Value Set; OUD Weekly Drug Treatment Service Value Set), if the service includes a range of dates, then use the earliest date as the date of service. Use this date for all

relevant events (the SUD episode date, negative diagnosis history and numerator events).

Direct transfer

A **direct transfer** is when the discharge date from the first inpatient setting precedes the admission date to a second inpatient setting by one calendar day or less. For example:

- An inpatient discharge on June 1, followed by an admission to another inpatient setting on June 1, *is a direct transfer*.
- An inpatient discharge on June 1, followed by an admission to an inpatient setting on June 2, *is a direct transfer*.
- An inpatient discharge on June 1, followed by an admission to another inpatient setting on June 3, *is not a direct transfer*; these are two distinct inpatient stays.

Use the following method to identify admissions to and discharges from inpatient settings:

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

Eligible Population

Product line

Exchange.

Stratifications

Report the following stratifications by race and total, and stratifications by ethnicity and total:

- Race:
  - American Indian or Alaska Native.
  - Asian.
  - Black or African American.
  - Native Hawaiian or Other Pacific Islander.
  - White.
  - Some Other Race.
  - Two or More Races.
  - Asked But No Answer.
  - Unknown.
  - Total.
- Ethnicity:
  - Hispanic or Latino.
  - Not Hispanic or Latino.
  - Asked But No Answer.
  - Unknown.
  - Total.

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

Ages

13 years and older as of the SUD episode date. Report three age stratifications and a total:

- 13–17 years.
- 18–64 years.
- 65+ years
- Total.

The total is the sum of the age stratifications.

SUD diagnosis cohort stratification

Report the following SUD diagnosis cohort stratifications and a total:

- Alcohol use disorder.
- Opioid use disorder.
- Other substance use disorder.
- Total.

The total is the sum of the SUD diagnosis cohort stratifications.

Continuous enrollment

194 days prior to the SUD episode date through 47 days after the SUD Episode Date (242 total days).

Allowable gap

None.

Anchor date

None.

Benefits

Medical, pharmacy and chemical dependency (inpatient and outpatient).

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

Event/diagnosis

New episode of SUD during the intake period.

Follow the steps below to identify the denominator for both rates.

Step 1

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

- An outpatient visit (Visit Setting Unspecified Value Set) ***with*** (Outpatient POS Value Set) ***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*** (Non-residential Substance Abuse Treatment Facility POS Value Set) ***with*** one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- A community mental health center visit (Visit Setting Unspecified Value Set) ***with*** 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. Do not include laboratory claims (claims with POS code 81).
- 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 member 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), withdrawal management events (Detoxification Value Set) or lab claims (claims with POS code 81).

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

For visits with an SUD diagnosis that resulted in an inpatient stay (where the inpatient stay becomes the SUD Episode), use the earliest date of service to

determine the negative SUD diagnosis history (so that the visit that resulted in the inpatient stay is not considered a positive diagnosis history).

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

Step 3

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

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

Step 4

- Remove SUD episodes that do not meet continuous enrollment criteria. Members must be continuously enrolled from 194 days before the SUD episode date through 47 days after the SUD episode date (242 total days), with no gaps.

Step 5

Deduplicate eligible episodes. If a member has more than one eligible episode on the same day, include only one eligible episode. For example, if a member 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: *The denominator for this measure is based on episodes, not on members. All eligible episodes that were not removed or deduplicated remain in the denominator.*

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), place the member in the other substance use disorder cohort.

Include SUD episodes in all SUD diagnosis cohorts for which they meet criteria. For example, if the SUD episode has a diagnosis of alcohol use disorder and opioid use disorder, include the episode in the alcohol use disorder and opioid use disorder cohorts.

Required exclusions

Exclude members who meet either of the following criteria:

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

- Members who die any time during the measurement year.

Administrative Specification

Denominator The eligible population.

Numerator

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*** (Non-residential Substance Abuse Treatment Facility POS Value Set) ***with*** one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- A community mental health center visit (Visit Setting Unspecified Value Set) ***with*** 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). Do not include laboratory claims (claims with POS code 81).
- A telephone visit (Telephone Visits Value Set) ***with*** one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- An e-visit or virtual check-in (Online Assessments Value Set) ***with*** one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- A weekly or monthly opioid treatment service (OUD Weekly Non Drug Service Value Set; OUD Monthly Office Based Treatment Value Set; OUD Weekly Drug Treatment Service Value Set).
- For SUD episodes in the alcohol use disorder cohort, an alcohol use disorder medication treatment dispensing event (Alcohol Use Disorder Treatment Medications List) or a medication administration event (Naltrexone Injection Value Set).
- For SUD episodes in the opioid use disorder cohort, an opioid use disorder medication treatment dispensing event (Naltrexone Oral Medications List; Naltrexone Injection Medications List; Buprenorphine Oral Medications List; Buprenorphine Injection Medications List; Buprenorphine Implant Medications List; Buprenorphine Naloxone Medications List) or a medication administration event (Naltrexone Injection Value Set, Buprenorphine Oral Value Set, Buprenorphine Oral Weekly Value Set, Buprenorphine Injection Value Set, Buprenorphine Implant Value Set, Buprenorphine Naloxone Value Set, Methadone Oral Value Set, Methadone Oral Weekly Value Set).

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

Remove the member from the denominator for both indicators (Initiation of SUD Treatment and Engagement of SUD Treatment) if the initiation of treatment event is an inpatient stay with a discharge date after November 27 of the measurement year.

Engagement of SUD Treatment

Follow the steps below to identify numerator compliance.

If Initiation of SUD Treatment was an inpatient admission, the 34-day period for engagement begins the day after discharge.

Step 1 Identify all SUD episodes compliant for the Initiation of SUD Treatment numerator. SUD episodes that are not compliant for Initiation of SUD Treatment are not compliant for Engagement of SUD Treatment.

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

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

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

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

- Engagement visit.
- Engagement medication treatment event.

Two engagement visits may be on the same date of service, but they must be with different providers to count as two events. An engagement visit on the same date of service as an engagement medication treatment event meets criteria (there is no requirement that they be with different providers).

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

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

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

- An outpatient visit (BH Outpatient Value Set) ***with*** one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- An intensive outpatient encounter or partial hospitalization (Visit Setting Unspecified Value Set) ***with*** 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*** (Non-residential Substance Abuse Treatment Facility POS Value Set) ***with*** one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- A community mental health center visit (Visit Setting Unspecified Value Set) ***with*** 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). Do not include laboratory claims (claims with POS code 81).
- A telephone visit (Telephone Visits Value Set) ***with*** one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- An e-visit or virtual check-in (Online Assessments Value Set) ***with*** one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- An opioid treatment service (OUD Weekly Non Drug Service Value Set).

Engagement medication treatment events

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

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

Buprenorphine Oral Weekly Value Set; Buprenorphine Naloxone Value Set; Methadone Oral Value Set; Methadone Oral Weekly Value Set).

Alcohol Use Disorder Treatment Medications

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

Opioid Use Disorder Treatment Medications

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

Note

- *Organizations may have different methods for billing intensive outpatient encounters and partial hospitalizations. Some organizations may bill comparable to outpatient billing, with separate claims for each date of service; others may bill comparable to inpatient billing, with an admission date, a discharge date and units of service. Organizations whose billing is comparable to inpatient billing may count each unit of service as an individual visit. The unit of service must have occurred during the required time frame for the rate.*
- *Methadone is not included on the medication lists for this measure. Methadone for opioid use disorder (OUD) administered or dispensed by federally certified opioid treatment programs (OTP) is billed on a medical claim. A pharmacy claim for methadone would be indicative of treatment for pain rather than OUD.*

Data Elements for Reporting

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

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

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

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

Metric	Race	Data Element	Reporting Instructions
Initiation	AmericanIndianOrAlaskaNative	EligiblePopulation	For each Stratification, repeat per Metric
Engagement	Asian	Numerator	For each Metric and Stratification
	BlackOrAfricanAmerican	Rate	(Percent)
	NativeHawaiianOrOtherPacificIslander		
	White		
	SomeOtherRace		
	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	EligiblePopulation	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)**

***This measure was developed by NCQA with input from the National Kidney Foundation.**

SUMMARY OF CHANGES TO MY 2025 HEDIS FOR QRS

- Removed the data source reporting requirement from the race and ethnicity stratification.

HEDIS FOR QRS SPECIFIC GUIDANCE

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

Description

The percentage of members 18–85 years of age with diabetes (type 1 and type 2) who received a kidney health evaluation, defined by an estimated glomerular filtration rate (eGFR) ***and*** a urine albumin-creatinine ratio (uACR), during the measurement year.

Eligible Population

Product line Exchange.

Stratifications Report the following stratifications by race and total, and stratifications by ethnicity and total:

- Race:
  - American Indian or Alaska Native.
  - Asian.
  - Black or African American.
  - Native Hawaiian or Other Pacific Islander.
  - White.
  - Some Other Race.
  - Two or More Races.
  - Asked But No Answer.
  - Unknown.
  - Total.
- Ethnicity:
  - Hispanic or Latino.
  - Not Hispanic or Latino.
  - Asked But No Answer.
  - Unknown.
  - Total.

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

Ages 18–85 years as of December 31 of the measurement year. Report three age stratifications and a total rate:

- 18–64.
- 65–75.
- 76–85.
- Total.

The total is the sum of the age stratifications.

Continuous enrollment The measurement year.

Allowable gap No more than one gap in enrollment of up to 45 days during the measurement year.

Anchor date December 31 of the measurement year.

Benefit Medical.

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

Claim/encounter data. Members who has at least two diagnoses of diabetes (Diabetes Value Set) on different dates of service during the measurement year or the year prior to the measurement year. Do not include laboratory claims (claims with POS code 81).

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) and have at least one diagnosis of diabetes (Diabetes Value Set) during the measurement year or the year prior to the measurement year. Do not include laboratory claims (claims with POS code 81).

Diabetes Medications

Description	Prescription		
Alpha-glucosidase inhibitors	• Acarbose	• Miglitol	
Amylin analogs	• Pramlintide		
Antidiabetic combinations	• Alogliptin-metformin • Alogliptin-pioglitazone • Canagliflozin-metformin • Dapagliflozin-metformin • Dapagliflozin-saxagliptin • Empagliflozin-linagliptin • Empagliflozin-linagliptin-metformin	• Empagliflozin-metformin • Ertugliflozin-metformin • Ertugliflozin-sitagliptin • Glimepiride-pioglitazone • Glipizide-metformin • Glyburide-metformin • Linagliptin-metformin	• Metformin-pioglitazone • Metformin-repaglinide • Metformin-rosiglitazone • Metformin-saxagliptin • Metformin-sitagliptin
Insulin	• Insulin aspart • Insulin aspart-insulin aspart protamine • Insulin degludec • Insulin degludec-liraglutide • Insulin detemir • Insulin glargine • Insulin glargine-lixisenatide	• Insulin glulisine • Insulin isophane human • Insulin isophane-insulin regular • Insulin lispro • Insulin lispro-insulin lispro protamine • Insulin regular human • Insulin human inhaled	

Description	Prescription		
Meglitinides	• Nateglinide	• Repaglinide	
Biguanides	• Metformin		
Glucagon-like peptide-1 (GLP1) agonists	• Albiglutide • Dulaglutide • Exenatide • Liraglutide	• Lixisenatide • Semaglutide • Tirzepatide	
Sodium glucose cotransporter 2 (SGLT2) inhibitor	• Canagliflozin • Dapagliflozin	• Ertugliflozin • Empagliflozin	
Sulfonylureas	• Chlorpropamide • Glimepiride	• Glipizide • Glyburide	• Tolazamide • Tolbutamide
Thiazolidinediones	• Pioglitazone	• Rosiglitazone	
Dipeptidyl peptidase-4 (DDP-4) inhibitors	• Alogliptin • Linagliptin	• Saxagliptin • Sitagliptin	

Required exclusions

Exclude members who meet any of the following criteria:

- Members with a diagnosis of ESRD (ESRD Diagnosis Value Set) any time during the member's history on or prior to December 31 of the measurement year. Do not include laboratory claims (claims with POS code 81).
- Members who had dialysis (Dialysis Procedure Value Set) any time during the member's history on or prior to December 31 of the measurement year.
- Members who use hospice services (Hospice Encounter Value Set; Hospice Intervention Value Set) or elect to use a hospice benefit at any time during the measurement year. Organizations that use the Monthly Membership Detail Data File to identify these members must use only the run date of the file to determine if the member elected to use a hospice benefit during the measurement year.
- Members who die any time during the measurement year.
- Members receiving palliative care (Palliative Care Assessment Value Set; Palliative Care Encounter Value Set; Palliative Care Intervention Value Set) any time during the measurement year.
- Members who had an encounter for palliative care (ICD-10-CM code Z51.5) any time during the measurement year. Do not include laboratory claims (claims with POS code 81).
- Members 66–80 years of age as of December 31 of the measurement year with frailty **and** advanced illness. Members must meet **both** frailty and advanced illness criteria to be excluded:
  1. **Frailty.** At least two indications of frailty (Frailty Device Value Set; Frailty Diagnosis Value Set; Frailty Encounter Value Set; Frailty Symptom Value Set) with different dates of service during the measurement year. Do not include laboratory claims (claims with POS code 81).
  2. **Advanced Illness.** Either of the following during the measurement year or the year prior to the measurement year:

  - Advanced illness (Advanced Illness Value Set) on at least two different dates of service. Do not include laboratory claims (claims with POS code 81).
  - Dispensed dementia medication (Dementia Medications List).
- Members 81 years of age and older as of December 31 of the measurement year with at least two indications of frailty (Frailty Device Value Set; Frailty Diagnosis Value Set; Frailty Encounter Value Set; Frailty Symptom Value Set) with different dates of service during the measurement year. Do not include laboratory claims (claims with POS code 81).

Dementia Medications

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

Administrative Specification

Denominator The eligible population.

Numerator

Kidney Health Evaluation Members who received ***both*** an eGFR and a uACR during the measurement year on the same or different dates of service:

- At least one eGFR (Estimated Glomerular Filtration Rate Lab Test Value Set).
- At least one uACR identified by either of the following:
  - ***Both*** a quantitative urine albumin test (Quantitative Urine Albumin Lab Test Value Set) ***and*** a urine creatinine test (Urine Creatinine Lab Test Value Set) ***with*** service dates four days or less apart. For example, if the service date for the quantitative urine albumin test was December 1 of the measurement year, then the urine creatinine test must have a service date on or between November 27 and December 5 of the measurement year.
  - A uACR (Urine Albumin Creatinine Ratio Lab Test Value Set).

Data Elements for Reporting

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

Table KED-A-4: Data Elements for Kidney Health Evaluation for Patients With Diabetes

Metric	Age	Data Element	Reporting Instructions
KidneyHealthEvaluation	18-64	EligiblePopulation	For each Stratification
	65-75	ExclusionAdminRequired	For each Stratification
	76-85	NumeratorByAdmin	For each Stratification
	Total	NumeratorBySupplemental	For each Stratification
		Rate	(Percent)

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	EligiblePopulation	For each Stratification
	Asian	Numerator	For each Stratification
	BlackOrAfricanAmerican	Rate	(Percent)
	NativeHawaiianOrOtherPacificIslander		
	White		
	SomeOtherRace		
	TwoOrMoreRaces		
	AskedButNoAnswer		
	Unknown		

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

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

Medical Assistance With Smoking and Tobacco Use Cessation (MSC)

SUMMARY OF CHANGES TO MY 2025 HEDIS FOR QRS

- No changes to this measure.

HEDIS FOR QRS SPECIFIC GUIDANCE

- Measure collection is based on enrollee responses to a subset of the QHP Enrollee Survey questions. Refer to the CMS MQI website (https://www.cms.gov/medicare/quality/health-insurance-marketplace-initiatives) for more information about the QHP Enrollee Survey, including a crosswalk of survey questions associated with the QRS survey measures. The QHP Enrollee Survey response data are submitted to CMS.

Description

The following components of this measure assess different facets of providing medical assistance with smoking and tobacco use cessation:

- *Advising Smokers and Tobacco Users to Quit.* A rolling average represents the percentage of members 18 years of age and older who were current smokers or tobacco users and who received advice to quit during the measurement year.
- *Discussing Cessation Medications.* A rolling average represents the percentage of members 18 years of age and older who were current smokers or tobacco users and who discussed or were recommended cessation medications during the measurement year.
- *Discussing Cessation Strategies.* A rolling average represents the percentage of members 18 years of age and older who were current smokers or tobacco users and who discussed or were provided cessation methods or strategies during the measurement year.

Eligible Population

Product line	Exchange.
Ages	18 years and older as of December 31 of the measurement year.
Continuous enrollment	The last 6 months of the measurement year.
Allowable gap	No more than one gap in enrollment of up to 45 days during the measurement year.
Anchor date	December 31 of the measurement year.
Current enrollment	Currently enrolled at the time the survey is completed.
Required exclusion	Members who die any time during the measurement year.

Protocol and Survey Instrument

Collected annually by CMS as part of the QHP Enrollee Survey using a rolling average methodology.

Questions Included in the Measure

Table MSC-4: Medical Assistance With Smoking and Tobacco Use Cessation

Question		Response Choices
Q46	Do you now smoke cigarettes or use tobacco every day, some days, or not at all?	Every day Some days Not at all ➔If Not at all, Go to Question 50 Don't know ➔If Don't know, Go to Question 50
Q47	In the last 6 months, how often were you advised to quit smoking or using tobacco by a doctor or other health provider in your plan?	Never Sometimes Usually Always
Q48	In the last 6 months, how often was medication recommended or discussed by a doctor or health provider to assist you with quitting smoking or using tobacco? Examples of medication are: nicotine gum, patch, nasal spray, inhaler, or prescription medication.	Never Sometimes Usually Always
Q49	In the last 6 months, how often did your doctor or health provider discuss or provide methods and strategies other than medication to assist you with quitting smoking or using tobacco? Examples of methods and strategies are: telephone helpline, individual or group counseling, or cessation program.	Never Sometimes Usually Always

Calculation of Medical Assistance With Smoking and Tobacco Use Cessation

Rolling averages are calculated using the formula below.

Rate = (Year 1 Numerator + Year 2 Numerator) / (Year 1 Denominator + Year 2 Denominator)

Advising Smokers and Tobacco Users to Quit

Denominator The number of members who responded to the survey and indicated that they were current smokers or tobacco users. Member response choices *must* be as follows to be included in the denominator:

Q46 = "Every day" or "Some days."

Q47 = "Never" or "Sometimes" or "Usually" or "Always."

Numerator The number of members in the denominator who indicated that they received advice to quit from a doctor or other health provider by answering "Sometimes" or "Usually" or "Always" to Q47.

Discussing Cessation Medications

Denominator The number of members who responded to the survey and indicated that they were current smokers or tobacco users. Member response choices *must* be as follows to be included in the denominator:

Q46 = "Every day" or "Some days."

Q48 = "Never" or "Sometimes" or "Usually" or "Always."

Numerator The number of members in the denominator who indicated that their doctor or health provider recommended or discussed cessation medications by answering "Sometimes" or "Usually" or "Always" to Q48.

Discussing Cessation Strategies

Denominator The number of members who responded to the survey and indicated that they were current smokers or tobacco users. Member response choices *must* be as follows to be included in the denominator:

Q46 = "Every day" or "Some days."

Q49 = "Never" or "Sometimes" or "Usually" or "Always."

Numerator The number of members in the denominator who indicated that their doctor or health provider discussed or provided cessation methods and strategies by answering "Sometimes" or "Usually" or "Always" to Q49.

*Oral Evaluation, Dental Services (OED)**

SUMMARY OF CHANGES TO HEDIS MY 2025 FOR QRS

- No changes to this measure.

Description

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

Eligible Population

Product line Exchange.

Ages Under 21 years as of December 31 of the measurement year. Report four age stratifications and a total rate:

- 0–2 years.
- 3–5 years.
- 6–14 years.
- 15–20 years.
- Total.

The total is the sum of the age stratifications.

Continuous enrollment July 1–December 31 of the measurement year.

Allowable gap No gaps in enrollment during the continuous enrollment period.

Anchor date None.

Benefit Dental.

Event/diagnosis None.

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

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

Administrative Specification

Denominator The eligible population.

Numerator A comprehensive or periodic oral evaluation (Oral Evaluation Value Set) with a dental provider (Dental Provider Value Set) during the measurement year.

Data Elements for Reporting

Organizations that submit HEDIS for QRS data to NCQA 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	EligiblePopulation	For each Stratification
	6-14	ExclusionAdminRequired	For each Stratification
	15-20	NumeratorByAdmin	For each Stratification
	Total	NumeratorBySupplemental	For each Stratification
		Rate	(Percent)

Plan All-Cause Readmissions (PCR)

SUMMARY OF CHANGES TO MY 2025 HEDIS FOR QRS

- No changes to this measure.

HEDIS FOR QRS SPECIFIC GUIDANCE

- HEDIS for QRS uses the commercial risk weights for risk adjustment.

Description

For members 18–64 years of age, the number of acute inpatient and observation stays during the measurement year that were followed by an unplanned acute readmission for any diagnosis within 30 days and the predicted probability of an acute readmission.

Definitions

IHS	Index hospital stay. An acute inpatient or observation stay with a discharge on or between January 1 and December 1 of the measurement year, as identified in the denominator.
Index Admission Date	The IHS admission date.
Index Discharge Date	The IHS discharge date. The Index Discharge Date must occur on or between January 1 and December 1 of the measurement year.
Index Readmission Stay	An acute 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 (required exclusions) of the numerator.
Plan population	Members in the eligible population prior to exclusion of outliers (denominator steps 1–5). The plan population is only used as a denominator for the Outlier Rate. Members must be 18 and older as of the earliest Index Discharge Date. The plan population is based on members, not discharges. Count members only once in the plan population. Assign members to the product/product line in which they are enrolled at the start of the continuous enrollment period of their earliest IHS. If the member has a gap at the beginning of this continuous enrollment period, assign the member to the product/product line in which they were enrolled as of their first enrollment segment during this continuous enrollment period.

Outlier	Members in the eligible population with three or more IHS between January 1 and December 1 of the measurement year. Assign members to the product/product line in which they are enrolled at the start of the continuous enrollment period of their earliest IHS. If the member has a gap at the beginning of this continuous enrollment period, assign the member to the product/product line in which they were enrolled as of their first enrollment segment during this continuous enrollment period.
Nonoutlier	Members in the eligible population who are not considered outliers.
Classification Period	365 days prior to and including Index Discharge Date.

Eligible Population

Product line	Exchange.
Ages	18–64 years as of the Index Discharge Date.
Continuous enrollment	365 days prior to the Index Discharge Date through 30 days after the Index Discharge Date.
Allowable gap	No more than one gap in enrollment of up to 45 days during the 365 days prior to the Index Discharge Date and no gap during the 30 days following the Index Discharge date.
Anchor date	Index Discharge Date.
Benefit	Medical.
Event/diagnosis	An acute inpatient or observation stay discharge on or between January 1 and December 1 of the measurement year. The denominator for this measure is based on discharges, not members. Include all acute inpatient or observation stay discharges for nonoutlier members who had one or more discharges on or between January 1 and December 1 of the measurement year. Follow the steps below to identify acute inpatient and observation stays.
Required exclusion	Members who use hospice services (Hospice Encounter Value Set; Hospice Intervention Value Set) or elect to use a hospice benefit any time during the measurement year. Organizations that use the Monthly Membership Detail Data File to identify these members must use only the run date of the file to determine if the member elected to use a hospice benefit during the measurement year.

Administrative Specification

Denominator	The eligible population.
Step 1	Identify all acute inpatient and observation stay discharges on or between January 1 and December 1 of the measurement year. To identify acute inpatient and observation stay discharges: 1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set) and observation stays (Observation Stay Value Set). 2. Exclude nonacute inpatient stays (Nonacute Inpatient Stay Value Set).

3. Identify the discharge date for the stay.

Inpatient and observation stays where the discharge date from the first setting and the admission date to the second setting are 2 or more calendar days apart must be considered distinct stays.

The measure includes acute discharges from any type of facility (including behavioral healthcare facilities).

Step 2 *Direct transfers:* For discharges with one or more direct transfers, use the last discharge.

Using the discharges identified in step 1, identify direct transfers between acute inpatient and observation or between observation and acute inpatient using the definition found in the *Guidelines for Risk Adjusted Utilization Measures.*.

Exclude the hospital stay if the direct transfer's discharge date occurs after December 1 of the measurement year.

Step 3 Exclude hospital stays where the Index Admission Date is the same as the Index Discharge Date.

Step 4 Exclude hospital stays for the following reasons:

- The member died during the stay.
- Members with a principal diagnosis of pregnancy (Pregnancy Value Set) on the discharge claim.
- A principal diagnosis of a condition originating in the perinatal period (Perinatal Conditions Value Set) on the discharge claim.

Note: *For hospital stays where there was a direct transfer (identified in step 2), use the original stay and any direct transfer stays to identify exclusions in this step.*

Step 5 Calculate continuous enrollment.

Step 6 Remove hospital stays for outlier members and report these members as outliers in Table PCR-4.

Note: *Count discharges with one or more direct transfers (identified in step 2) as one discharge when identifying outlier members.*

Step 7 Assign each remaining acute inpatient or observation stay to an age and stratification category using the reporting instructions below.

Risk Adjustment Determination

For each IHS among nonoutlier members, use the following steps to identify risk adjustment categories based on presence of observation stay status at discharge, surgeries, discharge condition, comorbidity, age and gender.

Observation stay Determine if the IHS at discharge was an observation stay (Observation Stay Value Set). For direct transfers, determine the hospitalization status using the last discharge.

Surgeries Determine if the member underwent surgery during the stay (Surgery Procedure Value Set). Consider an IHS to include a surgery if at least one procedure code is present from any provider between the admission and discharge dates.

Discharge condition Assign a discharge Clinical Condition (CC) category code or codes to the IHS based on its principal discharge diagnosis, using Table CC_Mapping. For direct transfers, use the principal discharge diagnosis from the last discharge.

Exclude diagnoses that cannot be mapped to Table CC_Mapping.

COVID-19 discharge Assign a COVID-19 discharge code to the IHS if its principal discharge diagnosis was COVID-19 (ICD-10-CM code U07.1). For direct transfers, use the principal discharge diagnosis from the last discharge.

Comorbidities Refer to *Risk Adjustment Comorbidity Category Determination* in the *Guidelines for Risk Adjusted Utilization Measures.*

Risk Adjustment Weighting

For each IHS among nonoutliers, use the following steps to identify risk adjustment weights based on observation stays status at discharge, surgeries, discharge condition, comorbidity, age and gender. Use the **Commercial** Risk Weights for risk adjustment. Refer to the reporting indicator column in the risk adjustment tables to ensure that weights are linked appropriately.

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

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

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

Step 4 For each IHS with a comorbidity HCC Category, link the comorbidity weights.

Step 5 For each IHS with a COVID-19 discharge, link the COVID-19 discharge weight.

Step 6 Link the age and gender weights for each IHS.

Step 7 Sum all weights associated with the IHS (i.e., observation stay, presence of surgery, principal discharge diagnosis, comorbidities, age and gender) and use the formula below to calculate the Estimated Readmission Risk for each IHS.

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 8 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 9 Use the formula below and the Estimated Readmission Risk calculated in step 6 to calculate the variance for each IHS.

Variance = Estimated Readmission Risk x (1 – Estimated Readmission Risk)

Truncate the variance *for each IHS* to 10 decimal places.

For example: If the Estimated Readmission Risk is 0.1518450741 for an IHS, then the variance for this IHS is 0.1518450741 x 0.8481549259 = 0.1287881475.

Note: *Organizations must sum the variances for each stratification and age when populating the Variance cells in the reporting tables. When reporting, round the variance to 4 decimal places using the .5 rule.*

Numerator At least one acute readmission for any diagnosis within 30 days of the Index Discharge Date.

Step 1 Identify all acute inpatient and observation stays with an admission date on or between January 3 and December 31 of the measurement year. To identify acute inpatient admissions:

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

Step 2 *Direct transfers:* For discharges with one or more direct transfers, use the last discharge.

Using the discharges identified in step 1, identify direct transfers between acute inpatient and observation or between observation and acute inpatient using the definition found in the *Risk Adjusted Utilization Guidelines.*

Step 3 Exclude acute hospitalizations with any of the following criteria on the discharge claim:

- Members with a principal diagnosis of pregnancy (Pregnancy Value Set).
- A principal diagnosis for a condition originating in the perinatal period (Perinatal Conditions Value Set).
- A planned hospital stay using any of the following:
  - A principal diagnosis of maintenance chemotherapy (Chemotherapy Encounter Value Set).
  - A principal diagnosis of rehabilitation (Rehabilitation Value Set).
  - An organ transplant (Kidney Transplant Value Set, Bone Marrow Transplant Value Set, Organ Transplant Other Than Kidney Value Set, Introduction of Autologous Pancreatic Cells Value Set).
  - A potentially planned procedure (Potentially Planned Procedures Value Set) without a principal acute diagnosis (Acute Condition Value Set).

Note: *For hospital stays where there was a direct transfer (identified in step 2), use the original stay and any direct transfer stays to identify exclusions in this step.*

Step 4 For each IHS identified in the denominator, determine if any of the acute inpatient and observation stays identified in the numerator have an admission date within 30 days after the Index Discharge Date.

Note: *Count each acute hospitalization only once toward the numerator for the last denominator event.*

If a single numerator event meets criteria for multiple denominator events, only count the last denominator event. For example, consider the following events:

- *Acute inpatient stay 1: May 1–10.*
- *Acute inpatient stay 2: May 15–25 (principal diagnosis of maintenance chemotherapy).*
- *Acute inpatient stay 3: May 30–June 5.*

All three acute inpatient stays are included as denominator events. Stay 2 is excluded from the numerator because it is a planned hospitalization. Stay 3 is within 30 days of Stay 1 and Stay 2. Count Stay 3 as a numerator event only toward the last denominator event (Stay 2, May 15–25).

Reporting: Number of Members in Plan Population

Step 1 Determine the member's age as of the earliest Index Discharge Date.

Step 2 Report the count of members in the plan population for each age group as the MemberCount.

Reporting: Number of Outliers

Step 1 Determine the member's age as of the earliest Index Discharge Date.

Step 2 Report the count of outlier members for each age group as the OutlierMemberCount.

Calculated: Outlier Rate

The number of outlier members (OutlierMemberCount) divided by the number of members in the plan population (MemberCount), displayed as a permillage (multiplied by 1,000), for each age group and the totals. Calculated by IDSS as the OutlierRate.

Reporting: Denominator

Count the number of IHS among nonoutlier members for each age group. Report these values as the Denominator.

Reporting: Numerator

Count the number of observed IHS among nonoutlier members with a readmission within 30 days of discharge for each age group and report these values as the ObservedCount.

Calculated: Observed Readmission Rate

The Count of Observed 30-Day Readmissions (ObservedCount) divided by the Count of Index Stays (Denominator) for each group and totals. Calculated by IDSS at the ObservedRate.

Reporting: Count of Expected 30-Day Readmissions

Step 1 Calculate the Count of Expected Readmissions among nonoutlier members for each age group.

Step 2 Round to 4 decimal places using the .5 rule and report these values as the ExpectedCount.

Calculated: Expected Readmission Rate

The Count of Expected 30-Day Readmissions (ExpectedCount) divided by the Count of Index Stays (Denominator) for each age group and totals. Calculated by IDSS as the ExpectedRate.

Reporting: Variance

Step 1 Calculate the total (sum) variance for each age group.

Step 2 Round to 4 decimal places using the .5 rule and report these values as the CountVariance.

Calculated: O/E Ratio

The Count of Observed 30-Day Readmissions (ObservedCount) divided by the Count of Expected 30-Day Readmissions (ExpectedCount) for each age group and totals. Calculated by IDSS as the OE.

Note

- *Supplemental data may not be used for this measure, except for required exclusions.*

Data Elements for Reporting

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

Table PCR-4: Data Elements for Plan All-Cause Readmissions

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

Prenatal and Postpartum Care (PPC)

SUMMARY OF CHANGES TO MY 2025 HEDIS FOR QRS

- Removed the data source reporting requirement from the race and ethnicity stratification.

HEDIS FOR QRS SPECIFIC GUIDANCE

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

Description

The percentage of deliveries of live births on or between October 8 of the year prior to the measurement year and October 7 of the measurement year. For these members, the measure assesses the following facets of prenatal and postpartum care:

- *Timeliness of Prenatal Care.* The percentage of deliveries that received a prenatal care visit in the first trimester, on or before the enrollment start date or within 42 days of enrollment in the organization.
- *Postpartum Care.* The percentage of deliveries that had a postpartum visit on or between 7 and 84 days after delivery.

Definitions

First trimester 280–176 days prior to delivery (or estimated delivery date [EDD]).

Eligible Population

Product line Exchange.

Stratification Report the following stratifications by race and total, and stratifications by ethnicity and total:

- Race:
  - American Indian or Alaska Native.
  - Asian.
  - Black or African American.
  - Native Hawaiian or Other Pacific Islander.
  - White.
  - Some Other Race.
  - Two or More Races.
  - Asked But No Answer.
  - Unknown.
  - Total.
- Ethnicity:
  - Hispanic or Latino.
  - Not Hispanic or Latino.
  - Asked But No Answer.
  - Unknown.
  - Total.

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

Age None specified.

Continuous enrollment 43 days prior to delivery through 60 days after delivery.

Allowable gap None.

Anchor date Date of delivery.

Benefit Medical.

Event/diagnosis Live birth deliveries on or between October 8 of the year prior to the measurement year and October 7 of the measurement year. Include deliveries that occur in any setting.

Follow the steps below to identify the eligible population, which is the denominator for both rates.

Step 1 Identify deliveries. Identify all members with a delivery (Deliveries Value Set) on or between October 8 of the year prior to the measurement year and October 7 of the measurement year.

Note: *The intent is to identify the date of delivery (the date of the "procedure"). If the date of delivery cannot be interpreted on the claim, use the date of service or, for inpatient claims, the date of discharge.*

Step 2 Remove non-live births (Non Live Births Value Set).

Step 3 Identify continuous enrollment. Determine if enrollment was continuous 43 days prior to delivery through 60 days after delivery, with no gaps.

Step 4 Remove multiple deliveries in a 180-day period. If a member 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 denominator for this measure is based on deliveries, not on members. All eligible deliveries that were not removed in steps 1–4 remain in the denominator.*

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

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

Administrative Specification

Denominator The eligible population.

Numerator

Timeliness of Prenatal Care A prenatal visit during the required time frame. Follow the steps below to identify numerator compliance.

Step 1 Identify members who were continuously enrolled (with no gaps) from at least 219 days before delivery (or EDD) through 60 days after delivery.

These members must have a prenatal visit during the first trimester.

Step 2 Identify members who were not continuously enrolled from at least 219 days before delivery (or EDD) through 60 days after delivery.

These members must have a prenatal visit any time during the period that begins 280 days prior to delivery and ends 42 days after their enrollment start date.

Do not count visits that occur on or after the date of delivery. Visits that occur prior to the member's enrollment start date during the pregnancy meet criteria.

Step 3 Identify prenatal visits that occurred during the required time frame (the time frame identified in step 1 or 2). Any of the following, where the practitioner type is an OB/ GYN or other prenatal care practitioner or PCP, meet criteria for a prenatal visit:

- A bundled service (Prenatal Bundled Services Value Set) where the organization can identify the date when prenatal care was initiated (because bundled service codes are used on the date of delivery, these codes may be used only if the claim form indicates when prenatal care was initiated).
- A visit for prenatal care (Stand Alone Prenatal Visits Value Set). Do not include codes with a modifier (CPT CAT II Modifier Value Set).
- A prenatal visit (Prenatal Visits Value Set) ***with*** a pregnancy-related diagnosis code (Pregnancy Diagnosis Value Set).

Postpartum Care A postpartum visit on or between 7 and 84 days after delivery. Any of the following meet criteria:

- A postpartum visit (Postpartum Care Value Set). Do not include codes with a modifier (CPT CAT II Modifier Value Set).
- An encounter for postpartum care (Encounter for Postpartum Care Value Set). Do not include laboratory claims (claims with POS code 81).
- Cervical cytology (Cervical Cytology Lab Test Value Set; Cervical Cytology Result or Finding Value Set).
- A bundled service (Postpartum Bundled Services Value Set) where the organization can identify the date when postpartum care was rendered (because bundled service codes are used on the date of delivery, not on the date of the postpartum visit, these codes may be used only if the claim form indicates when postpartum care was rendered).

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

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

Hybrid Specification

Denominator

A systematic sample drawn from the eligible population.

Organizations may reduce the sample size using the current year's administrative rate or the prior year's audited rate for the lower of the two indicators.

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

Numerator

Timeliness of Prenatal Care

A prenatal visit during the required time frame. Refer to *Administrative Specification* to identify the required time frame for each member based on the date of enrollment in the organization and the gaps in enrollment during the pregnancy.

Administrative

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

Medical record

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

- Documentation indicating the member is pregnant or references to the pregnancy; for example:
  - Documentation in a standardized prenatal flow sheet, ***or***
  - Documentation of last menstrual period (LMP), EDD or gestational age, ***or***
  - A positive pregnancy test result, ***or***
  - Documentation of gravidity and parity, ***or***
  - Documentation of complete obstetrical history, ***or***
  - Documentation of prenatal risk assessment and counseling/education.
- A basic physical obstetrical examination that includes auscultation for fetal heart tone, ***or*** pelvic exam with obstetric observations, ***or*** measurement of fundus height (a standardized prenatal flow sheet may be used).
- Evidence that a prenatal care procedure was performed, such as:
  - Screening test in the form of an obstetric panel (must include all of the following: hematocrit, differential WBC count, platelet count, hepatitis B surface antigen, rubella antibody, syphilis test, RBC antibody screen, Rh and ABO blood typing), ***or***
  - TORCH antibody panel alone, ***or***
  - A rubella antibody test/titer with an Rh incompatibility (ABO/Rh) blood typing, ***or***
  - Ultrasound of a pregnant uterus.

Postpartum Care

A postpartum visit on or between 7 and 84 days after delivery, as documented through either administrative data or medical record review.

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

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

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

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

Note

- *Criteria for identifying prenatal care for members who were not enrolled during the first trimester allow more flexibility than criteria for members who were enrolled.*
  - *For members who were enrolled at least 219 days before delivery, the organization has sufficient opportunity to provide prenatal care by the end of the first trimester.*
  - *For members who were not enrolled at least 219 days before delivery, the organization has sufficient opportunity to provide prenatal care within 42 days after enrollment.*
- *Services that occur over multiple visits count toward this measure if all services are within the time frame established in the measure. Ultrasound and lab results alone are not considered a visit; they must be combined with an office visit with an appropriate practitioner in order to count for this measure.*
- *For each member, the organization must use one date (date of delivery or EDD) to define the start and end of the first trimester. If multiple EDDs are documented, the organization must define a method to determine which EDD to use, and use that date consistently. If the organization elects to use EDD, and the EDD is not on or between October 8 of the year prior to the measurement year and October 7 of the measurement year, the member is removed as a valid data error and replaced by the next member of the oversample. The LMP may not be used to determine the first trimester.*
- *The organization may use EDD to identify the first trimester for the Timeliness of Prenatal Care rate and use the date of delivery for the Postpartum Care rate.*

- *A Pap test does not count as a prenatal care visit for the administrative and hybrid specification of the Timeliness of Prenatal Care rate, but is acceptable for the Postpartum Care rate as evidence of a pelvic exam. A colposcopy alone is not numerator compliant for either rate.*
- *The intent is that a prenatal visit is with a PCP or OB/GYN or other prenatal care practitioner. Ancillary services (lab, ultrasound) may be delivered by an ancillary provider. Nonancillary services (e.g., fetal heart tone, prenatal risk assessment) must be delivered by the required provider type.*
- *The intent is to assess whether prenatal and preventive care was rendered on a routine, outpatient basis, rather than assessing treatment for emergent events.*
- *Refer to Appendix 1 for the definition of* PCP and OB/GYN and other prenatal practitioner.
- *For both rates and for both Administrative and Hybrid data collection methods, services provided during a telephone visit, e-visit or virtual check-in are eligible for use in reporting.*

Data Elements for Reporting

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

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

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

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

Metric
TimelinessPrenatalCare
PostpartumCare

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

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

Use of Imaging Studies for Low Back Pain (LBP)

SUMMARY OF CHANGES TO MY 2025 HEDIS FOR QRS

- Revised step 1 of the event/diagnosis to no longer require a diagnosis of uncomplicated low back pain to be in conjunction with a specific visit type.
- Added a diagnosis of osteoporosis to required exclusions.

Description

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

Calculation

The measure is reported as an inverted rate [1 – (numerator/eligible population)]. A higher score indicates appropriate treatment of low back pain (i.e., the proportion for whom imaging studies did not occur).

Definitions

Intake period January 1–December 3 of the measurement year. The intake period is used to identify the first eligible encounter with a principal diagnosis of low back pain.

IESD Index episode start date. The earliest date of service for an eligible encounter during the intake period with a principal diagnosis of low back pain.

Negative diagnosis history A period of 180 days (6 months) prior to the IESD when the member had no claims/encounters with any diagnosis of low back pain.

Eligible Population

Product line Exchange.

Ages 18–75 years as of December 31 of the measurement year.

Report two age stratifications and a total rate:

- 18–64.
- 65–75.
- Total.

The total is the sum of the age stratifications.

Continuous enrollment 180 days prior to the IESD through 28 days after the IESD.

Allowable gap None.

Anchor date IESD.

Benefit Medical.

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

Step 1

Identify members 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). Do not include laboratory claims (claims with POS code 81).

Step 2

Determine the IESD. For each member identified in step 1, determine the earliest episode of low back pain. If the member had more than one encounter, include only the first encounter.

Step 3

Test for negative diagnosis history. Remove members with a diagnosis of uncomplicated low back pain (Uncomplicated Low Back Pain Value Set) during the 180 days prior to the IESD. Do not include laboratory claims (claims with POS code 81).

Step 4

Calculate continuous enrollment. Members must be continuously enrolled for 180 days prior to the IESD through 28 days after the IESD.

Required exclusions

Exclude members who meet any of the following criteria:

- Cancer, HIV, history of organ transplant, osteoporosis or spondylopathy (Diagnosis History That May Warrant Imaging Value Set) any time during the member's history through 28 days after the IESD. Do not include laboratory claims (claims with POS code 81).
- Organ transplant, lumbar surgery or medication treatment for osteoporosis (Procedure History That May Warrant Imaging Value Set) any time during the member's history through 28 days after the IESD.
- IV drug abuse, neurologic impairment or spinal infection (Recent Diagnoses That May Warrant Imaging Value Set) any time during the 365 days prior to the IESD through 28 days after the IESD. Do not include laboratory claims (claims with POS code 81).
- Trauma or a fragility fracture (Recent Injuries That May Warrant Imaging Value Set) any time during the 90 days prior to the IESD through 28 days after the IESD. Do not include laboratory claims (claims with POS code 81).
- *Prolonged use of corticosteroids.* 90 consecutive days of corticosteroid treatment any time during the 366-day period that begins 365 days prior to the IESD and ends on the IESD.

  To identify consecutive treatment days, identify calendar days covered by at least one dispensed corticosteroid (Corticosteroid Medications List). For overlapping prescriptions and multiple prescriptions on the same day assume the member started taking the second prescription after exhausting the first prescription. For example, if a member had a 30-days prescription dispensed on June 1 and a 30-days 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 a member had a 90-day prescription dispensed on the IESD, there is one covered calendar day (the IESD).

No gaps are allowed.

Corticosteroid Medications

Description	Prescription	
Corticosteroid	• Hydrocortisone • Cortisone • Prednisone • Prednisolone	• Methylprednisolone • Triamcinolone • Dexamethasone • Betamethasone/Betamethasone acetate

- A dispensed prescription to treat osteoporosis (Osteoporosis Medication List) any time during the member's history through 28 days after the IESD.

Osteoporosis Medications

Description	Prescription	
Bisphosphonates	• Alendronate • Alendronate-cholecalciferol • Ibandronate	• Risedronate • Zoledronic acid
Other agents	• Abaloparatide • Denosumab • Raloxifene	• Romosozumab • Teriparatide

- Members receiving palliative care (Palliative Care Assessment Value Set; Palliative Care Encounter Value Set; Palliative Care Intervention Value Set) during the measurement year.
- Members who had an encounter for palliative care (ICD-10-CM code Z51.5) any time during the measurement year. Do not include laboratory claims (claims with POS code 81).
- Members who use hospice services (Hospice Encounter Value Set; Hospice Intervention Value Set) or elect to use a hospice benefit any time during the measurement year. Organizations that use the Monthly Membership Detail Data File to identify these members must use only the run date of the file to determine if the member elected to use a hospice benefit during the measurement year.
- Members who die any time during the measurement year.
- Members 66 years of age and older as of December 31 of the measurement year with frailty ***and*** advanced illness. Members must meet ***both*** frailty and advanced illness criteria to be excluded:
  1. **Frailty.** At least two indications of frailty (Frailty Device Value Set; Frailty Diagnosis Value Set; Frailty Encounter Value Set; Frailty Symptom Value Set) with different dates of service during the measurement year. Do not include laboratory claims (claims with POS code 81).
  2. **Advanced Illness.** Either of the following during the measurement year or the year prior to the measurement year:
     - Advanced illness (Advanced Illness Value Set) on at least two different dates of service. Do not include laboratory claims (claims with POS code 81).
     - Dispensed dementia medication (Dementia Medication List).

Dementia Medications

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

Administrative Specification

Denominator The eligible population.

Numerator An imaging study (Imaging Study Value Set) with a diagnosis of uncomplicated low back pain (Uncomplicated Low Back Pain Value Set) on the IESD or in the 28 days following the IESD.

Note

- *Although denied claims are not included when assessing the numerator, all claims (paid, suspended, pending and denied) must be included when identifying the eligible population.*
- *Do not include supplemental data when identifying the eligible population or assessing the numerator. Supplemental data can be used for only required exclusions for this measure.*

Data Elements for Reporting

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

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

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

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

SUMMARY OF CHANGES TO MY 2025 HEDIS FOR QRS

- No changes to this measure.

Description

The percentage of members 3–17 years of age who had an outpatient visit with a PCP or OB/GYN and who had evidence of the following during the measurement year:

- BMI Percentile*.
- Counseling for Nutrition.
- Counseling for Physical Activity.

**Because BMI norms for youth vary with age and gender, this measure evaluates whether BMI percentile is assessed rather than an absolute BMI value.*

Definitions

BMI percentile The percentile ranking based on the CDC's BMI-for-age growth charts, which indicates the relative position of the patient's BMI number among others of the same gender and age.

Eligible Population

Product line Exchange.

Ages 3–17 years as of December 31 of the measurement year. Report two age stratifications and a total for each of the three indicators:

1. 3–11 years.
2. 12–17 years.
3. Total.

The total is the sum of the age stratifications.

Continuous enrollment The measurement year.

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

Anchor date December 31 of the measurement year.

Benefit Medical.

Event/diagnosis An outpatient visit (Outpatient Value Set) with a PCP or an OB/GYN during the measurement year.

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

- Members who have a diagnosis of pregnancy (Pregnancy Value Set) any time during the measurement year. Do not include laboratory claims (claims with POS code 81).

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

Administrative Specification

Denominator The eligible population.

Numerators

BMI Percentile BMI percentile (BMI Percentile Value Set) during the measurement year. Do not include laboratory claims (claims with POS code 81).

Counseling for Nutrition Counseling for nutrition during the measurement year. Either of the following meets criteria:

- Nutrition Counseling Value Set.
- ICD10CM code Z71.3. Do not include laboratory claims (claims with POS code 81).

Counseling for Physical Activity Counseling for physical activity during the measurement year. Either of the following meets the criteria:

- Physical Activity Counseling Value Set.
- Encounter for Physical Activity Counseling Value Set. Do not include laboratory claims (claims with POS code 81).

Hybrid Specification

Denominator A systematic sample drawn from the eligible population for the total age band (3–17 years). The total sample is stratified by age to report rates for the 3–11 and 12–17 age stratifications.

Organizations may reduce the sample size using the current year's administrative rate or the prior year's audited rate for the lowest of the three indicator rates for the total age band. Refer to the *Guidelines for Calculations and Sampling* for information on reducing the sample size.

Numerators

BMI Percentile BMI percentile during the measurement year as identified by administrative data or medical record review.

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

Medical record Documentation must include height, weight and BMI percentile during the measurement year. The height, weight and BMI percentile must be from the same data source.

Either of the following meets criteria for BMI percentile:

- BMI percentile documented as a value (e.g., 85th percentile).

- BMI percentile plotted on age-growth chart.

Only evidence of the BMI percentile or BMI percentile plotted on an age-growth chart meets criteria.

Member-collected biometric values (height, weight, BMI percentile) that meet the requirements of *General Guideline:* Member-Reported Services *and* Biometric Values are eligible for use in reporting.

Ranges and thresholds do not meet criteria for this indicator. A distinct BMI percentile is required for numerator compliance. Documentation of >99% or <1% meets criteria because a distinct BMI percentile is evident (i.e., 100% or 0%).

Counseling for Nutrition Documentation of counseling for nutrition or referral for nutrition education during the measurement year as identified by administrative data or medical record review.

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

Medical record Documentation must include a note indicating the date and at least one of the following:

- Discussion of current nutrition behaviors (e.g., eating habits, dieting behaviors).
- Checklist indicating nutrition was addressed.
- Counseling or referral for nutrition education.
- Member received educational materials on nutrition during a face-to-face visit.
- Anticipatory guidance for nutrition.
- Weight or obesity counseling.

Counseling for Physical Activity Documentation of counseling for physical activity or referral for physical activity during the measurement year as identified by administrative data or medical record review.

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

Medical record Documentation must include a note indicating the date and at least one of the following:

- Discussion of current physical activity behaviors (e.g., exercise routine, participation in sports activities, exam for sports participation).
- Checklist indicating physical activity was addressed.
- Counseling or referral for physical activity.
- Member received educational materials on physical activity during a face-to-face visit.
- Anticipatory guidance specific to the child's physical activity.
- Weight or obesity counseling.

Note

- *The following notations or examples of documentation do not count as numerator compliant:*
  - ***BMI***
    - *No BMI percentile documented in medical record or plotted on age-growth chart.*
    - *Notation of BMI value only.*
    - *Notation of height and weight only.*
  - ***Nutrition***
    - *No counseling/education on nutrition and diet.*
    - *Counseling/education before or after the measurement year.*
    - *Notation of "health education" or "anticipatory guidance" without specific mention of nutrition.*
    - *A physical exam finding or observation alone (e.g., well-nourished) is not compliant because it does not indicate counseling for nutrition.*
    - *Documentation related to a member's "appetite" does not meet criteria.*
  - ***Physical Activity***
    - *No counseling/education on physical activity.*
    - *Notation of "cleared for gym class" alone without documentation of a discussion.*
    - *Counseling/education before or after the measurement year.*
    - *Notation of "health education" or "anticipatory guidance" without specific mention of physical activity.*
    - *Notation of anticipatory guidance related solely to safety (e.g., wears helmet or water safety) without specific mention of physical activity recommendations.*
    - *Notation solely related to screen time (computer or television) without specific mention of physical activity.*
    - *Services may be rendered during a visit other than a well-child visit. These services count if the specified documentation is present, regardless of the primary intent of the visit; however, services specific to the assessment of treatment of an acute or chronic condition do not count toward the Counseling for Nutrition and Counseling for Physical Activity indicators.*
- *For example, the following documentation is specific to the assessment or treatment of an acute or chronic condition and does not meet criteria:*
  - *Notation that a member with chronic knee pain is able to run without limping.*
  - *Notation that a member has exercise-induced asthma.*
  - *Notation that a member with diarrhea is following the BRAT diet.*
  - *Notation that a member has decreased appetite as a result of an acute or chronic condition.*
- *Services rendered for obesity or eating disorders may be used to meet criteria for the Counseling for Nutrition and Counseling for Physical Activity indicators if the specified documentation is present.*
- *Referral to the Special Supplemental Nutrition Program for Women, Infants and Children (WIC) may be used to meet criteria for the Counseling for Nutrition indicator.*
- *The BMI Percentile, Counseling for Nutrition and Counseling for Physical Activity indicators do not require a specific setting; therefore, services rendered during a telephone visit, e-visit or virtual check-in meet criteria.*
- *Refer to Appendix 1 for the definition of PCP and OB/GYN and other prenatal care practitioner.*

Data Elements for Reporting

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

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

Metric	Age	Data Element	Reporting Instructions	A
BMIPercentile	3-11	CollectionMethod	For each Metric, repeat per Stratification	✓
NutritionCounseling	12-17	EligiblePopulation*	For each Metric and Stratification	✓
PhysicalActivityCounseling	Total	ExclusionAdminRequired*	For each Metric and Stratification	✓
		NumeratorByAdminElig	For each Metric and Stratification	
		CYAR	Only for Total (Percent)	
		MinReqSampleSize	Repeat per Metric and Stratification	
		OversampleRate	Repeat per Metric and Stratification	
		OversampleRecordsNumber	(Count)	
		ExclusionValidDataErrors	Repeat per Metric and Stratification	
		ExclusionEmployeeOrDep	Repeat per Metric and Stratification	
		OversampleRecsAdded	Repeat per Metric and Stratification	
		Denominator	For each Stratification, repeat per Metric	
		NumeratorByAdmin	For each Metric and Stratification	✓
		NumeratorByMedicalRecords	For each Metric and Stratification	
		NumeratorBySupplemental	For each Metric and Stratification	✓
		Rate	(Percent)	✓

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

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

SUMMARY OF CHANGES TO MY 2025 HEDIS FOR QRS

- Removed telehealth well visits from the numerator.
- Removed the data source reporting requirement from the race and ethnicity stratification.

HEDIS FOR QRS SPECIFIC GUIDANCE

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

Description

The percentage of members who had the following number of well-child visits with a PCP during the last 15 months. The following rates are reported:

1. *Well-Child Visits in the First 15 Months*. Children who turned 15 months old during the measurement year: Six or more well-child visits.
2. *Well-Child Visits for Age 15 Months–30 Months*. Children who turned 30 months old during the measurement year: Two or more well-child visits.

Note

- *This measure has the same structure as measures in the Effectiveness of Care domain. The organization must follow the Guidelines for Effectiveness of Care Measures when calculating this measure.*

Eligible Population: *Rate 1*—Well-Child Visits in the First 15 Months

Product line Exchange.

Stratifications Report the following stratifications by race and total, and stratifications by ethnicity and total:

- Race:
  - American Indian or Alaska Native.
  - Asian.
  - Black or African American.
  - Native Hawaiian or Other Pacific Islander.
  - White.
  - Some Other Race.
  - Two or More Races.
  - Asked But Not Answer.
  - Unknown.
  - Total.
- Ethnicity:
  - Hispanic or Latino.
  - Not Hispanic or Latino.
  - Asked But No Answer.
  - Unknown.

- Total.

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

Ages Children who turn 15 months old during the measurement year. Calculate the 15-month birthday as the child's first birthday plus 90 days.

Continuous enrollment 31 days–15 months of age. Calculate 31 days of age by adding 31 days to the date of birth.

Allowable gap No more than one gap in enrollment of up to 45 days during the continuous enrollment period.

Anchor date The date when the child turns 15 months old.

Benefit Medical.

Event/diagnosis None.

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

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

Administrative Specification: *Rate 1*—Well-Child Visits in the First 15 Months

Denominator The Rate 1 eligible population.

Numerator Six or more well-child visits on different dates of service on or before the 15-month birthday. Either of the following meet criteria:

- A well-care visit (Well-Care Value Set).
- An encounter for well-care (Encounter for Well Care Value Set). Do not include laboratory claims (claims with POS code 81).

Do not include telehealth visits (visits billed with a code that indicates telehealth: Telehealth POS Value Set; Online Assessments Value Set; Telephone Visits Value Set).

The well-child visit must occur with a PCP, but the PCP does not have to be the practitioner assigned to the child.

Eligible Population: *Rate 2*—Well-Child Visits for Age 15 Months–30 Months

Product line Exchange.

Stratifications Report the following stratifications by race and total, and stratifications by ethnicity and total:

- Race:
  - American Indian or Alaska Native.
  - Asian.

  - Black or African American.
  - Native Hawaiian or Other Pacific Islander.
  - White.
  - Some Other Race.
  - Two or More Races.
  - Asked But Not Answer.
  - Unknown.
  - Total.
- Ethnicity:
  - Hispanic or Latino.
  - Not Hispanic or Latino.
  - Asked But No Answer.
  - Unknown.
  - Total.

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

Ages	Children who turn 30 months old during the measurement year. Calculate the 30-month birthday as the second birthday plus 180 days.
Continuous enrollment	15 months plus 1 day–30 months of age. Calculate the 15-month birthday plus 1 day as the first birthday plus 91 days.
Allowable gap	No more than one gap in enrollment of up to 45 days during the continuous enrollment period.
Anchor date	The date when the child turns 30 months old.
Benefit	Medical.
Event/diagnosis	None.
Required exclusions	Exclude members who meet either of the following criteria: • Members who use hospice services (Hospice Encounter Value Set; Hospice Intervention Value Set) or elect to use a hospice benefit any time during the measurement year. Organizations that use the Monthly Membership Detail Data File to identify these members must use only the run date of the file to determine if the member elected to use a hospice benefit during the measurement year. • Members who die any time during the measurement year.

Administrative Specification: *Rate 2*—Well-Child Visits for Age 15 Months–30 Months

Denominator	The Rate 2 eligible population.
Numerator	Two or more well-child visits on different dates of service between the child's 15-month birthday plus 1 day and the 30-month birthday. Either of the following meet criteria: • A well-care visit (Well-Care Value Set) • An encounter for well-care (Encounter for Well Care Value Set). Do not include laboratory claims (claims with POS code 81).

Do not include telehealth visits (visits billed with a code that indicates telehealth: Telehealth POS Value Set; Online Assessments Value Set; Telephone Visits Value Set).

The well-child visit must occur with a PCP, but the PCP does not have to be the practitioner assigned to the child.

Note

- *Refer to Appendix 1 for the definition of* PCP.
- *This measure is based on the American Academy of Pediatrics Bright Futures: Guidelines for Health Supervision of Infants, Children and Adolescents (published by the National Center for Education in Maternal and Child Health). Visit the Bright Futures website for more information about well-child visits.*

Data Elements for Reporting

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

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

Metric	Data Element	Reporting Instructions
Age15Months	EligiblePopulation	For each Metric
Age15To30Months	ExclusionAdminRequired	For each Metric
	NumeratorByAdmin	For each Metric
	NumeratorBySupplemental	For each Metric
	Rate	(Percent)

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

Metric	Race	Data Element	Reporting Instructions
Age15Months	AmericanIndianOrAlaskaNative	EligiblePopulation	For each Metric and Stratification
Age15To30Months	Asian	Numerator	For each Metric and Stratification
	BlackOrAfricanAmerican	Rate	(Percent)
	NativeHawaiianOrOtherPacificIslander		
	White		
	SomeOtherRace		
	TwoOrMoreRaces		
	AskedButNoAnswer		
	Unknown		

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

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

Measures Reported Using Electronic Clinical Data Systems

Guidelines for Measures Reported Using Electronic Clinical Data Systems (ECDS)

SUMMARY OF CHANGES TO MY 2025 HEDIS FOR QRS

- Deleted *General Guideline 6:* Presentation of Codes in HEDIS for QRS Digital Measures. The definitions can be found in *Appendix 1: Glossary*.

HEDIS for QRS Specific Guidance

- In the Draft 2025 Call Letter, CMS proposed adding one measure specified for ECDS reporting to the 2026 QRS measure set:
  - Blood Pressure Control for Patients with Hypertension (BPC-E).

  Refer to the Final 2025 Call Letter and *2026 QRS and QHP Enrollee Survey Technical Guidance* for reporting this measure.
- In the Draft 2025 Call Letter, CMS proposes to transition the following measures to ECDS only reporting, beginning with the 2026 ratings year:
  - Cervical Cancer Screening (CCS-E).
  - Childhood Immunization Status (CIS-E).
  - Immunization for Adolescents (IMA-E).

  Refer to the Final 2025 Call Letter and *2026 QRS and QHP Enrollee Survey Technical Guidance* for reporting this measure.
- These guidelines apply to the following measures:
  - Adult Immunization Status (AIS-E).
  - Breast Cancer Screening (BCS-E).
  - Blood Pressure Control for Patients with Hypertension (BPC-E).
  - Cervical Cancer Screening (CCS-E).
  - Childhood Immunization Status (CIS-E).
  - Colorectal Cancer Screening (COL-E).
  - Depression Screening and Follow-Up for Adolescents and Adults (DSF-E).
  - Immunizations for Adolescents (IMA-E).
  - Social Need Screening and Intervention (SNS-E).

Description

HEDIS for QRS quality measures reported using ECDS inspire innovative use of electronic clinical data to document high-quality patient care that demonstrates commitment to evidence-based practices. Organizations that report HEDIS for QRS using ECDS encourage exchange of the information needed to provide high-quality services, ensuring that the information reaches the right people at the right time.

The ECDS reporting standard represents a step forward in adapting HEDIS for QRS to accommodate the expansive information available in electronic clinical datasets used for patient care and quality improvement.

ECDS are the network of data containing a plan member's personal health information and records of their experiences within the health care system. They may also support other care-related activities directly or indirectly, including evidence-based decision support, quality management and outcome reporting. Data in these systems are structured such that automated quality measurement queries can

be consistently and reliably executed, providing results quickly and efficiently to the team responsible for the care of health plan members.

Health plans that establish an enterprise network of interoperable electronic data systems will foster a member-centered, team-based approach to improving health care quality and better communication across health care service providers. Visit The Future of HEDIS for more information and FAQs about ECDS reporting.

Guidelines

HEDIS for QRS measures reported using ECDS follow the *General Guidelines for Data Collection and Reporting,* unless there is an ECDS-specific guideline listed below that overrides those rules. This hierarchy only exists in specific cases where there is an ECDS guideline listed. If no ECDS-specific guideline is listed, then organizations should default to those found in *General Guidelines for Data Collection and Reporting.*

1. Initial Population

The initial population for any HEDIS for QRS measure reported using ECDS includes all members who satisfy criteria, including age and participation criteria.

2. HEDIS Definitions and Requirements for ECDS Reporting

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

Denominator What is reported to NCQA for the measure denominator results, typically defined in the specifications included in this publication as "the initial population, minus exclusions."

3. Data Collection Methods

Electronic Method Measures reported using ECDS are specified for the Electronic Method of data collection.

Electronic transactional data may be used to identify the initial population.

To qualify for HEDIS for QRS ECDS reporting, data must use standard layouts, meet the measure technical specification requirements and be accessible by the care team upon request. Organizations meet this requirement if they are able to provide the requested information (e.g., phone, secure email, direct feed, provider portal, file request) to providers who are treating their members. Organizations should have documented processes for tracking these requests to be reviewed as part of the HEDIS audit.

Practitioners or practitioner groups that are accountable for clinical services provided to members must not be prevented from accessing any data used by a health plan for quality measure reporting, regardless of the initial Source System of Record (SSoR).

SSoR HEDIS for QRS measure data in ECDS reporting are submitted by each SSoR accessed to produce the measure result. The SSoR is the authoritative dataset containing the standardized elements the organization requires to generate and report digital quality measure results.

Datasets for ECDS reporting may natively contain both standard and nonstandard data. Refer to *General Guideline:* Supplemental Data for electronic clinical data proof-of-service and verification requirements. Each electronic data source used for HEDIS for QRS ECDS reporting must have:

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

Each SSoR is a data repository where semantic differences in non-standard data have been resolved through integrity testing, and the data has been structured so it can be reliably queried by a HEDIS for QRS digital quality measure (dQM).

Source priority

When quality data elements to support the measure are identified in multiple data sources, a hierarchy is applied.

Each SSoR used for HEDIS for QRS ECDS reporting is categorized using the following priority:

1. Electronic health record (EHR)/personal health record (PHR) (the system of data origin such as laboratory, pharmacy, pathology, radiology).
2. Health information exchange (HIE)/clinical registry.
3. Case management system.
4. Administrative.

Organizations compare the list of all unique systems containing relevant member data and assign members based on the highest-ranked data category in the hierarchy. SSoRs are mapped using the data type that is loaded to the master file that identifies member eligibility for each component of a quality measure. The applied hierarchy does not imply relevance or validity of a data source; rather, it is applied in cases where a member's data are in multiple locations.

Members are assigned to only one SSoR category for each measure element (e.g., initial population, denominator, exclusions, numerator).

For example, if administrative data are used to identify the initial population, the member is assigned to the administrative cohort for the initial population. If a numerator event is identified through a query of the organization's case management system, the member is assigned to that cohort for the numerator even though that member may have been included in the measure's initial population using administrative data.

Organizations must complete data collection for the SSoRs by the supplemental data collection deadline. Refer to *General Guideline:* Audit Preparation for information about the timeline. When appropriate, an SSoR can be refreshed according to the organization's scheduled refreshes and accounted appropriately for the measure. Refer to *General Guideline:* Obtaining Information for the Systematic Sample.

4. Types of ECDS Data

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

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

Data sources are categorized using the following criteria:

EHR/PHR

EHRs and PHRs are transactional systems that store clinically relevant information collected directly from or managed by a patient. An EHR contains the medical and treatment histories of patients; a PHR includes both the standard clinical data collected in a provider's office or another care setting, in addition to information curated directly in the PHR by the patient though an application programming interface (API).

This data category includes biometric information and clinical samples obtained directly from a patient as well as clinical findings resulting from samples collected from a patient (e.g., pathology, laboratory and pharmacy records generated from entities not directly connected to the patient's EHR).

HIE/clinical registry

HIEs and clinical registries eligible for this reporting category include state HIEs, IIS, public health agency systems, regional HIEs (RHIO), Patient-Centered Data Homes™ or other registries developed for research or to support quality improvement and patient safety initiatives.

Doctors, nurses, pharmacists, other health care providers and patients can use HIEs to access and share vital medical information, with the goal of creating a complete patient record.[6] HIEs used for ECDS reporting must use standard protocols to ensure security, privacy, data integrity, sender and receiver authentication and confirmation of delivery.

Clinical registries collect information about people with a specific disease or condition, or patients who may be willing to participate in research about a disease. Registries can be sponsored by a government agency, nonprofit organization, health care facility or private company, and decisions regarding use of the data in the registry are the responsibility of the registry's governing committee.7

Case management system

A shared database of member information collected through a collaborative process of member assessment, care planning, care coordination or monitoring of a member's functional status and care experience.

Case management systems eligible for this category of ECDS reporting include any system developed to support the organization's case/disease management activities, including activities performed by delegates.

[6]https://www.healthit.gov/providers-professionals/health-information-exchange/what-hie
[7]https://www.nih.gov/health-information/nih-clinical-research-trials-you/list-registries

Administrative Includes data from administrative claims processing systems for all services incurred (paid, suspended, pending and denied) during the period defined by each measure's participation as well as member management files, member eligibility and enrollment files, electronic member rosters, internal audit files, and member call service databases.

5. Member Allocation for HEDIS for QRS ECDS Reporting

Member eligibility is determined by participation in the organization during the participation period. Include all eligible members with the measure-specified benefits during the specified participation period. Members must be allocated to a product/product line for HEDIS for QRS ECDS reporting. Allocation requirements are specified in the guidance section of the measures.

*Adult Immunization Status (AIS-E)**

***Developed with support from the Department of Health and Human Services (DHHS), Office of the Assistant Secretary for Health (OASH), National Vaccine Program Office (NVPO) and the Hepatitis Education Project**

SUMMARY OF CHANGES TO MY 2025 HEDIS FOR QRS

- Added hepatitis B immunization indicator.
- Updated clinical recommendation statement and citations.
- Updated the denominator age range for the pneumococcal immunization indicator.
- Removed the herpes zoster live vaccine from the herpes zoster immunization indicator.
- Revised the numerator criteria of the herpes zoster vaccine to on or after October 20, 2017, through the end of the measurement period.
- Updated age stratifications for the influenza, Td/Tdap and zoster immunization indicators.
- Removed data criteria (element level).
- Removed programming guidance.
- Removed the data source reporting requirement from the race and ethnicity stratification.

HEDIS FOR QRS SPECIFIC GUIDANCE

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

Description	The percentage of members 19 years of age and older who are up to date on recommended routine vaccines for influenza, tetanus and diphtheria (Td) or tetanus, diphtheria and acellular pertussis (Tdap), zoster, pneumococcal and hepatitis B.
Measurement period	January 1–December 31.
Clinical recommendation statement	The Advisory Committee on Immunization Practices recommends annual influenza vaccination; and tetanus, diphtheria and acellular pertussis (Tdap) and/or tetanus and diphtheria (Td) vaccine; herpes zoster vaccine; pneumococcal vaccination and hepatitis B vaccination for adults at various ages.
Citations	Murthy, N. A.P. Wodi, A.P., V.V. McNally, M.F. Daley, S. Cineas. 2024. "Advisory Committee on Immunization Practices Recommended Immunization Schedule for Adults Aged 19 Years or Older—United States, 2024." *MMWR Morb Mortal Wkly Rep* 73:11–15. DOI: http://dx.doi.org/10.15585/mmwr.mm7301a3
Characteristics	
Scoring	Proportion.
Type	Process.

Stratification	• Influenza. – Product line: ▪ Exchange – Age (as of the start of the measurement period): ▪ 19–64 years. ▪ 65 years and older. – Race: ▪ Race—American Indian or Alaska Native. ▪ Race—Black or African American. ▪ Race—Asian. ▪ Race—Native Hawaiian or Other Pacific Islander. ▪ Race—White. ▪ Race—Some Other Race. ▪ Race—Two or More Races. ▪ Race—Asked But No Answer. ▪ Race—Unknown. – Ethnicity: ▪ Ethnicity—Hispanic or Latino. ▪ Ethnicity—Not Hispanic or Latino. ▪ Ethnicity—Asked But No Answer. ▪ Ethnicity—Unknown. • Td/Tdap. – Product line: ▪ Exchange. – Age (as of the start of the measurement period): ▪ 19–64 years. ▪ 65 years and older. – Race: ▪ Race—American Indian or Alaska Native. ▪ Race—Black or African American. ▪ Race—Asian. ▪ Race—Native Hawaiian or Other Pacific Islander. ▪ Race—White. ▪ Race—Some Other Race. ▪ Race—Two or More Races. ▪ Race—Asked But No Answer. ▪ Race—Unknown. – Ethnicity: ▪ Ethnicity—Hispanic or Latino. ▪ Ethnicity—Not Hispanic or Latino. ▪ Ethnicity—Asked But No Answer. ▪ Ethnicity—Unknown.

	• Zoster. – Product line: ▪ Exchange. – Age (as of the start of the measurement period): ▪ 50–64 years. ▪ 65 years and older. – Race: ▪ Race—American Indian or Alaska Native. ▪ Race—Black or African American. ▪ Race—Asian. ▪ Race—Native Hawaiian or Other Pacific Islander. ▪ Race—White. ▪ Race—Some Other Race. ▪ Race—Two or More Races. ▪ Race—Asked But No Answer. ▪ Race—Unknown. – Ethnicity: ▪ Ethnicity—Hispanic or Latino. ▪ Ethnicity—Not Hispanic or Latino. ▪ Ethnicity—Asked But No Answer. ▪ Ethnicity—Unknown. • Pneumococcal. – Product line: ▪ Exchange. – Age (as of the start of the measurement period): ▪ 65 years and older. – Race: ▪ Race—American Indian or Alaska Native. ▪ Race—Black or African American. ▪ Race—Asian. ▪ Race—Native Hawaiian or Other Pacific Islander. ▪ Race—White. ▪ Race—Some Other Race. ▪ Race—Two or More Races. ▪ Race—Asked But No Answer. ▪ Race—Unknown. – E*thnicity:* ▪ Ethnicity—Hispanic or Latino. ▪ Ethnicity—Not Hispanic or Latino. ▪ Ethnicity—Asked But No Answer ▪ Ethnicity—Unknown. • Hepatitis B. – Product line: ▪ Exchange.

	– Age (as of the start of the measurement period): ▪ 19–30 years. ▪ 31–59 years. – Race: ▪ Race—American Indian or Alaska Native. ▪ Race—Black or African American. ▪ Race—Asian. ▪ Race—Native Hawaiian or Other Pacific Islander. ▪ Race—White. ▪ Race—Some Other Race. ▪ Race—Two or More Races. ▪ Race—Asked But No Answer. ▪ Race—Unknown. – Ethnicity*:* ▪ Ethnicity—Hispanic or Latino. ▪ Ethnicity—Not Hispanic or Latino. ▪ Ethnicity—Asked But No Answer. ▪ Ethnicity—Unknown.
Risk adjustment	None.
Improvement notation	A higher rate indicates better performance.
Guidance	**General Rules:** All measure rates are specified based on clinical guideline recommendations for the age group included in the rate. **Allocation:** The member was enrolled with a medical benefit throughout the participation period. No more than one gap in enrollment of up to 45 days during the measurement period. The member must be enrolled on the last day of the measurement period. **Reporting:** For all plans, the race and ethnicity stratifications are mutually exclusive, and the sum of all categories in each stratification is the total population.
Definitions	
Participation	The identifiers and descriptors for each organization's coverage used to define members' eligibility for measure reporting. Allocation for reporting is based on eligibility during the participation period.
Participation period	The measurement period.

Initial population	**Initial population 1** Members 19 years and older at the start of the measurement period who also meet the criteria for participation. **Initial population 2** Same as the initial population 1. **Initial population 3** Members 50 years and older at the start of the measurement period who also meet the criteria for participation. **Initial population 4** Members 65 years and older at the start of the measurement period who also meet the criteria for participation. **Initial population 5** Members 19–59 years at the start of the measurement period who also meet the criteria for participation.
Exclusions	**Exclusions 1** • 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 to determine if the member elected to use a hospice benefit during the measurement period. • Members who die any time during the measurement period. **Exclusions 2** Same as exclusions 1. **Exclusions 3** Same as exclusions 1. **Exclusions 4** Same as exclusions 1. **Exclusions 5** Same as exclusions 1.
Denominator	**Denominator 1** The initial population 1, minus exclusions. **Denominator 2** Same as denominator 1. **Denominator 3** The initial population 3, minus exclusions. **Denominator 4** The initial population 4, minus exclusions. **Denominator 5** The initial population 5, minus exclusions.

Numerator	**Numerator 1—Immunization Status: Influenza** • Members who received an 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) on or between July 1 of the year prior to the measurement period and June 30 of the measurement period, ***or*** • Members with anaphylaxis due to the influenza vaccine (SNOMEDCT code 471361000124100) any time before or during the measurement period. **Numerator 2—Immunization Status: Td/Tdap** • Members who received at least one Td vaccine (Td Immunization Value Set; Td Vaccine Procedure Value Set) or one Tdap vaccine (CVX code 115; Tdap Vaccine Procedure Value Set) between 9 years prior to the start of the measurement period and the end of the measurement period, ***or*** • Members with a history of one of the following contraindications any time before or during the measurement period: – 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 3—Immunization Status: Zoster** • Members who received two doses of the herpes zoster recombinant vaccine (CVX code 187; Herpes Zoster Recombinant Vaccine Procedure Value Set) at least 28 days apart, on October 20, 2017, through the end of the measurement period, ***or*** • Members with 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** • Members who received at least one dose of an adult pneumococcal vaccine (Adult Pneumococcal Immunization Value Set; Adult Pneumococcal Vaccine Procedure Value Set) on or after the member's 19th birthday and before or during the measurement period, ***or*** • Members with anaphylaxis due to the pneumococcal vaccine (SNOMEDCT code 471141000124102) any time before or during the measurement period. **Numerator 5—Immunization Status: Hepatitis B** • Members who 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. For example, if the member's date of birth is December 1, the newborn hepatitis B vaccination must be on or between December 1 and December 8.

	• Members who received a 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. • Members who had a hepatitis B surface antigen, hepatitis B surface antibody or total antibody to hepatitis B core antigen test, with a positive result any time before or during the measurement period. Either of the following meets criteria: – A test (Hepatitis B Tests With Threshold of 10 Value Set) with a result greater than 10 mIU/mL. – A test (Hepatitis B Prevaccination Tests Value Set) with a finding of immunity (Hepatitis B Immunity Finding Value Set). • Members with a history of hepatitis B illness (Hepatitis B Value set) any time before or during the measurement period. Do not include laboratory claims (claims with POS code 81). • Members with anaphylaxis due to the hepatitis B vaccine (SNOMED CT code 428321000124101) any time before or during the measurement period.

Data Elements for Reporting

Organizations that submit HEDIS for QRS data to NCQA provide the following data elements in a specified file.

Table AIS-E-A-4: Data Elements for Adult Immunization Status

Metric	Age	Data Element	Reporting Instructions
Influenza	19-64	InitialPopulation	For each Metric and Stratification
TdTdap	65+	ExclusionsByEHR	For each Metric and Stratification
	Total	ExclusionsByCaseManagement	For each Metric and Stratification
		ExclusionsByHIERegistry	For each Metric and Stratification
Zoster	50-64	ExclusionsByAdmin	For each Metric and Stratification
	65+	Exclusions	(Sum over SsoRs)
	Total	Denominator	For each Metric and Stratification
		NumeratorByEHR	For each Metric and Stratification
Pneumococcal	65+	NumeratorByCaseManagement	For each Metric and Stratification
		NumeratorByHIERegistry	For each Metric and Stratification
HepatitisB	19-30	NumeratorByAdmin	For each Metric and Stratification
	31-59	Numerator	(Sum over SsoRs)
	Total	Rate	(Percent)

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	NativeHawaiianOrOtherPacificIslander	Numerator	For each Metric and Stratification
HepatitisB	White	Rate	(Percent)
	SomeOtherRace		
	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)

SUMMARY OF CHANGES TO HEDIS MY 2025

- This is a first-year measure.
- Revised the exclusions and numerator.

HEDIS FOR QRS SPECIFIC GUIDANCE

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

Description	The percentage of members 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.
Clinical recommendation statement	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. “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 Whelton, P.K., R.M. Carey, W.S. Aronow, D.E. Casey, K.J. Collins, C. Dennison Himmelfarb, S.M. DePalma, et al. “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 (June 2018): e13–115. https://doi.org/10.1161/HYP.0000000000000065
Characteristics	
Scoring **Type** **Stratification**	Proportion. Outcome. • <140/90 mm Hg. – Product line: ▪ Commercial. ▪ Medicaid. ▪ Medicare. – Race (for each product line): ▪ Race—American Indian or Alaska Native. ▪ Race—Asian. ▪ Race—Black or African American. ▪ Race—Native Hawaiian or Other Pacific Islander. ▪ Race—White. ▪ Race—Some Other Race. ▪ Race—Two or More Races. ▪ Race—Asked But No Answer. ▪ Race—Unknown. – Ethnicity (for each product line): ▪ Ethnicity—Hispanic or Latino. ▪ Ethnicity—Not Hispanic or Latino. ▪ Ethnicity—Asked But No Answer. ▪ Ethnicity—Unknown.
Risk adjustment **Improvement notation** **Guidance**	None. Increased score indicates improvement. **Allocation:** The member was enrolled with a medical benefit during the measurement period. No more than one gap in enrollment of up to 45 days during the measurement period. To determine continuous enrollment for a Medicaid beneficiary for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage (e.g., a member whose coverage lapses for 2 months [60 days] is not continuously enrolled). The member must be enrolled on the last day of the measurement period. **Reporting:** For all plans, the race and ethnicity stratifications are mutually exclusive, and the sum of all categories in each stratification is the total population.

Definitions	
Participation	The identifiers and descriptors for each organization's coverage used to define members' eligibility for measure reporting. Allocation for reporting is based on eligibility during the participation period.
Participation period	The measurement period.
Initial population	Members who are 18–85 years old as of the last day of the measurement period 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.
Exclusions	• 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 to determine if the member elected to use a hospice benefit during the measurement period. • Members who die any time during the measurement period. • Members receiving palliative care (Palliative Care Assessment Value Set; Palliative Care Encounter Value Set; Palliative Care Intervention Value Set) any time during the measurement period. • Members who had an encounter for palliative care (ICD-10-CM code Z51.5) any time during the measurement period. Do not include laboratory claims (claims with POS code 81). • Members 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. • Members with a diagnosis that indicates end-stage renal disease (ESRD) (ESRD Diagnosis Value Set; History of Nephrectomy or Kidney Transplant Value Set), any time during the member's history on or prior to the last day of the measurement period. Do not include laboratory claims (claims with POS code 81).

	• Members with a procedure that indicates ESRD: dialysis (Dialysis Procedure Value Set), nephrectomy (Total Nephrectomy Value Set; Partial Nephrectomy Value Set) or kidney transplant (Kidney Transplant Value Set) any time during the member's history on or prior to the last day of the measurement period. • Members with a diagnosis of pregnancy (Pregnancy Value Set) any time during the measurement period. Do not include laboratory claims (claims with POS code 81). • Medicare members 66 years of age and older as of the last day of the measurement period who meet either of the following: • Enrolled in an Institutional SNP (I-SNP) any time during the measurement period. • Living long-term in an institution any time during the measurement period as identified by the LTI flag in the Monthly Membership Detail Data File. Use the run date of the file to determine if a member had an LTI flag during the measurement period. • Members 66–80 years of age as of the last day of the measurement period (all product lines) with frailty ***and*** advanced illness. Members must meet ***both*** frailty and advanced illness criteria to be excluded: 1. **Frailty.** At least two indications of frailty (Frailty Device Value Set; Frailty Diagnosis Value Set; Frailty Encounter Value Set; Frailty Symptom Value Set) with different dates of service during the measurement period. Do not include laboratory claims (claims with POS code 81). 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. Do not include laboratory claims (claims with POS code 81). – Dispensed dementia medication (Dementia Medications List). • Members 81 years of age and older as of the last day of the measurement period (all product lines) with at least two indications of frailty (Frailty Device Value Set; Frailty Diagnosis Value Set; Frailty Encounter Value Set; Frailty Symptom Value Set) with different dates of service during the measurement period. Do not include laboratory claims (claims with POS code 81).
Denominator	The initial population, minus exclusions.
Numerator	The systolic and diastolic BP values <140/90 (Systolic Blood Pressure Value Set; Diastolic Blood Pressure Value Set) from the most recent day a BP was recorded during the measurement period, on or after the date of the second hypertension event. 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.

	The member is numerator compliant if the representative BP is <140/90 mm Hg. The member is not compliant if the BP is ≥140/90 mm Hg, if there is no BP reading during the measurement 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.

Data Elements for Reporting

Organizations that submit data to NCQA provide the following data elements in a specified file.

Table BPC-E-A-1/2/3: Data Elements for Blood Pressure Control for Patients With Hypertension

Metric	Data Element	Reporting Instructions
BPUnder140Over90	InitialPopulation	Report once
	ExclusionsByEHR	Report once
	ExclusionsByCaseManagement	Report once
	ExclusionsByHIERegistry	Report once
	ExclusionsByAdmin	Report once
	Exclusions	(Sum over SSoRs)
	Denominator	Report once
	NumeratorByEHR	Report once
	NumeratorByCaseManagement	Report once
	NumeratorByHIERegistry	Report once
	NumeratorByAdmin	Report once
	Numerator	(Sum over SSoRs)
	Rate	(Percent)

Table BPC-E-B-1/2/3: 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
	NativeHawaiianOrOtherPacificIslander	Numerator	For each Stratification
	White	Rate	(Percent)

Metric	Race	Data Element	Reporting Instructions
	SomeOtherRace		
	TwoOrMoreRaces		
	AskedButNoAnswer		
	Unknown		

Table BPC-E-C-1/2/3: 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)

SUMMARY OF CHANGES TO MY 2025 HEDIS FOR QRS

- Revised the description, clinical recommendation statement, citations, stratification, initial population and Data Elements for Reporting table.
- Removed "Programming Guidance" from the Characteristics section.
- Added a laboratory claim exclusion to the Absence of Left Breast Value Set and Absence of Right Breast Value Set.
- Removed Data criteria (element level) section.
- Removed the data source reporting requirement from the race and ethnicity stratification.

HEDIS FOR QRS SPECIFIC GUIDANCE

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

Description	The percentage of members 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.
Clinical recommendation statement	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. Wanda K. Nicholson, Michael Silverstein, John B. Wong, Michael J. Barry, David Chelmow, Tumaini Rucker Coker, et al. "Screening for Breast Cancer: U.S. Preventive Services Task Force Recommendation Statement." JAMA 331, no. 22 (June 11, 2024): 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-andGender-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.
Stratification	• Breast Cancer Screening. – Product line: ▪ Exchange. – Age: ▪ 42–51 years. ▪ 52–74 years. – Race: ▪ Race—American Indian or Alaska Native. ▪ Race—Asian. ▪ Race—Black or African American. ▪ Race—Native Hawaiian or Other Pacific Islander. ▪ Race—White. ▪ Race—Some Other Race. ▪ Race—Two or More Races. ▪ Race—Asked But No Answer. ▪ Race—Unknown. – Ethnicity: ▪ Ethnicity—Hispanic or Latino. ▪ Ethnicity—Not Hispanic or Latino. ▪ Ethnicity—Asked But No Answer. ▪ Ethnicity—Unknown.
Risk adjustment	None.
Improvement notation	A higher rate indicates better performance.
Guidance	**Allocation:** The member was enrolled with a medical benefit October 1 two years prior to the measurement period through the end of the measurement period. No more than one gap in enrollment of us to 45 days for each full calendar year (i.e., the measurement period and the year prior to the measurement period).

	No gaps in enrollment are allowed from October 1 two years prior to the measurement period through December 31 two years prior to the measurement period. The member must be enrolled on the last day of the measurement period. **Reporting:** For all plans, the race and ethnicity stratifications are mutually exclusive, and the sum of all categories in each stratification is the total population.
Definitions	
Participation **Participation period**	The identifiers and descriptors for each organization's coverage used to define members' eligibility for measure reporting. Allocation for reporting is based on eligibility during the participation period. October 1 two years prior to the measurement period through the end of the measurement period.
Initial population	Members 42–74 years of age by the end of the measurement period who were recommended for routine breast cancer screening and also meet the criteria for participation. Include members recommended for routine breast cancer screening with any of the following criteria: • Administrative Gender of Female (AdministrativeGender code female) at any time in the member's history. • Sex Assigned at Birth (LOINC code 76689-9) of Female (LOINC code LA3-6) at any time in the member's history. • Sex Parameter for Clinical Use of Female (SexParameterForClinicalUse code female-typical) during the measurement period.
Exclusions	• 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 to determine if the member elected to use a hospice benefit during the measurement period. • Members who die any time during the measurement period. • Members who had a bilateral mastectomy or both right and left unilateral mastectomies any time during the member's history through the end of the measurement period. Any of the following meet the criteria for bilateral mastectomy: – Bilateral mastectomy (Bilateral Mastectomy Value Set). – Unilateral mastectomy (Unilateral Mastectomy Value Set) with a bilateral modifier (CPT Modifier code 50) (same procedure). – Unilateral mastectomy found in clinical data (Clinical Unilateral Mastectomy Value Set) with a bilateral modifier (SNOMED CT Modifier code 51440002) (same procedure). ***Note:*** *The "clinical" mastectomy value sets identify mastectomy; the word "clinical" refers to the data source, not to the type of mastectomy.*

– History of bilateral mastectomy (History of Bilateral Mastectomy Value Set).
– Any combination of codes from the table below that indicate a mastectomy on ***both*** the left ***and*** right side on the same date of service or on different dates of service.

Left Mastectomy (any of the following)	Right Mastectomy (any of the following)
Unilateral mastectomy (Unilateral Mastectomy Value Set) ***with*** a left-side modifier (CPT Modifier code LT) (same procedure)	Unilateral mastectomy (Unilateral Mastectomy Value Set) ***with*** a right-side modifier (CPT Modifier code RT) (same procedure)
Unilateral mastectomy found in clinical data (Clinical Unilateral Mastectomy Value Set) ***with*** a left-side qualifier value (SNOMED CT Modifier code 7771000) (same procedure)	Unilateral mastectomy found in clinical data (Clinical Unilateral Mastectomy Value Set) ***with*** a right-side qualifier value (SNOMED CT Modifier code 24028007) (same procedure)
Absence of the left breast (Absence of Left Breast Value Set). Do not include laboratory claims (claims with POS code 81)	Absence of the right breast (Absence of Right Breast Value Set). Do not include laboratory claims (claims with POS code 81)
Left unilateral mastectomy (Unilateral Mastectomy Left Value Set)	Right unilateral mastectomy (Unilateral Mastectomy Right Value Set)

- Members who had gender-affirming chest surgery (CPT code 19318) with a diagnosis of gender dysphoria (Gender Dysphoria Value Set) any time during the member's history through the end of the measurement period.
- Members 66 years of age and older by the end of the measurement period, with frailty and advanced illness. Members must meet both frailty and advanced illness criteria to be excluded:
  1. **Frailty.** At least two indications of frailty (Frailty Device Value Set; Frailty Diagnosis Value Set; Frailty Encounter Value Set; Frailty Symptom Value Set) with different dates of service during the measurement period. Do not include laboratory claims (claims with POS 81).
  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. Do not include laboratory claims (claims with POS code 81).
     – Dispensed dementia medication (Dementia Medications List).
- Members receiving palliative care (Palliative Care Assessment Value Set; Palliative Care Encounter Value Set; Palliative Care Intervention Value Set) any time during the measurement period.

	• Members who had an encounter for palliative care (ICD-10-CM code Z51.5) any time during the measurement period. Do not include laboratory claims (claims with POS 81).
Denominator	The initial population, minus exclusions.
Numerator	One or more mammograms (Mammography Value Set) any time on or between October 1 two years prior to the measurement period and the end of the measurement period.

Data Elements for Reporting

Organizations that submit HEDIS for QRS data to NCQA provide the following data elements in a specified file.

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	ExclusionsByEHR	For each stratification
	Total	ExclusionsByCaseManagement	For each stratification
		ExclusionsByHIERegistry	For each stratification
		ExclusionsByAdmin	For each stratification
		Exclusions	(Sum over SSoRs)
		Denominator	For each stratification
		NumeratorByEHR	For each stratification
		NumeratorByCaseManagement	For each stratification
		NumeratorByHIERegistry	For each stratification
		NumeratorByAdmin	For each stratification
		Numerator	(Sum over SSoRs)
		Rate	(Percent)

Table 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
	NativeHawaiianOrOtherPacificIslander	Numerator	For each Stratification
	White	Rate	(Percent)
	SomeOtherRace		
	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)

SUMMARY OF CHANGES TO MY 2025 HEDIS FOR QRS

- Removed "Programming Guidance" from the *Characteristics* section.
- Removed the *Data criteria (element level)* section.
- Removed the data source reporting requirement from the race and ethnicity stratification.

HEDIS FOR QRS SPECIFIC GUIDANCE

- ECDS reporting is required for this measure.
- HEDIS for QRS does not require race and ethnicity stratification reporting.

Description	• The percentage of women 21–64 years of age who were recommended for routine cervical cancer screening who were screened for cervical cancer using any of the following criteria: • Members 21–64 years of age who were recommended for routine cervical cancer screening and had cervical cytology performed within the last 3 years. • Members 30–64 years of age were recommended for routine cervical cancer screening and had cervical high-risk human papillomavirus (hrHPV) testing performed within the last 5 years. • Members 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.
Clinical recommendation statement	The U.S. Preventive Services Task Force (USPSTF) recommends screening for cervical cancer every 3 years with cervical cytology alone in women aged 21–29 years. 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 co-testing (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-andGender-Diverse-Adults-Spring-2021-1.pd 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 **Type**	Proportion. Process.

Stratification	• Cervical Cancer Screening. – Product line: ▪ Exchange. – Race: ▪ Race—American Indian or Alaska Native. ▪ Race—Asian. ▪ Race—Black or African American. ▪ Race—Native Hawaiian or Other Pacific Islander. ▪ Race—White. ▪ Race—Some Other Race. ▪ Race—Two or More Races. ▪ Race—Asked But No Answer. ▪ Race—Unknown. – Ethnicity: ▪ Ethnicity—Hispanic or Latino. ▪ Ethnicity—Not Hispanic or Latino. ▪ Ethnicity—Asked But No Answer. ▪ Ethnicity—Unknown.
Risk adjustment	None.
Improvement notation	A higher rate indicates better performance.
Guidance	**Allocation:** The member was enrolled with a medical benefit throughout the measurement period. No more than one gap in enrollment of up to 45 days during the measurement period. The member must be enrolled on the last day of the measurement period. **Reporting:** For all plans, the race and ethnicity stratifications are mutually exclusive, and the sum of all categories in each stratification is the total population.
Definitions	
Participation	The identifiers and descriptors for each organization's coverage used to define members' eligibility for measure reporting. Allocation for reporting is based on eligibility during the participation period.
Participation period	The measurement period.
Initial population	Members 24–64 years as of the end of the measurement period who were recommended for routine cervical cancer screening, and meet the criteria for participation. Include members recommended for routine cervical cancer screening with any of the following criteria:

	– Administrative Gender of Female (AdministrativeGender code female) any time in the member's history. – Sex Assigned at Birth (LOINC code 76689-9) of Female (LOINC code LA3-6) any time in the member's history. – Sex Parameter for Clinical Use of Female (SexParameterForClinicalUse code female-typical) during the measurement period.
Exclusions	• 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 to determine if the member elected to use a hospice benefit during the measurement period. • Members who die any time during the measurement period. • Hysterectomy with no residual cervix (Hysterectomy With No Residual Cervix Value Set) any time during the member's history through December 31 of measurement year. • Cervical agenesis or acquired absence of cervix (Absence of Cervix Diagnosis Value Set) any time during the member's history through the end of the measurement period. Do not include laboratory claims (claims with POS 81). • Members receiving palliative care (Palliative Care Assessment Value Set; Palliative Care Encounter Value Set; Palliative Care Intervention Value Set) any time during the measurement period. • Members who had an encounter for palliative care (ICD-10-CM code Z51.5) any time during the measurement period. Do not include laboratory claims (claims with POS 81). • Members with Sex Assigned at Birth (LOINC code 76689-9) of Male (LOINC code LA2-8) at any time during the patient's history.
Denominator	The initial population, minus exclusions.
Numerator	The number of members recommended for routine cervical cancer screening who were screened for cervical cancer. Either of the following meets criteria: • Members 24–64 years of age by the end 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. • Members 30–64 years of age by the end 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 measurement period or the 4 years prior to the measurement period and who were 30 years or older on 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.*

Data Elements for Reporting

Organizations that submit HEDIS for QRS data to NCQA provide the following data elements in a specified file.

Table CCS-E-4: Data Elements for Cervical Cancer Screening

Metric	Data Element	Reporting Instructions
CervicalCancerScreening	InitialPopulation	Report once
	ExclusionsByEHR	Report once
	ExclusionsByCaseManagement	Report once
	ExclusionsByHIERegistry	Report once
	ExclusionsByAdmin	Report once
	Exclusions	(Sum over SSoRs)
	Denominator	Report once
	NumeratorByEHR	Report once
	NumeratorByCaseManagement	Report once
	NumeratorByHIERegistry	Report once
	NumeratorByAdmin	Report once
	Numerator	(Sum over SSoRs)
	Rate	(Percent)

Table CCS-E-B-4: Data Elements for Cervical Cancer Screening: Stratifications by Race

Metric	Race	Data Element	Reporting Instructions
CervicalCancerScreening	AmericanIndianOrAlaskaNative	InitialPopulation	For each stratification
	Asian	Exclusions	For each stratification
	BlackOrAfricanAmerican	Denominator	For each stratification
	NativeHawaiianOrOtherPacificIslander	Numerator	For each stratification
	White	Rate	(Percent)
	SomeOtherRace		
	TwoOrMoreRaces		
	AskedButNoAnswer		
	Unknown		

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

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)

SUMMARY OF CHANGES TO MY 2025 HEDIS FOR QRS

- Updated the clinical recommendation statement and citations.
- Removed "Programming Guidance" from the Characteristics section.
- Added organ and bone marrow transplants to the Exclusions section.
- Removed the Data criteria (element) section.
- Removed the data source reporting requirement from the race and ethnicity stratification.

HEDIS FOR QRS SPECIFIC GUIDANCE

- HEDIS for QRS reports only Combination 10 and related antigens.
- ECDS reporting is required for this measure.
- HEDIS for QRS does not require race and ethnicity stratification reporting.

Description	The percentage of children 2 years of age who had four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV); one measles, mumps and rubella (MMR); three haemophilus influenza type B (HiB); three hepatitis B (HepB), one chicken pox (VZV); four pneumococcal conjugate (PCV); one hepatitis A (HepA); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday. The measure calculates a rate for each vaccine and one combination rate.
Measurement period	January 1–December 31.
Clinical recommendation statement	This measure looks for childhood vaccinations that should be completed by age 2, in accordance with the Centers for Disease Control and Prevention Advisory Committee on Immunization Practices (ACIP) recommended child and adolescent immunization schedule (Wodi et al, 2024).
Citations	Wodi, A.P., Murthy, N., McNally, V.V., Daley, M.F., Cineas, S. 2024. "Advisory Committee on Immunization Practices Recommended Immunization Schedule for Children and Adolescents Aged 18 Years or Younger – United States, 2024." *MMWR Morb Mortal Wkly Rep* 73:6-10. DOI: https://doi.org/10.15585/mmwr.mm7301a2
Characteristics	
Scoring **Type** **Stratification**	Proportion. Process. • DTaP. – Product line: ▪ Exchange.

	• IPV. – Product line: ▪ Exchange. • MMR. – Product line: ▪ Exchange. • HiB. – Product line: ▪ Exchange. • Hepatitis B. – Product line: ▪ Exchange. • VZV. – Product line: ▪ Exchange. • Pneumococcal Conjugate. – Product line: ▪ Exchange. • Hepatitis A. – Product line: ▪ Exchange. • Rotavirus. – Product line: ▪ Exchange. • Influenza. – Product line: ▪ Exchange. • Combination 10. – Product line: ▪ Exchange. – Race: ▪ Race—American Indian or Alaska Native. ▪ Race—Asian. ▪ Race—Black or African American. ▪ Race—Native Hawaiian or Other Pacific Islander. ▪ Race—White. ▪ Race—Some Other Race. ▪ Race—Two or More Races. ▪ Race—Asked But No Answer. ▪ Race—Unknown. – Ethnicity: ▪ Ethnicity—Hispanic or Latino.

	▪ Ethnicity—Not Hispanic or Latino. ▪ Ethnicity—Asked But No Answer. ▪ Ethnicity—Unknown.
Risk adjustment	None.
Improvement notation	A higher rate indicates better performance.
Guidance	**Allocation:** The member was enrolled with a medical benefit throughout the 365 days prior to their second birthday. No more than one gap in enrollment of up to 45 days during the 365 days prior to the member's second birthday. The member must be enrolled on their second birthday. **Reporting:** Apply race and ethnicity stratifications to Numerator 13—Combination 10 only. For all plans, the race and ethnicity stratifications are mutually exclusive, and the sum of all categories in each stratification is the total population.
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	365 days prior to the member's second birthday through the member's second birthday.
Initial population	**Initial population 1** Children who turn 2 years of age during the measurement period and also meet the criteria for participation. **Initial population 2** Same as the initial population 1. **Initial population 3** Same as the initial population 1. **Initial population 4** Same as the initial population 1. **Initial population 5** Same as the initial population 1. **Initial population 6** Same as the initial population 1. **Initial population 7** Same as the initial population 1. **Initial population 8** Same as the initial population 1.

	Initial population 9 Same as the initial population 1. **Initial population 10** Same as the initial population 1. **Initial population 13** Same as the initial population 1.
Exclusions	**Exclusions 1** • Members 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 to determine if the member elected to use a hospice benefit during the measurement period. • Members who die any time during the measurement period. • Members who had a contraindication to a childhood vaccine on or before their second birthday. – Contraindications to Childhood Vaccines Value Set. Do not include laboratory claims (claims with POS 81). – Organ and Bone Marrow Transplants Value Set. **Exclusions 2** Same as exclusions 1. **Exclusions 3** Same as exclusions 1. **Exclusions 4** Same as exclusions 1. **Exclusions 5** Same as exclusions 1. **Exclusions 6** Same as exclusions 1. **Exclusions 7** Same as exclusions 1. **Exclusions 8** Same as exclusions 1. **Exclusions 9** Same as exclusions 1. **Exclusions 10** Same as exclusions 1. **Exclusions 13** Same as exclusions 1.

Denominator	**Denominator 1** The initial population, minus exclusions. **Denominator 2** Same as denominator 1. **Denominator 3** Same as denominator 1. **Denominator 4** Same as denominator 1. **Denominator 5** Same as denominator 1. **Denominator 6** Same as denominator 1. **Denominator 7** Same as denominator 1. **Denominator 8** Same as denominator 1. **Denominator 9** Same as denominator 1. **Denominator 10** Same as denominator 1. **Denominator 13** Same as denominator 1.
Numerator	**Numerator 1—DTaP** Children with any of the following on or before their second birthday meet criteria: • At least four DTaP vaccinations (DTaP Immunization Value Set; DTaP Vaccine Procedure Value Set), with different dates of service. Do not count a vaccination administered prior to 42 days after birth. • Anaphylaxis due to the diphtheria, tetanus or pertussis vaccine (Anaphylaxis Due to Diphtheria, Tetanus or Pertussis Vaccine Value Set). • Encephalitis due to the diphtheria, tetanus or pertussis vaccine. (Encephalitis Due to Diphtheria, Tetanus or Pertussis Vaccine Value Set). **Numerator 2—IPV** Children with either of the following on or before their second birthday meet criteria: • At least three IPV vaccinations (Inactivated Polio Vaccine (IPV) Immunization Value Set; Inactivated Polio Vaccine (IPV) Procedure Value Set) with different dates of service. Do not count a vaccination administered prior to 42 days after birth. • Anaphylaxis due to the IPV vaccine (SNOMED CT code 471321000124106).

Numerator 3—MMR
Children with either of the following meet criteria:

- At least one MMR vaccination (Measles, Mumps and Rubella (MMR) Immunization Value Set; Measles, Mumps and Rubella (MMR) Vaccine Procedure Value Set) on or between the child's first and second birthdays.
- All of the following any time on or before the child's second birthday (on the same or different date of service). Do not include laboratory claims (claims with POS 81).
  - History of measles illness (Measles Value Set).
  - History of mumps illness (Mumps Value Set).
  - History of rubella illness (Rubella Value Set).
  - Anaphylaxis due to the MMR vaccine (SNOMED CT code 471331000124109) on or before the child's second birthday.

Numerator 4—HiB
Children with either of the following on or before their second birthday meet criteria:

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

Numerator 5—Hepatitis B
Children with any of the following on or before the child's second birthday meet criteria:

- At least three hepatitis B vaccinations (Hepatitis B Immunization Value Set; Hepatitis B Vaccine Procedure Value Set), with different dates of service.
  - One of the three vaccinations can be a newborn hepatitis B vaccination (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. For example, if the member's date of birth is December 1, the newborn hepatitis B vaccination must be on or between December 1 and December 8.
- History of hepatitis B illness (Hepatitis B Value Set). Do not include laboratory claims (claims with POS 81).
- Anaphylaxis due to the hepatitis B vaccine (SNOMED CT code 428321000124101).

Numerator 6—VZV
Children with any of the following meet criteria:

- At least one VZV vaccination (Varicella Zoster (VZV) Immunization Value Set; Varicella Zoster (VZV) Vaccine Procedure Value Set) with a date of service on or between the child's first and second birthdays.
- History of varicella zoster (e.g., chicken pox) illness (Varicella Zoster Value Set) on or before the child's second birthday. Do not include laboratory claims (claims with POS 81).
- Anaphylaxis due to the VZV vaccine (SNOMED CT code 471341000124104) on or before the child's second birthday.

Numerator 7—Pneumococcal Conjugate
Children with either of the following on or before their second birthday meet criteria:

- At least four pneumococcal conjugate vaccinations (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—Hepatitis A
Children with any of the following meet criteria:

- At least one hepatitis A vaccination (Hepatitis A Immunization Value Set; Hepatitis A Vaccine Procedure Value Set) with a date of service on or between the child's first and second birthdays.
- History of hepatitis A illness (Hepatitis A Value Set) on or before the child's second birthday. Do not include laboratory claims (claims with POS 81).
- Anaphylaxis due to the hepatitis A vaccine (SNOMED CT code 471311000124103) on or before the child's second birthday.

Numerator 9—Rotavirus
Children with any of the following meet criteria:

- At least two doses of the two-dose rotavirus vaccine (CVX code 119; Rotavirus Vaccine (2 Dose Schedule) Procedure Value Set) on different dates of service on or before the child's second birthday. Do not count a vaccination administered prior to 42 days after birth.
- At least three doses of the three-dose rotavirus vaccine (Rotavirus (3 Dose Schedule) Immunization Value Set; Rotavirus Vaccine (3 Dose Schedule) Procedure Value Set) on different dates of service on or before the child's second birthday. Do not count a vaccination administered prior to 42 days after birth.
- At least one dose of the two-dose rotavirus vaccine (CVX code 119; Rotavirus Vaccine (2 Dose Schedule) Procedure Value Set) and at least two doses of the three-dose rotavirus vaccine (Rotavirus (3 Dose Schedule) Immunization Value Set; Rotavirus Vaccine (3 Dose Schedule) Procedure Value Set, all on different dates of service, on or before the child's second birthday. Do not count a vaccination administered prior to 42 days after birth.
- Anaphylaxis due to the rotavirus vaccine (SNOMED CT code 428331000124103) on or before the child's second birthday.

Numerator 10—Influenza
Children with either of the following on or before their second birthday meet criteria:

- At least two influenza vaccinations (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) administered on the child's second birthday meets criteria for one of the two required vaccinations. • Anaphylaxis due to the influenza vaccine (SNOMED CT code 471361000124100). **Numerator 13—Combination 10** Members who are numerator compliant for DTaP, IPV, MMR, HiB, hepatitis B, VZV, pneumococcal, hepatitis A, rotavirus and influenza indicators.

Data Elements for Reporting

Organizations that submit HEDIS for QRS data to NCQA provide the following data elements in a specified file.

Table CIS-E-A-4: Data Elements for Childhood Immunization Status

Metric	Data Element	Reporting Instructions
DTaP	InitialPopulation	Repeat per Metric
IPV	ExclusionsByEHR	Repeat per Metric
MMR	ExclusionsByCaseManagement	Repeat per Metric
HiB	ExclusionsByHIERegistry	Repeat per Metric
HepatitisB	ExclusionsByAdmin	Repeat per Metric
VZV	Exclusions	(Sum over SSoRs)
PneumococcalConjugate	Denominator	Repeat per Metric
HepatitisA	NumeratorByEHR	For each Metric
Rotavirus	NumeratorByCaseManagement	For each Metric
Influenza	NumeratorByHIERegistry	For each Metric
Combo10	NumeratorByAdmin	For each Metric
	Numerator	(Sum over SSoRs)
	Rate	(Percent)

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
	NativeHawaiianOrOtherPacificIslander	Numerator	For each Stratification
	White	Rate	(percent)
	SomeOtherRace		
	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)

SUMMARY OF CHANGES TO MY 2025 HEDIS FOR QRS

- Removed "Programming Guidance" from the *Characteristics* section.
- Removed the *Data criteria (element level)* section.
- Removed the data source reporting requirement from the race and ethnicity stratification.

HEDIS FOR QRS SPECIFIC GUIDANCE

- ECDS reporting is required for this measure.
- HEDIS for QRS does not require race and ethnicity stratification reporting.

Description	The percentage of members 45–75 years of age who had appropriate screening for colorectal cancer.
Measurement period	January 1–December 31.
Clinical recommendation statement	The U.S. Preventive Services Task Force "recommends screening for colorectal cancer in all adults aged 50 to 75 years (A recommendation) and all adults aged 45 to 49 years (B recommendation)." Potential screening methods include an annual guaiac-based fecal occult blood test (gFOBT), annual fecal immunochemical test (FIT), multitargeted stool DNA with FIT test (sDNA FIT) every 3 years, colonoscopy every 10 years, CT colonography every 5 years, flexible sigmoidoscopy every 5 years or flexible sigmoidoscopy every 10 years, with FIT every year.
Citations	U.S. Preventive Services Task Force. 2021. "Screening for Colorectal Cancer: U.S. Preventive Services Task Force Recommendation Statement." *JAMA* 325(19):1965–77. doi:10.1001/jama.2021.6238
Characteristics	
Scoring	Proportion.
Type	Process.
Stratification	• Colorectal Cancer Screening. – Product line: ▪ Exchange. – Age: ▪ 46–50 years. ▪ 51–75 years. – Race: ▪ Race—American Indian or Alaska Native. ▪ Race—Asian ▪ Race—Black or African American.

	▪ Race—Native Hawaiian or Other Pacific Islander. ▪ Race—White. ▪ Race—Some Other Race. ▪ Race—Two or More Races. ▪ Race—Asked But No Answer. ▪ Race—Unknown. – Ethnicity: ▪ Ethnicity—Hispanic or Latino. ▪ Ethnicity—Not Hispanic or Latino. ▪ Ethnicity—Asked But No Answer. ▪ Ethnicity—Unknown.
Risk adjustment	None.
Improvement notation	A higher rate indicates better performance.
Guidance	**Allocation:** The member was enrolled with a medical benefit during the measurement period and the year prior to the participation period. No more than one gap in enrollment of up to 45 days during each calendar year (i.e., the measurement period and the year prior to the measurement period). The member must be enrolled on the last day of the measurement period. **Reporting:** For all plans, the race and ethnicity stratifications are mutually exclusive and the sum of all categories in each stratification is the total population.
Definitions	
Participation	The identifiers and descriptors for each organization's coverage used to define members' eligibility for measure reporting. Allocation for reporting is based on eligibility during the participation period.
Participation period	The measurement period and the year prior to the measurement period.
Initial population	Members 46–75 years as of the end of the measurement period who also meet the criteria for participation.
Exclusions	• Members 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 to determine if the member elected to use a hospice benefit during the measurement period. • Members who die any time during the measurement period. • Members who had colorectal cancer (Colorectal Cancer Value Set) any time during the member's history through December 31 of the measurement year. Do not include laboratory claims (claims with POS 81).

	• Members who had a total colectomy (Total Colectomy Value Set; SNOMEDCT code 119771000119101) any time during the member's history through December 31 of the measurement period. • Members 66 years of age and older by the end of the measurement period with frailty ***and*** advanced illness. Members must meet ***both*** frailty and advanced illness criteria to be excluded: 1. **Frailty.** At least two indications of frailty (Frailty Device Value Set; Frailty Diagnosis Value Set; Frailty Encounter Value Set; Frailty Symptom Value Set) with different dates of service during the measurement period Do not include laboratory claims (claims with POS 81). 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. Do not include laboratory claims (claims with POS 81). – Dispensed dementia medication (Dementia Medications List). • Members receiving palliative care (Palliative Care Assessment Value Set; Palliative Care Encounter Value Set; Palliative Care Intervention Value Set) any time during the measurement period. • Members who had an encounter for palliative care (ICD-10-CM code Z51.5) any time during the measurement year. Do not include laboratory claims (claims with POS 81).
Denominator	The initial population, minus exclusions.
Numerator	Members with one or more screenings for colorectal cancer. Any of the following meet criteria: • Fecal occult blood test (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; SNOMEDCT code 708699002) during the measurement period or the 2 years prior to the measurement period. • Flexible sigmoidoscopy (Flexible Sigmoidoscopy Value Set; SNOMEDCT 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; SNOMEDCT code 851000119109) during the measurement period or the 9 years prior to the measurement period.

Data Elements for Reporting

Organizations that submit HEDIS for QRS data to NCQA provide the following data elements in a specified file.

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

Metric	Age	Data Element	Reporting Instructions
ColorectalCancerScreening	46-50	InitialPopulation	For each Stratification
	51-75	ExclusionsByEHR	For each Stratification
	Total	ExclusionsByCaseManagement	For each Stratification
		ExclusionsByHIERegistry	For each Stratification
		ExclusionsByAdmin	For each Stratification
		Exclusions	(Sum over SSoRs)
		Denominator	For each Stratification
		NumeratorByEHR	For each Stratification
		NumeratorByCaseManagement	For each Stratification
		NumeratorByHIERegistry	For each Stratification
		NumeratorByAdmin	For each Stratification
		Numerator	(Sum over SSoRs)
		Rate	(Percent)

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

Metric	Race	Data Element	Reporting Instructions
ColorectalCancerScreening	AmericanIndianOrAlaskaNative	InitialPopulation	For each Stratification
	Asian	Exclusions	For each Stratification
	BlackOrAfricanAmerican	Denominator	For each Stratification
	NativeHawaiianOrOtherPacificIslander	Numerator	For each Stratification
	White	Numerator	For each Stratification
	SomeOtherRace	Rate	(Percent)
	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)**

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

SUMMARY OF CHANGES TO MY 2025 HEDIS FOR QRS

- Removed "Programming Guidance" from the *Characteristics* section.
- Removed the *Data criteria (element level)* section.
- Added a laboratory claim exclusion to a direct reference code.

Description	The percentage of members 12 years of age and older who were screened for clinical depression using a standardized instrument and, if screened positive, received follow-up care. • *Depression Screening.* The percentage of members who were screened for clinical depression using a standardized instrument. • *Follow-Up on Positive Screen.* The percentage of members who received follow-up care within 30 days of a positive depression screen finding.
Measurement period	January 1–December 31.
Clinical recommendation statement	The U.S. Preventive Services Task Force (USPSTF) recommends screening for depression among adolescents 12–18 years and the general adult population, including pregnant and postpartum women. (B recommendation) The USPSTF also recommends that screening be implemented with adequate systems in place to ensure accurate diagnosis, effective treatment and appropriate follow-up. (B recommendation)
Citations	US Preventive Services Task Force et al. "Screening for Depression and Suicide Risk in Adults: US Preventive Services Task Force Recommendation Statement." *JAMA* vol. 329,23 (2023): 2057–67. US Preventive Services Task Force et al. "Screening for Depression and Suicide Risk in Children and Adolescents: US Preventive Services Task Force Recommendation Statement." *JAMA* vol. 328,15 (2022): 1534–42.
Characteristics	
Scoring **Type** **Stratification**	• Proportion. • Process. • Depression Screening. – Product line: ▪ Exchange. – Age (as of the start of the measurement period): ▪ 12–17 years. ▪ 18–64 years. ▪ 65 years and older.

	• Follow-Up on Positive Screen. – Product line: ▪ Exchange. – Age (as of the start of the measurement period): ▪ 12–17 years. ▪ 18–64 years. ▪ 65 years and older.
Risk adjustment	None.
Improvement notation	A higher rate indicates better performance.
Guidance	**General Rules:** 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. **Allocation:** The member was enrolled with a medical benefit throughout the measurement period. No more than one gap in enrolment of up to 45 days during the measurement period. The member must be enrolled on the last day of the measurement period. **Reporting:** The total is the sum of the age stratifications.
Definitions	
Participation	The identifiers and descriptors for each organization's coverage used to define members' eligibility for measure reporting. Allocation for HEDIS for QRS reporting is based on eligibility during the participation period.
Participation period	The measurement period.
Depression screening instrument	A standard assessment instrument that has been normalized and validated for the appropriate patient population. Eligible screening instruments with thresholds for positive findings include:

Instruments for Adolescents (≤17 years)	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
Edinburgh Postnatal Depression Scale (EPDS)	99046-5	Total score ≥10
PROMIS Depression	71965-8	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)	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

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

<table>
<tr><td></td><td>
<table>
<tr><th>Instruments for Adults (18+ years)</th><th>Total Score LOINC Codes</th><th>Positive Finding</th></tr>
<tr><td>My Mood Monitor (M-3)®</td><td>71777-7</td><td>Total score ≥5</td></tr>
<tr><td>PROMIS Depression</td><td>71965-8</td><td>Total score (T Score) ≥60</td></tr>
<tr><td>Clinically Useful Depression Outcome Scale (CUDOS)</td><td>90221-3</td><td>Total score ≥31</td></tr>
</table>
[1]Brief screening instrument. All other instruments are full-length.
[2]Proprietary; may be cost or licensing requirement associated with use.
</td></tr>
<tr><td>Initial population</td><td>Initial population 1
Members 12 years of age and older at the start of the measurement period who also meet criteria for participation.

Initial population 2
Same as the initial population 1.</td></tr>
<tr><td>Exclusions</td><td>Exclusions 1
• Members with a history of bipolar disorder (Bipolar Disorder Value Set; Other Bipolar Disorder Value Set) any time during the member's history through the end of the year prior to the measurement period. Do not include laboratory claims (claims with POS code 81).
• Members with depression (Depression Value Set) that starts during the year prior to the measurement period. Do not include laboratory claims (claims with POS code 81).
• 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 to determine if the member elected to use a hospice benefit during the measurement period.
• Members who die any time during the measurement period.

Exclusions 2
Same as exclusions 1.</td></tr>
<tr><td>Denominator</td><td>Denominator 1
The initial population, minus exclusions.

Denominator 2
All members from numerator 1 with a positive depression screen finding between January 1 and December 1 of the measurement period.</td></tr>
<tr><td>Numerator</td><td>Numerator 1—Depression Screening
Members with a documented result for depression screening, using an age-appropriate standardized instrument, performed between January 1 and December 1 of the measurement period.</td></tr>
</table>

	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 (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) • A diagnosis of encounter for exercise counseling (ICD-10-CM code Z71.82). Do not include laboratory claims (claims with POS code 81). • 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. ***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 Elements for Reporting

Organizations that submit HEDIS for QRS data to NCQA provide the following data elements in a specified file.

Table DSF-E-4: Data Elements for Depression Screening and Follow-Up for Adolescents and Adults

Metric	Age	Data Element	Reporting Instructions
Screening	12-17	InitialPopulation	For each stratification, repeat per metric
FollowUp	18-64	ExclusionsByEHR	For each stratification, repeat per metric
	65+	ExclusionsByCaseManagement	For each stratification, repeat per metric
	Total	ExclusionsByHIERegistry	For each stratification, repeat per metric
		ExclusionsByAdmin	For each stratification, repeat per metric
		Exclusions	(Sum over SSoRs)
		Denominator	For each Metric and Stratification
		NumeratorByEHR	For each Metric and Stratification
		NumeratorByCaseManagement	For each Metric and Stratification
		NumeratorByHIERegistry	For each Metric and Stratification
		NumeratorByAdmin	For each Metric and Stratification
		Numerator	(Sum over SSoRs)
		Rate	(Percent)

*Immunizations for Adolescents (IMA-E)**

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

SUMMARY OF CHANGES TO MY 2025 HEDIS FOR QRS

- Updated the clinical recommendation statement and citations.
- Removed "Programming Guidance" from the Characteristics section.
- Added the pentavalent meningococcal vaccine to the meningococcal indicator numerator and expanded the age range from 11-13 to 10-13.
- Removed the Data criteria (element level) section.
- Removed the data source reporting requirement from the race and ethnicity stratification.

HEDIS FOR QRS SPECIFIC GUIDANCE

- HEDIS for QRS only reports Combination 2 and related antigens.
- HEDIS for QRS does not require race and ethnicity stratification reporting.

Description	The percentage of adolescents 13 years of age who had one dose of meningococcal vaccine, one tetanus, diphtheria toxoids and acellular pertussis (Tdap) vaccine, and have completed the human papillomavirus (HPV) vaccine series by their 13th birthday. The measure calculates a rate for each vaccine and two combination rates.
Measurement period	January 1–December 31.
Clinical recommendation statement	*HPV*: The Advisory Committee on Immunization Practices (ACIP) recommends routine HPV vaccination for adolescents at age 11 or 12 years; vaccination may be given starting at age 9 years. In a two-dose schedule of HPV vaccine, the minimum interval between the first and second doses is 5 months. Persons who initiated vaccination with 9vHPV, 4vHPV or 2vHPV before their 15th birthday and received 2 doses of any HPV vaccine at the recommended dosing schedule (0, 6–12 months), or received three doses of any HPV vaccine at the recommended dosing schedule (0, 1–2, 6 months), are considered adequately vaccinated (Meites, Kempe, and Markowitz 2016). *Tdap*: ACIP recommends a single dose of vaccine be administered at age 11 or 12 years (Liang et al. 2018). *Meningococcal*: ACIP recommends routine vaccination with a quadrivalent meningococcal conjugate vaccine (MenACWY) for adolescents aged 11 or 12 years, with a booster dose at age 16 years (Mbaeyi et al. 2020), 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 (CDC, 2023).

Citations	Centers for Disease Control and Prevention (CDC). 2023. "Meningococcal." https://www.cdc.gov/vaccines/vpd/mening/index.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: 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: 10.15585/mmwr.mm6549a5.
Characteristics	
Scoring	Proportion.
Type	Process.
Stratification	• Meningococcal Serogroups A, C, W, Y. – Product line: ▪ Exchange. – Race: ▪ Race—American Indian or Alaska Native. ▪ Race—Asian. ▪ Race—Black or African American. ▪ Race—Native Hawaiian or Other Pacific Islander. ▪ Race—White. ▪ Race—Some Other Race. ▪ Race—Two or More Races. ▪ Race—Asked But No Answer. ▪ Race—Unknown. – Ethnicity: ▪ Ethnicity—Hispanic or Latino. ▪ Ethnicity—Not Hispanic or Latino. ▪ Ethnicity—Asked But No Answer. ▪ Ethnicity—Unknown. • Tdap. – Product line: ▪ Exchange. – Race: ▪ Race—American Indian or Alaska Native. ▪ Race—Asian.

	▪ Race—Black or African American. ▪ Race—Native Hawaiian or Other Pacific Islander. ▪ Race—White. ▪ Race—Some Other Race. ▪ Race—Two or More Races. ▪ Race—Asked But No Answer. ▪ Race—Unknown. – Ethnicity: ▪ Ethnicity—Hispanic or Latino. ▪ Ethnicity—Not Hispanic or Latino. ▪ Ethnicity—Asked But No Answer. ▪ Ethnicity—Unknown. • HPV. – Product line: ▪ Exchange. – Race: ▪ Race—American Indian or Alaska Native. ▪ Race—Asian. ▪ Race—Black or African American. ▪ Race—Native Hawaiian or Other Pacific Islander. ▪ Race—White. ▪ Race—Some Other Race. ▪ Race—Two or More Races. ▪ Race—Asked But No Answer. ▪ Race—Unknown. – Ethnicity: ▪ Ethnicity—Hispanic or Latino. ▪ Ethnicity—Not Hispanic or Latino. ▪ Ethnicity—Asked But No Answer. ▪ Ethnicity—Unknown. • Combination 2: Meningococcal, Tdap, HPV. – Product line: ▪ Exchange. – Race: ▪ Race—Asian. ▪ Race—Black or African American. ▪ Race—Native Hawaiian or Other Pacific Islander. ▪ Race—White. ▪ Race—Some Other Race. ▪ Race—Two or More Races. ▪ Race—Asked But No Answer. ▪ Race—Unknown.

	– Ethnicity: ▪ Ethnicity—Hispanic or Latino. ▪ Ethnicity—Not Hispanic or Latino. ▪ Ethnicity—Asked But No Answer. ▪ Ethnicity—Unknown.
Risk adjustment	None.
Improvement notation	A higher rate indicates better performance.
Guidance	**General Rules:** To align with ACIP recommendations, the quadrivalent (serogroups A, C, W and Y) and pentavalent meningococcal vaccines (serogroups A, C, W, Y and B) are included in the measure. To align with ACIP recommendations, the minimum interval for the two-dose HPV vaccination schedule is 150 days , with a 4-day grace period (146 days). **Allocation:** The member was enrolled with a medical benefit throughout the 365 days prior to their 13th birthday. No more than one gap in enrollment of up to 45 days during the participation period. The member must be enrolled on their 13th birthday. **Reporting:** For all plans, the race and ethnicity stratifications are mutually exclusive, and the sum of all categories in each stratification is the total population.
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	365 days prior to the member's 13th birthday through the member's 13th birthday
Initial Population	**Initial population 1** Adolescents who turn 13 years of age during the measurement period who also meet criteria for participation. **Initial population 2** Same as the initial population 1. **Initial population 3** Same as the initial population 1. **Initial population 5** Same as the initial population 1.

Exclusions	**Exclusions 1** • Members in hospice or using hospice services (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 to determine if the member elected to use a hospice benefit during the measurement period. • Members who die any time during the measurement period. **Exclusions 2** Same as exclusions 1. **Exclusions 3** Same as exclusions 1. **Exclusions 5** Same as exclusions 1.
Denominator	**Denominator 1** The initial population, minus exclusions. **Denominator 2** Same as denominator 1. **Denominator 3** Same as denominator 1. **Denominator 5** Same as denominator 1.
Numerator	**Numerator 1—Meningococcal Serogroups A, C, W, Y** Members with either of the following meet criteria: • At least one meningococcal 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 member's 10th and 13th birthdays. • Anaphylaxis due to the meningococcal vaccine (SNOMED CT code 428301000124106) any time on or before the member's 13th birthday. **Numerator 2—Tdap** Members with any of the following meet criteria: • At least one tetanus, diphtheria toxoids and acellular pertussis (Tdap) vaccine (CVX code 115; Tdap Vaccine Procedure Value Set) with a date of service on or between the member's 10th and 13th birthdays. • Anaphylaxis due to the tetanus, diphtheria or pertussis vaccine (Anaphylaxis Due to Diphtheria, Tetanus or Pertussis Vaccine Value Set) any time on or before the member's 13th birthday. • Encephalitis due to the tetanus, diphtheria or pertussis vaccine (Encephalitis Due to Diphtheria, Tetanus or Pertussis Vaccine Value Set) any time on or before the member's 13th birthday.

	Numerator 3—HPV Members with any of the following meet criteria: • At least two HPV vaccines (HPV Immunization Value Set; HPV Vaccine Procedure Value Set), on or between the member's 9th and 13th birthdays and with dates of service at least 146 days apart. For example, if the service date for the first vaccine was March 1, then the service date for the second vaccine must be on or after July 25. • At least three HPV vaccines (HPV Immunization Value Set; HPV Vaccine Procedure Value Set), with different dates of service on or between the member's 9th and 13th birthdays. • Anaphylaxis due to the HPV vaccine (SNOMED CT code 428241000124101) any time on or before the member's 13th birthday. **Numerator 5—Combination 2: Meningococcal, Tdap, HPV** Adolescents who are Numerator compliant for all three indicators (Meningococcal, Tdap, HPV).

Data Elements for Reporting

Organizations that submit HEDIS for QRS data to NCQA provide the following data elements in a specified file.

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

Metric	Data Element	Reporting Instructions
Meningococcal	InitialPopulation	Repeat per Metric
Tdap	Exclusions	Repeat per Metric
HPV	Denominator	Repeat per Metric
Combo2	NumeratorByEHR	For each Metric
	NumeratorByCaseManagement	For each Metric
	NumeratorByHIERegistry	For each Metric
	NumeratorByAdmin	For each Metric
	Numerator	(Sum over SSoRs)
	Rate	(Percent)

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

Metric	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	NativeHawaiianOrOtherPacificIslander	Numerator	For each Metric and Stratification
	White	Rate	(Percent)
	SomeOtherRace		
	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)

Social Need Screening and Intervention (SNS-E)

SUMMARY OF CHANGES TO MY 2025 HEDIS FOR QRS

- Removed "Programming Guidance" from the *Characteristics* section.
- Updated the description of the intervention categories.
- Removed the *Data criteria (element level)* section.
- Revised the housing instability, homelessness and housing inadequacy screening instruments definition.

Description	The percentage of members who were screened, using prespecified instruments, at least once during the measurement period for unmet food, housing and transportation needs, and received a corresponding intervention if they screened positive. • *Food Screening.* The percentage of members who were screened for food insecurity. • *Food Intervention.* The percentage of members who received a corresponding intervention within 30 days (1 month) of screening positive for food insecurity. • *Housing Screening.* The percentage of members who were screened for housing instability, homelessness or housing inadequacy. • *Housing Intervention.* The percentage of members who received a corresponding intervention within 30 days (1 month) of screening positive for housing instability, homelessness or housing inadequacy. • *Transportation Screening.* The percentage of members who were screened for transportation insecurity. • *Transportation Intervention.* The percentage of members who received a corresponding intervention within 30 days (1 month) of screening positive for transportation insecurity.
Measurement period	January 1–December 31.
Clinical recommendation statement	American Academy of Family Physicians (AAFP) urges health insurers and payors to provide appropriate payment to support health care practices to identify, monitor, assess, and address SDoH. American Academy of Pediatrics (AAP) recommends surveillance for risk factors related to social determinants of health during all patient encounters. American Diabetes Association (ADA) recommends assessing food insecurity, housing insecurity/homelessness, financial barriers and social capital/social community support to inform treatment decisions, with referral to appropriate local community resources.
Citations	American Academy of Family Physicians. 2019. "Advancing Health Equity by Addressing the Social Determinants of Health in Family Medicine (Position Paper)." https://www.aafp.org/about/policies/all/social-determinants-health-family-medicine-position-paper.html

	American Academy of Pediatrics. 2016. "Poverty and Child Health in the United States." https://pediatrics.aappublications.org/content/137/4/e20160339#sec-12 American Diabetes Association. 2022. "Standards of Medical Care in Diabetes-2022." Diabetes Care 45(Suppl 1): S4–7. DOI:10.2337/dc22-Srev The Gravity Project. "Terminology Workstream Dashboard." The Gravity Project Confluence, n.d. https://confluence.hl7.org/display/GRAV/Terminology+Workstream+Dashboard
Characteristics	
Scoring	Proportion.
Type	Process.
Stratification	• Food Screening. – Product line: ▪ Exchange. – Age (as of the start of the measurement period): ▪ ≤17 years. ▪ 18–64 years. ▪ 65 and older. • Food Intervention. – Product line: ▪ Exchange. – Age (as of the start of the measurement period): ▪ ≤17 years. ▪ 18–64 years. ▪ 65 and older. • Housing Screening. – Product line: ▪ Exchange. – Age (as of the start of the measurement period): ▪ ≤17 years. ▪ 18–64 years. ▪ 65 and older. • Housing Intervention. – Product line: ▪ Exchange. – Age (as of the start of the measurement period): ▪ ≤17 years. ▪ 18–64 years. ▪ 65 and older.

	• Transportation Screening. – Product line: ▪ Exchange. – Age (as of the start of the measurement period): ▪ ≤17 years. ▪ 18–64 years. ▪ 65 and older. • Transportation Intervention. – Product line: ▪ Exchange. – Age (as of the start of the measurement period): ▪ ≤17 years. ▪ 18–64 years. ▪ 65 and older.
Risk adjustment	None.
Improvement notation	A higher rate indicates better performance.
Guidance	**Allocation:** The member was enrolled with a medical benefit throughout the participation period. No more than one gap in enrollment of up to 45 days during the measurement period. The member must be enrolled on the last day of the measurement period. **Reporting:** The total is the sum of the age stratifications.
Definitions	
Participation	The identifiers and descriptors for each organization's coverage used to define members' eligibility for measure reporting. Allocation for reporting is based on eligibility during the participation period.
Participation period	The measurement period.
Food insecurity	Uncertain, limited or unstable access to food that is adequate in quantity and in nutritional quality; culturally acceptable; safe; and acquired in socially acceptable ways.
Housing instability	Currently consistently housed but experiencing any of the following circumstances in the past 365 days: being behind on rent or mortgage, multiple moves, cost burden or risk of eviction.
Homelessness	Currently living in an environment that is not meant for permanent human habitation (e.g., car, park, sidewalk, abandoned building, on the street); not having a consistent place to sleep at night; or because of economic difficulties, currently living in a shelter, motel, temporary or transitional living situation.

Housing inadequacy

Housing does not meet habitability standards.

Transportation insecurity

Uncertain, limited or no access to safe, reliable, accessible, affordable and socially acceptable transportation infrastructure and modalities necessary for maintaining one's health, well-being or livelihood.

Food insecurity instruments

Eligible screening instruments with thresholds for positive findings include:

Food Insecurity Instruments	Screening Item LOINC Codes	Positive Finding LOINC Codes
Accountable Health Communities (AHC) Health-Related Social Needs (HRSN) Screening Tool	88122-7	LA28397-0 LA6729-3
	88123-5	LA28397-0 LA6729-3
American Academy of Family Physicians (AAFP) Social Needs Screening Tool	88122-7	LA28397-0 LA6729-3
	88123-5	LA28397-0 LA6729-3
American Academy of Family Physicians (AAFP) Social Needs Screening Tool—short form	88122-7	LA28397-0 LA6729-3
	88123-5	LA28397-0 LA6729-3
Health Leads Screening Panel®[1]	95251-5	LA33-6
Hunger Vital Sign™[1] (HVS)	88124-3	LA19952-3
Protocol for Responding to and Assessing Patients' Assets, Risks and Experiences [PRAPARE]®[1]	93031-3	LA30125-1
Safe Environment for Every Kid (SEEK)®[1]	95400-8	LA33-6
	95399-2	LA33-6
U.S. Household Food Security Survey [U.S. FSS]	95264-8	LA30985-8 LA30986-6
U.S. Adult Food Security Survey [U.S. FSS]	95264-8	LA30985-8 LA30986-6
U.S. Child Food Security Survey [U.S. FSS]	95264-8	LA30985-8 LA30986-6
U.S. Household Food Security Survey–Six-Item Short Form [U.S. FSS]	95264-8	LA30985-8 LA30986-6
We Care Survey	96434-6	LA32-8
WellRx Questionnaire	93668-2	LA33-6

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

Housing instability, homelessness and housing inadequacy screening instruments

Eligible screening instruments with thresholds for positive findings include:

Housing Instability and Homelessness Instruments	Screening Item LOINC Codes	Positive Finding LOINC Codes
Accountable Health Communities (AHC) Health-Related Social Needs (HRSN) Screening Tool	71802-3	LA31994-9 LA31995-6
American Academy of Family Physicians (AAFP) Social Needs Screening Tool	99550-6	LA33-6
American Academy of Family Physicians (AAFP) Social Needs Screening Tool—short form	71802-3	LA31994-9 LA31995-6
Children's Health Watch Housing Stability Vital Signs™1	98976-4	LA33-6
	98977-2	≥2
	98978-0	LA33-6
Health Leads Screening Panel®1	99550-6	LA33-6
Protocol for Responding to and Assessing Patients' Assets, Risks and Experiences [PRAPARE]®1	93033-9	LA33-6
	71802-3	LA30190-5
We Care Survey	96441-1	LA33-6
WellRx Questionnaire	93669-0	LA33-6

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

Housing Inadequacy Instruments	Screening Item LOINC Codes	Positive Finding LOINC Codes
Accountable Health Communities (AHC) Health-Related Social Needs (HRSN) Screening Tool	96778-6	LA31996-4 LA28580-1 LA31997-2 LA31998-0 LA31999-8 LA32000-4 LA32001-2
American Academy of Family Physicians (AAFP) Social Needs Screening Tool	96778-6	LA32691-0 LA28580-1 LA32693-6 LA32694-4 LA32695-1 LA32696-9 LA32001-2
American Academy of Family Physicians (AAFP) Social Needs Screening Tool—short form	96778-6	LA31996-4 LA28580-1 LA31997-2 LA31998-0

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

Housing Inadequacy Instruments	Screening Item LOINC Codes	Positive Finding LOINC Codes
		LA31999-8 LA32000-4 LA32001-2
Norwalk Community Health Center Screening Tool [NCHC]	99134-9	LA33-6
	99135-6	LA31996-4 LA28580-1 LA31997-2 LA31998-0 LA31999-8 LA32000-4 LA32001-2

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

Transportation insecurity screening instruments

Eligible screening instruments with thresholds for positive findings include:

Transportation Insecurity Instruments	Screening Item LOINC Codes	Positive Finding LOINC Codes
Accountable Health Communities (AHC) Health-Related Social Needs (HRSN) Screening Tool	93030-5	LA33-6
American Academy of Family Physicians (AAFP) Social Needs Screening Tool	99594-4	LA33-6
American Academy of Family Physicians (AAFP) Social Needs Screening Tool—short form	99594-4	LA33093-8 LA30134-3
Comprehensive Universal Behavior Screen (CUBS)	89569-8	LA29232-8 LA29233-6 LA29234-4
Health Leads Screening Panel®1	99553-0	LA33-6
Inpatient Rehabilitation Facility - Patient Assessment Instrument (IRF-PAI)—version 4.0 [CMS Assessment]	101351-5	LA30133-5 LA30134-3
Outcome and assessment information set (OASIS) form—version E—Discharge from Agency [CMS Assessment]	101351-5	LA30133-5 LA30134-3
Outcome and assessment information set (OASIS) form—version E—Resumption of Care [CMS Assessment]	101351-5	LA30133-5 LA30134-3

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

	<table><tr><th>Transportation Insecurity Instruments</th><th>Screening Item LOINC Codes</th><th>Positive Finding LOINC Codes</th></tr><tr><td>Outcome and assessment information set (OASIS) form—version E—Start of Care [CMS Assessment]</td><td>101351-5</td><td>LA30133-5 LA30134-3</td></tr><tr><td>Protocol for Responding to and Assessing Patients' Assets, Risks and Experiences [PRAPARE]®1</td><td>93030-5</td><td>LA30133-5 LA30134-3</td></tr><tr><td>PROMIS®1</td><td>92358-1</td><td>LA30024-6 LA30026-1 LA30027-9</td></tr><tr><td>WellRx Questionnaire</td><td>93671-6</td><td>LA33-6</td></tr></table> [1]Proprietary; may be cost or licensing requirement associated with use. ***Note**: The SNS-E screening numerator counts only screenings that use instruments in the measure specification as identified by the associated LOINC code(s). Allowed screening instruments and LOINC codes for each social need domain are listed above.* *NCQA recognizes that organizations might need to adapt or modify instruments to meet the needs of their membership. To clarify:* • *The SNS-E measure specification does not prohibit cultural adaptations or linguistic translations from being counted toward the measure's screening numerators.* • *Only screenings documented using the LOINC codes specified in the SNS-E measure count toward the measure's screening numerators.* • *The Regenstrief Institute, which maintains the LOINC database, has indicated that LOINC codes are not developed at the level of granularity that distinguishes between original and adapted or translated instruments*. • *Tool developers have varying policies with regard to cultural adaptation and translations; some state that users may adapt screening instruments, others state that organizations must obtain permission first. NCQA urges organizations to refer to the tool developer for information about adaptations or translations that are available or allowed.*
Interventions	An intervention corresponding to the type of need identified on or up to 30 days after the date of the first positive screening during the measurement period. • A positive food insecurity screen finding must be met by a food insecurity intervention. • A positive housing instability or homelessness screen finding must be met by a housing instability or homelessness intervention. • A positive housing inadequacy screen finding must be met by a housing inadequacy intervention. • A positive transportation insecurity screen finding must be met by a transportation insecurity intervention.

	Interventions may include any of the following intervention categories: adjustment, assistance, coordination, counseling, education, evaluation of eligibility, evaluation/assessment, provision or referral.
Initial population	**Initial population 1** Members of any age enrolled at the start of the measurement period who also meet criteria for participation. **Initial population 2** Same as the initial population 1. **Initial population 3** Same as the initial population 1. **Initial population 4** Same as the initial population 1. **Initial population 5** Same as the initial population 1. **Initial population 6** Same as the initial population 1.
Exclusions	**Exclusions 1** • Members 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 to determine if the member elected to use a hospice benefit during the measurement period. • Members who die any time during the measurement period. **Exclusions 2** Same as exclusions 1. **Exclusions 3** Same as exclusions 1. **Exclusions 4** Same as exclusions 1. **Exclusions 5** Same as exclusions 1. **Exclusions 6** Same as exclusions 1.
Denominator	**Denominator 1** The initial population, minus exclusions. **Denominator 2** All members in numerator 1 with a positive food insecurity screen finding between January 1 and December 1 of the measurement period. **Denominator 3** Same as denominator 1.

	Denominator 4 All members in numerator 3 with a positive housing instability, homelessness or housing inadequacy screen finding between January 1 and December 1 of the measurement period. **Denominator 5** Same as denominator 1. **Denominator 6** All members in numerator 5 with a positive transportation insecurity screen finding between January 1 and December 1 of the measurement period.
Numerator	**Numerator 1—Food Screening** Members in denominator 1 with a documented result for food insecurity screening performed between January 1 and December 1 of the measurement period. **Numerator 2—Food Intervention** Members in denominator 2 receiving a food insecurity intervention (Food Insecurity Procedures Value Set) on or up to 30 days after the date of the first positive food insecurity screen (31 days total). **Numerator 3—Housing Screening** Members in denominator 3 with a documented result for housing instability, homelessness or housing inadequacy screening performed between January 1 and December 1 of the measurement period. **Numerator 4—Housing Intervention** Members in denominator 4 receiving an intervention corresponding to the type of housing need identified on or up to 30 days after the date of the first positive housing screen (31 days total). • Housing Instability Intervention (Housing Instability Procedures Value Set). • Homelessness Intervention (Homelessness Procedures Value Set). • Housing Inadequacy Intervention (Inadequate Housing Procedures Value Set). **Numerator 5—Transportation Screening** Members in denominator 5 with a documented result for transportation insecurity screening performed between January 1 and December 1 of the measurement period. **Numerator 6—Transportation Intervention** Members in denominator 6 receiving a transportation insecurity intervention (Transportation Insecurity Procedures Value Set) on or up to 30 days after the date of the first positive transportation screen (31 days total).

Data Elements for Reporting

Organizations that submit HEDIS for QRS data to NCQA provide the following data elements in a specified file.

Table SNS-E-: Data Elements for Social Need Screening and Intervention

Metric	Age	Data Element	Reporting Instructions
FoodScreening*	0-17	InitialPopulation	For each Metric and Stratification
FoodIntervention	18-64	ExclusionsByEHR	For each Metric and Stratification
HousingScreening*	65+	ExclusionsByCaseManagement	For each Metric and Stratification
HousingIntervention	Total	ExclusionsByHIERegistry	For each Metric and Stratification
TransportationScreening*		ExclusionsByAdmin	For each Metric and Stratification
TransportationIntervention		Exclusions	(Sum over SSoRs)
		Denominator	For each Metric and Stratification
		NumeratorByEHR	For each Metric and Stratification
		NumeratorByCaseManagement	For each Metric and Stratification
		NumeratorByHIERegistry	For each Metric and Stratification
		NumeratorByAdmin	For each Metric and Stratification
		Numerator	(Sum over SSoRs)
		Rate	(Percent)

**These metrics share an initial population. Repeat the initial population, denominator and exclusions data elements for all three screening metrics.*

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 eligible 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.
anchor date	The date when a member must be enrolled with the organization. No gaps in enrollment may include this date.
attestation	A statement ensuring the validity of a report or document (e.g., practitioner attestation).
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 eligible population through claims data (e.g., diabetic members are identified by claims showing diagnoses for diabetes or dispensing insulin).
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.
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.
eligible population	All members who satisfy a measure's specified criteria, including age, continuous enrollment, benefit, event and anchor date enrollment. ***Note:*** *Refer to the measurement specifications for eligible population criteria.*
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 eligible population.
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	*For ECDS reporting*, the initial population includes all members who satisfy criteria, including age and participation 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.
logical group	A category that contains measures with similar characteristics, such as dependence on carved-out benefits, practitioner specialty, contraindications and diagnosis code specificity. Should be used for measure selection (core set, convenience sample, medical record review validation) and expansion.
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	Period of time which a measure is calculated.
measurement year	The year that an organization evaluates HEDIS measures.
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.
member months	The cumulative number of months of organization enrollment by the current eligible population.
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.
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.
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	The practitioner who assumes responsibility for the member's care.
outpatient visits	Visits to providers that do not require hospital admission.
participation period	The period, or periods, when an individual must be continuously enrolled with a specified benefit type
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.

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/event/diagnosis in either the administrative data or the medical record.

positive numerator hit	A member 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.
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.
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.
QDM	Quality Data Model. A common data model that defines elements of quality measures (e.g., diagnosis, primary care encounter, screening test for a condition) in a standardized way.
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.
sample frame	The file that contains the eligible population for survey measures. The sample frame must be approved by the auditor before it is sent to the NCQA-Certified Survey Vendor.
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 eligible population. 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.
validity	The extent to which data correspond to an actual event or documentation that supports a measure.
value sets	A value set contains one 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.

Fast Healthcare Interoperability Resources (FHIR) Standards

CARIN Blue Button	CARIN for Blue Button® Framework and Common Payer Consumer Data Set is an implementation guide developed as part of the CARIN Alliance, providing a set of resources that payers can display to consumers via a FHIR API.
DEQM	Data Exchange for Quality Measures. An implementation guide that provides a framework for defining conformance profiles to enable the exchange of quality information and quality measure reporting.
FHIR profile	A set of constraints on a FHIR resource, represented as a structured definition.
Gaps in care reporting	Gaps in care are discrepancies between recommended best practices and services that are provided and documented.

US Core Implementation guide developed as part of the HL7 Argonaut project to support the ONC's U.S. Core Data for Interoperability (USCDI) in the FHIR framework.

Mapping Traditional HEDIS Measure and EDCS Measure Terms

Terms Used in Traditional HEDIS Measures	Terms Used in ECDS Measures
Eligible Population	Initial Population
Measurement Year	Measurement Period
Continuous Enrollment	Defined Under Allocation
Allowable Gap, Anchor Date, Benefits	Defined Under Allocation
Event/Diagnosis	Defined by the Initial Population
Required Exclusions	Exclusions
Value Sets, Medication Lists	Value Sets

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Appendix 2: Data Element Definitions

APPENDIX 2
DATA ELEMENT DEFINITIONS

Table 1: Data Element Definitions for Administrative and Hybrid Reporting

Data Element	Description	Admin	Hybrid	Meaning
CollectionMethod	Data collection methodology (Administrative or Hybrid)	✓	✓	Method used to collect HEDIS data. The Administrative Method is from transactional data for the eligible population and the Hybrid Method is from medical record or electronic medical record and transactional data for the sample. Only reported for measures allowing both the Administrative and the Hybrid Method.
Benefit	Benefit	✓	✓	For measures requiring a benefit other than Medical, the Benefit flag is reported in the Metadata section of the submission XML.
EligiblePopulation	Eligible population	✓	✓	Members who meet all criteria for the population. This is the universe of members for each measure.
ExclusionAdminRequired	Number of required exclusions	✓	✓	Number of members excluded from the eligible population based on transaction data because they did meet the required exclusion criteria (labeled "required exclusions" in the specification).
NumeratorByAdminElig	Number of numerator events by administrative data in eligible population		✓	The number of members in the eligible population who met the numerator criteria. *This may or may not include supplemental data, it depends on when an organization loads its supplemental data for reporting.*
CYAR	Current year's administrative rate		✓	This is a calculated field in IDSS. NumeratorByAdminElig / EligiblePopulation *This rate may or may not include numerator events by supplemental data.*
MinReqSampleSize	Minimum required sample size (MRSS)		✓	When selecting the sample, this is the required number of members in the sample. Organizations can reduce their samples using Tables 2 in the sampling guidelines.
OversampleRate	Oversampling rate		✓	The percentage of additional records used only to replace exclusions and valid data errors in the denominator reported as a proportion. Organizations that need more than a 20% oversample must contact NCQA. *The oversample rate should reflect the true percentage that an organization needs to maintain the MRSS and should not result in an amount larger than the eligible population.*
OversampleRecordsNumber	Number of oversample records		✓	This is a calculated field in IDSS. MinReqSampleSize * OversampleRate (rounded up to next whole number) *Oversample records should be used only to replace cases taken out of the sample because of valid data errors, false positives, etc., otherwise, not all records will be reported in the final denominator.*

Data Element	Description	Admin	Hybrid	Meaning
ExclusionValidDataErrors	Number of original sample records excluded because of valid data errors		✓	If medical record review shows that the member does not meet the criteria outlined in the eligible population, that member is considered a valid data error. If an administrative exclusion is found during data refresh, the member is also considered a valid data error.
ExclusionEmployeeOrDep	Number of employee/ dependent medical records excluded		✓	Number of records in the sample excluded because the member was an organization employee or a dependent of an organization employee. *Employees/dependents are only excluded from the sample, they are not removed from the eligible population.*
OversampleRecsAdded	Records added from the oversample list		✓	Replacement records for members in the denominator who had an exclusion or valid data error. *This number should not exceed the number of oversample records and should be accounted for in the exclusion categories above.*
Denominator	Denominator		✓	This population is the denominator used to report the measure. MRSS – exclusions + members added from the oversample list.
NumeratorByAdmin	Numerator events by administrative data	✓	✓	The number of members in the denominator who met numerator criteria using transactional data.
NumeratorBySupplemental	Numerator events by supplemental data	✓	✓	The number of members in the denominator who met numerator criteria using supplemental data (includes standard and nonstandard data). This data element is collected for only EOC and EOC-like measures.
NumeratorByMedicalRecords	Numerator events by medical records		✓	The number of members in the denominator who met numerator criteria using medical record data.
Numerator	Numerator	✓	✓	The number of members in the denominator who met numerator criteria as an aggregate across all data sources. This is reported in the Race Ethnicity Stratification Tables.
Rate	Reported rate	✓	✓	This is a calculated field in IDSS. *Administrative Method:* NumeratorByAdmin ÷ EligiblePopulation. *Hybrid Method*: (Numerator events by administrative data + numerator events by medical records) ÷ denominator. Measures that collect numerator events by supplemental data: *Administrative:* (Numerator events by administrative data + numerator events by supplemental data) ÷ eligible population. *Hybrid:* (Numerator events by administrative data + numerator events by supplemental data + numerator events by medical records) ÷ denominator.

Table 2: Data Element Definitions for ECDS Reporting Data Element

Data Element	Meaning
Benefit	For measures requiring a benefit other than Medical, the Benefit flag is reported in the Metadata section of the submission XML.
InitialPopulationByAdmin	Number of members in the initial population by the administrative Source System of Record (SSoR).
InitialPopulationByCaseManagement	Number of members in the initial population by the case management system SSoR.
InitialPopulationByEHR	Number of members in initial population by the electronic health record (EHR)/personal health record (PHR) SSoR.
InitialPopulationByHIERegistry	Number of members in initial population by the health information exchange/clinical registry SSoR.
InitialPopulation	For measures that report the Initial Population by SSoR, this is a calculated field in IDSS. Number of members in the initial population across all SSoRs.
ExclusionsByAdmin	Number of members excluded by the Administrative SSoR.
ExclusionsByCaseManagement	Number of members excluded by the case management registry SSoR.
ExclusionsByEHR	Number of members excluded by the Electronic health record (EHR)/personal health record (PHR) (the system of data origin such as laboratory, pharmacy, pathology, radiology) SSoR.
ExclusionsByHIERegistry	Number of members excluded by the Health Information Exchange systems or clinical registries SSoR.
Exclusions	Number of members that meet exclusion criteria across all SSoRs.
Denominator	Number of members in the denominator across all SSoRs. Unless noted otherwise, the denominator is the initial population minus exclusions.
NumeratorByAdmin	Number of members in the numerator by the administrative SSoR.
NumeratorByCaseManagement	Number of members in the numerator by the case management system SSoR.
NumeratorByEHR	Number of members in the numerator by the electronic health record (EHR)/personal health record (PHR) SSoR.
NumeratorByHIERegistry	Number of members in the numerator by the health information exchange/clinical registry SSoR.
Numerator	This is a calculated field in IDSS. Number of members in the numerator across all SSoRs.
Rate	This is a calculated field in IDSS. Numerator/Denominator

Reporting Instruction Explanations

Reporting Instructions	Explanation
Metadata	For Measures requiring a benefit other than Medical, the Benefit flag is reported in the Metadata section of the submission XML.
For each Metric	Report independent values for each metric.
For each Stratification*	Report independent values for each stratification.
For each Metric and Stratification*	Report independent values for each metric and stratification.
Report once	For single Indicator measures.
Repeat per Metric	The same value is repeated across all Metrics. Used e.g., when the same Eligible Population or Denominator is used for the calculation of multiple rates within a measure (e.g., CIS, IMA).
Repeat per Stratification*	The same value is repeated across all Stratifications. This is common for measures using the Hybrid collection method where a single sample is drawn for all stratifications. The sample corresponds to the Total stratification but plans only report the individual stratifications. Therefore, plans must repeat the sample data elements for all stratifications.
Repeat per Metric and Stratification*	The same value is repeated across all Metrics and Stratifications. For example, the Hybrid sample data elements for WCC when reporting using the Hybrid collection method.
For each Stratification, repeat per Metric*	Report independent values for each stratification but repeat these for the same stratifications over multiple metrics.
For each Metric, repeat per Stratification*	Report independent values for each Metric but repeat these for all Stratifications within each Metric (e.g., CollectionMethod).
Only for Total	Only used for CYAR in stratified measures. Plans report NumeratorByAdminElig (Number of numerator events by administrative data in eligible population (before exclusions)) for each stratification, but IDSS calculates the CYAR (Current year's administrative rate (before exclusions)), only at the total stratification. Only this total CYAR can be used to reduce the minimum required sample size for measures where this is allowed. Refer to the *Guidelines for Calculations and Sampling* for more information.

*****For measures with multiple stratifications, the reporting instructions apply for all stratification combinations.

Standard Administrative Data Element Table

Metric	Stratification (e.g., Age)	Data Element	Reporting Instructions
Added by measure	Added by measure	Benefit*	Added by measure
		EligiblePopulation	
		ExclusionAdminRequired	
		NumeratorByAdmin	
		NumeratorBySupplemental	
		Rate	

*****Only applies to measures that require a benefit other than medical.

Standard Hybrid Data Element Table

Metric	Stratification (e.g., Age)	Data Element	Reporting Instructions	A
Added by measure	Added by measure	CollectionMethod	Added by measure	✓
		Benefit*		✓
		EligiblePopulation		✓
		ExclusionAdminRequired		
		NumeratorByAdminElig		
		CYAR		
		MinReqSampleSize		
		OversampleRate		
		OversampleRecordsNumber		
		ExclusionValidDataErrors		
		ExclusionEmployeeOrDep		
		OversampleRecsAdded		
		Denominator		✓
		NumeratorByAdmin		
		NumeratorByMedicalRecords		✓
		NumeratorBySupplemental		✓
		Rate		

*Only applies to measures that require a benefit other than medical.

Standard ECDS Data Element Table

Metric	Stratification (e.g., Age)	Data Elements	Reporting Instructions
Added by Measure	Added by measure	Benefit*	Added by measure
		InitialPopulationByEHR	
		InitialPopulationByCaseManagement	
		InitialPopulationByHIERegistry	
		InitialPopulationByAdmin	
		InitialPopulation	
		ExclusionsByEHR	
		ExclusionsByCaseManagement	
		ExclusionsByHIERegistry	
		ExclusionsByAdmin	
		Exclusions	
		Denominator	
		NumeratorByEHR	

Metric	Stratification (e.g., Age)	Data Elements	Reporting Instructions
		NumeratorByCaseManagement	
		NumeratorByHIERegistry	
		NumeratorByAdmin	
		Numerator	
		Rate	

*Only applies to measures that require a benefit other than medical.

Note: *Not all measures use metrics, age and initial population/exclusions by data source. Refer to the measure specification for details.*

Standard Data Elements for Stratifications by Race

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

Standard Data Elements for Stratifications by Ethnicity

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

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3. QRS Clinical Measure Specifications

3.1 NCQA Measure Specifications

3.2 PQA Measure Specifications

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3.2 PQA Measure Specifications

Overview

Pharmacy Quality Alliance (PQA, Inc.)

PQA is a consensus-based, multi-stakeholder membership organization committed to optimizing health by advancing the quality of medication use. Established in 2006, PQA is a 501(c)3 designated non-profit alliance with over 240 member organizations.

PQA Measure Development Process

PQA uses a systematic, transparent, consensus-based process to draft, test, refine, endorse, and maintain measures of medication use quality. PQA evaluates measures against the following standard criteria: importance, scientific acceptability, feasibility, and usability. The end-product of measure development is an evidence-based, precisely specified, valid, reliable, feasible, and usable measure that is linked to national quality goals.

Measure Conceptualization:
The goal of the measure conceptualization phase is to generate and prioritize a list of measure concepts to be developed. This ensures that PQA devotes resources to developing measures that are high-impact and address areas of need. The measure conceptualization phase includes the following activities:

1. Environmental Scan
2. Measure Concept Advisory Group Input
3. Comment Period

Measure Specification:
During the measure specification phase, the goal is to create and refine initial specifications to produce specifications that are ready to be tested. The measure specification phase includes the following activities:

1. Initial Specification and Feasibility Testing
2. Technical Expert Panel Input

Measure Testing:
The goal of measure testing is to apply the measure specifications to test data representative of the intended measure population to determine the measure's scientific acceptability. PQA evaluates whether the measure meets the criteria of reliability (the measure consistently captures true differences in quality, as opposed to differences due to chance variation) and validity (the measure truly captures the intended concept of quality). Beyond scientific acceptability, measure testing may also evaluate the existence of performance gaps and inform remaining specification questions, such as the appropriateness of exclusions given their frequency in test data. The answers to these questions may result in additional refinement of the measure specifications. The measure testing phase includes the following activities:

1. Testing Plan Development
2. Initial Quality Metrics Expert Panel (QMEP) Review
3. Measure Testing
4. Face Validity Assessment
5. 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. Comment Period
2. All-Member Webinar
3. Membership Vote

Measure Implementation and Maintenance:
The measure lifecycle does not end when a measure is endorsed. In addition to PQA's role as a measure developer, PQA is a measure steward, which entails responsibility for supporting measures through implementation with outreach and education, supporting measure use with technical assistance, and measure maintenance to ensure that PQA measures remain current, impactful, and appropriate in light of new treatments or new clinical evidence or guidelines.

1. Measure Implementation
2. Technical Assistance
3. Measure Maintenance

Updated: 1/02/2025

General Guidelines for the *Annual Monitoring for Persons on Long-Term Opioid Therapy, International Normalized Ratio Monitoring for Individuals on Warfarin* and *Proportion of Days Covered* Measure Data Collection.

Refer to the General Guidelines for Data Collection in Section 3.1, Measurement Year 2025 (MY 2025) HEDIS® General Guidelines for the QRS Measure Technical Specifications, for details that will inform appropriate data collection for the *Annual Monitoring for Persons on Long-term Opioid Therapy, International Normalized Ratio Monitoring for Individuals on Warfarin, and Proportion of Days Covered* measure. All general guidelines apply, with the exception of the following items specified below.

PQA Posting of the Value Sets

The Value Sets for PQA measures will be available by request from PQA. Please refer to the PQA website in order to obtain the Value Sets, including National Drug Code (NDC) lists, at https://www.pqaalliance.org/QRS.

The final Value Sets, including NDC lists, for 2026 are available as of March 31, 2025. The NDC lists includes current NDCs from January 1, 2024 through December 31, 2024, and NDCs with obsolete dates of July 1, 2023 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 section.

Annual Monitoring for Persons on Long-Term Opioid Therapy (AMO)

Summary of Changes

The following changes have been incorporated into the measure specifications:

- Added exclusion for individuals receiving treatment for cancer-related pain.

Description

The percentage of members 18 years and older who are prescribed long-term opioid therapy and have not received a drug test at least once during the measurement year.

A lower rate indicates better performance.

Definitions

Opioid Analgesics	Limited to opioid medications indicated for pain. See Medication Table, AMO: Opioid Analgesics. Includes opioid medications indicated for pain.
Long-Term Opioid Therapy	≥90 days' cumulative supply of any combination of opioid analgesics (See Medication Table AMO: Opioid Analgesics) during the measurement year identified using prescription claims.
Prescription Claims	Only paid, non-reversed prescription claims are included in the data set to calculate the measure.
Drug Test	Any drug screens/tests for at least one of the following targeted drug classes: amphetamines, barbiturates, benzodiazepines, cannabinoids, cocaine, and opiates/opioids. • ≥1 medical or laboratory claim with specified Healthcare Common Procedure Coding System (HCPCS) codes or, Current Procedural Terminology (CPT) codes. See Value Set, Drug Test.

Eligible Population

Ages	18 years and older as of the first day of the measurement year.
Continuous Enrollment	The measurement year.
Allowable Gap	No more than one gap in continuous enrollment of up to 31 days during the measurement year. When enrollment is verified monthly, the member may not have more than a 1-month gap in coverage (i.e., a member whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).
Benefit	Medical and Pharmacy.

Required Exclusions

Exclude members who met ≥1 of the following during the measurement year:

- Hospice: Any member who uses hospice services (See Value Sets, Hospice Encounter; Hospice Intervention) or elects to use a hospice benefit any time during the measurement year.
    - Organizations that use the Monthly Membership Detail Data File to identify these members must use only the run date of the file to determine if the member elected to use a hospice benefit during the measurement year.
- Cancer: Any member with cancer during the measurement year. See Value Set, Cancer. Do not include diagnosis from laboratory claims (claims with POS code 81).
- Palliative Care: Any member in palliative care during the measurement year. See Value Set, Palliative Care. Do not include diagnosis from laboratory claims (claims with POS code 81).
- Cancer-Related Pain Treatment: Any individual receiving treatment for cancer-related pain during the measurement year. See Value Set, Cancer-Related Pain. Do not include diagnosis from laboratory claims (claims with POS code 81).

- Members who die any time during the measurement year.

Event/Diagnosis

Members who are prescribed long-term opioid therapy.

Use the steps below to determine the eligible population.

Step 1 Identify members aged 18 years and older as of the first day of the measurement year.

Step 2 Identify members who meet the continuous enrollment criteria.

Step 3 Identify members who are prescribed ≥90 days' cumulative supply of any combination of opioid analgesics (Medication Table, AMO: Opioid Analgesics) during the measurement year. The cumulative days' supply does not have to be consecutive. Exclude days' supply that extends beyond the end of the measurement year.

NOTE:

- The prescriptions claims can be for the same or different opioids.
- For multiple claims for the same or different opioids with the same date of service, calculate the number of days covered by an opioid using the prescriptions with the longest days' supply.
- For multiple claims for the same or different opioids with different dates of service, sum the days' supply for all the prescription claims, regardless of overlapping days' supply.

Step 4 Exclude members who met ≥1 of the following during the measurement year:

- Hospice: Any member who uses hospice services (See Value Sets, Hospice Encounter; Hospice Intervention) or elects to use a hospice benefit any time during the measurement year.
    - Organizations that use the Monthly Membership Detail Data File to identify these members must use only the run date of the file to determine if the member elected to use a hospice benefit during the measurement year.
- Cancer: Any member with ≥1 claims for cancer during the measurement year. See Value Set, Cancer. Do not include diagnosis from laboratory claims (claims with POS code 81).
- Palliative Care: Any member in palliative care during the measurement year. See Value Set, Palliative Care. Do not include diagnosis from laboratory claims (claims with POS code 81).

- Cancer-Related Pain Treatment: Any individual receiving treatment for cancer-related pain during the measurement year. See Value Set, Cancer-Related Pain. Do not include diagnosis from laboratory claims (claims with POS code 81).
- Members who die any time during the measurement year.

Administrative Specification

Denominator The eligible population.

Numerator Members in the denominator who have not received a drug test during the measurement year. See Value Set, Drug Test.

Medication Table

Table AMO: Opioid Analgesics [a,b]

Opioid Medications		
• benzhydrocodone	• hydrocodone	• oxycodone
• buprenorphine	• hydromorphone	• oxymorphone
• butorphanol	• levorphanol	• pentazocine
• codeine	• meperidine	• tapentadol
• dihydrocodeine	• methadone	• tramadol
• fentanyl	• morphine	

[a] Includes opioid medications indicated for pain; includes combination products.
[b] Excludes the following: medications prescribed or provided as part of medication-assisted treatment for opioid use disorder (i.e., buprenorphine sublingual tablets, Probuphine® Implant kit subcutaneous implant, and all buprenorphine/naloxone combination products); and formulations delivered by the intravenous (IV) or epidural (EP) route (IV and EP routes are excluded because they are not commonly prescribed as chronic pain medications).

This measure was developed by IMPAQ International, LLC and Health Services Advisory Group, Inc. (HSAG).

Data Elements for Reporting

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

Table AMO: Annual Monitoring for Persons on Long-Term Opioid Therapy

Metric	Data Element	Reporting Instructions
LongTermOpioidTheraphyMonitoring	Benefit	Metadata
	EligiblePopulation	Report once
	ExclusionAdminRequired	Report once
	NumeratorByAdmin	Report once
	Rate	(Percent)

International Normalized Ratio Monitoring for Individuals on Warfarin (INR)

Summary of Changes

The following changes have been incorporated into the measure specifications:

- None.

Description

The percentage of members 18 years of age and older who had at least one 56-day interval of warfarin therapy and who received at least one international normalized ratio (INR) monitoring test during each 56-day interval with active warfarin therapy.

A higher rate indicates better performance.

Definitions

Warfarin	See Medication Table, INR-A: Warfarin.
Prescription Claims	Only paid, non-reversed prescription claims are included in the data set to calculate the measure.
Index Prescription Start Date (IPSD)	The earliest date of service for warfarin during the measurement year.
Treatment Period	The period of time beginning on the IPSD and ending with the last day of supply for warfarin (date of service plus the days' supply for the last prescription claim for warfarin minus 1) during the measurement year. If the days' supply extends beyond the end of the measurement year, the treatment period ends on December 31 of the measurement year. The last prescription claim for warfarin should be used to determine the end of the treatment period even if there is days' supply from a previous prescription claim for warfarin that extends beyond the days' supply for the last prescription claim during the treatment period. *For example: If a member has prescription claims on November 30 for a 10 days' supply and December 1 for a 5 days' supply, the end of the treatment period is December 5.* If two prescription claims for warfarin occur on the same date of service, the date of service with the longest days' supply is used to determine the end of the treatment period. Gaps in prescription claims for warfarin can occur during the treatment period.
Hospital Stay	Any medical claim indicating a hospital stay (with appropriate revenue code) during the measurement year. See Value Set, Hospital Stay.
INR Test	Any laboratory or medical claim for an INR test during the measurement year. See Value Set, INR Test.

Eligible Population

Ages
18 years and older as of the first day of the measurement year.

Continuous enrollment
The treatment period.

Exclude members with more than one 1-day gap in enrollment during the treatment period. Note: This allows for a one-day gap to compensate for discrepancies in the enrollment data.

For example: If a member is eligible from 1/1-4/1 and 4/3-12/31, he/she would still be continuously enrolled despite the one-day gap in eligibility on 4/2.

Allowable gap
None.

Benefit
Medical and Pharmacy.

Required Exclusions
Exclude members who met ≥1 of the following during the measurement year:
- Members with a laboratory or medical claim for INR home monitoring during the measurement year. See Value Set, INR Home Monitoring Exclusion.
- Members who die any time during the measurement year.

Event/Diagnosis
Members dispensed warfarin during the measurement year.

Use the steps below to determine the eligible population.

Step 1 Identify members aged 18 years and older as of the first day of the measurement year.

Step 2 Identify members with ≥1 prescription claims for warfarin (Medication Table, INR-A: Warfarin) during the measurement year.

Step 3 Determine each member's treatment period. The member's treatment period begins on the IPSD and extends through the last day of supply for warfarin (date of service plus the days' supply for the last prescription claim for warfarin minus 1) during the measurement year.

Step 4 Identify members with a treatment period that is ≥56 days during the measurement year.

Step 5 Identify members who meet the continuous enrollment criteria.

Step 6
- Exclude members with a medical claim for INR home monitoring during the measurement year. See Value Set, INR Home Monitoring Exclusion.
- Exclude members who die any time during the measurement year.

Administrative Specification

Denominator
The eligible population.

Numerator
Members who received at least one INR monitoring test or were hospitalized during each 56-day interval during the treatment period.

Use the steps below to determine the members for the numerator.

Step 1 For each member in the denominator, determine the start and end dates for each full 56-day interval.

For example: A member has his/her first prescription claim for warfarin during the measurement year on January 1 and last prescription claim for warfarin during the measurement year on April 1 for a 30-days' supply. As a result, the member's treatment period is from January 1 through April 30, or 120 days. During the treatment period, the member has 2 full intervals. Interval 1 starts on January 1 and ends on February 25. Interval 2 starts on February 26 and ends on April 22 (in a non-leap year).

Note: Only full 56-day intervals are used for evaluating members for the numerator. Days after the last full interval are not included.

Step 2 For each member in the denominator, determine if there was an INR test (Value Set, INR Test) or a hospital stay of >48 hours (Value Set, Hospital Stay) during each interval.

Note: Hospital stays are only applied to the 56-day interval in which the admission date falls. If hours are not available, hospital stays of at least three days meet the numerator criteria. However, the entire hospital stay does not need to fall within the 56-day interval in which the admission date falls.

For example: A member has their first warfarin fill during the measurement year on January 1 and last warfarin fill during the measurement year on April 1 for a 30-days' supply. As a result, his/her treatment period is from January 1 through April 30, or 120 days. During the treatment period, the member has 2 full intervals. Interval 1 starts on January 1 and ends on February 25. Interval 2 starts on February 2/26 and ends on April 22 (in a non-leap year). The member is admitted to the hospital on February 25 and discharged on February 27 and also has an INR test on March 12. The hospital stay from February 25 through February 27 meets the numerator criteria for interval 1 and the INR test meets the numerator criteria for interval 2. The member meets the numerator criteria in each interval and would be counted in the numerator.

Step 3 Count the members with an INR test or hospitalization during all intervals as numerator compliant.

Medication Table

Table INR-A: Warfarin

Warfarin Medications
• warfarin

This measure was developed by IMPAQ International, LLC and Health Services Advisory Group, Inc. (HSAG).

Data Elements for Reporting

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

Table INR: Data Elements for International Normalized Ratio Monitoring for Individuals on Warfarin

Metric	Data Element	Reporting Instructions
WarfarinMonitoring	Benefit	Metadata
	EligiblePopulation	Report once
	ExclusionAdminRequired	Report once
	NumeratorByAdmin	Report once
	Rate	(Percent)

Proportion of Days Covered (PDC): 3 Rates

Summary of Changes

The following changes have been incorporated into the measure specifications:

- None.

Description

The percentage of members 18 years and older who met the Proportion of Days Covered (PDC) threshold of 80% during the measurement year.

A higher rate indicates better performance.

Report a rate for each of the following:

- Renin Angiotensin System Antagonists (PDC-RASA)
- Diabetes All Class (PDC-DR)
- Statins (PDC-STA)

Definitions

Proportion of Days Covered (PDC)	The proportion of days in the treatment period covered by prescription claims for the same medication or another in its therapeutic category.
PDC Threshold	The PDC level above which the medication has a reasonable likelihood of achieving most of the potential clinical benefit (80% for diabetes and cardiovascular drugs, and many chronic conditions).
Index Prescription Start Date (IPSD)	The earliest date of service for a target medication during the measurement year.
Prescription Claims	Only paid, non-reversed prescription claims are included in the data set to calculate the measure.
Treatment Period	The member's treatment period begins on the IPSD and extends through whichever comes first: the last day of enrollment during the measurement year, death, or the end of the measurement year. The treatment period should be at least 91 days.
Calculating Number of Days Covered for the Numerator	If multiple prescriptions for different target medications (i.e., two or more products within the same therapeutic category, but with different generic ingredients) are dispensed on the same day, count the number of days covered using the prescription with the longest days' supply. If multiple prescriptions for different target medications (i.e., two or more products within the same therapeutic category, but with different generic ingredients) are dispensed on different days with overlapping days' supply, count each day covered by a target medication only once within the treatment period. *For example: if a prescription for simvastatin and a prescription for atorvastatin are filled 5 days apart and each has a 30-day supply, then the total days covered is 35.* If multiple prescriptions for the same target medication (i.e., one or more products with the same generic ingredient) are dispensed on the same day or different days where the days' supply overlap, adjust the prescription start date to be the day after the previous fill has ended.

For example: if three prescriptions for the same target medication are dispensed on the same day, each with a 30-day supply, then a total of 90 days are covered.

Overlap adjustment should also occur when there is an overlap of a single target drug product to a combination product containing the single target drug (i.e., same generic ingredient) or when there is an overlap of a combination product to another combination product where at least one of the target drugs (i.e., same generic ingredient) is common.

Any days' supply that extends beyond the end of the treatment period are not included when calculating the total number of days covered.

The NDC list for each class of medications includes flags for each target medication. The flags will help determine whether the prescription (NDC) includes the same or different target medication.

Eligible Population

Ages	18 years and older as of the first day of the measurement year.
Continuous Enrollment	The treatment period. Exclude members with more than one 1-day gap in enrollment during the treatment period. Note: This allows for a one-day gap to compensate for discrepancies in the enrollment data. *For example: If a member is eligible from 1/1-4/1 and 4/3-12/31, he/she would still be continuously enrolled despite the one-day gap in eligibility on 4/2.*
Benefit	Medical and Pharmacy.

Administrative Specification

Report each of the rates separately. Members may be counted in the denominator for multiple rates if they have been dispensed the relevant medications; though for each rate, the proportion of days covered should only be counted once per member.

Rate 1: Renin Angiotensin System (RAS) Antagonists (PDC-RASA)

Additional Eligible Population Criteria	Members who filled at least two prescriptions for any RAS Antagonist: ACEI/ARB/direct renin inhibitor or ACEI/ARB/direct renin inhibitor Combination (Medication Table, RASA: RAS Antagonists) on different dates of service during the treatment period. The prescriptions can be for the same or different medications.
Denominator	The eligible population.

Required Exclusions

Any members with one or more of the following:

- Hospice: Any member who uses hospice services (See Value Sets, Hospice Encounter; Hospice Intervention) or elects to use a hospice benefit any time during the measurement year.
    - Organizations that use the Monthly Membership Detail Data File to identify these members must use only the run date of the file to determine if the member elected to use a hospice benefit during the measurement year.
- ESRD: An ESRD diagnosis is defined as having at least one claim with any of the listed ESRD diagnoses, including primary diagnosis or any other diagnosis fields during the measurement year. See PQA ESRD Value Set. Do not include diagnosis from laboratory claims (claims with POS code 81).
- Sacubitril/valsartan: A prescription claim for sacubitril/valsartan during the treatment period (Medication Table, SAC-VAL: Sacubitril/Valsartan Exclusion).

Table RASA: Renin Angiotensin System (RAS) Antagonists

Direct Renin Inhibitor Medications and Combinations		
• aliskiren (+/- hydrochlorothiazide)		
ARB Medications and Combinations		
• azilsartan (+/- chlorthalidone) • candesartan (+/- hydrochlorothiazide) • eprosartan (+/- hydrochlorothiazide)	• irbesartan (+/- hydrochlorothiazide) • losartan (+/- hydrochlorothiazide) • olmesartan (+/- amlodipine, hydrochlorothiazide)	• telmisartan (+/- amlodipine, hydrochlorothiazide) • valsartan (+/- amlodipine, hydrochlorothiazide, nebivolol) [a]
ACE Inhibitor Medications and Combinations		
• benazepril (+/- amlodipine, hydrochlorothiazide) • captopril (+/- hydrochlorothiazide) • enalapril (+/- hydrochlorothiazide) • fosinopril (+/- hydrochlorothiazide)	• lisinopril (+/- hydrochlorothiazide) • moexipril (+/- hydrochlorothiazide) • perindopril (+/- amlodipine)	• quinapril (+/- hydrochlorothiazide) • ramipril • trandolapril (+/- verapamil)

NOTE: Active ingredients are limited to oral formulations only. Excludes nutritional supplement/dietary management combination products.

[a] There are no active NDCs for valsartan/nebivolol.

Table SAC-VAL: Sacubitril/Valsartan Exclusion

ARB/Neprilysin Inhibitor Combination Medications
• sacubitril/valsartan

Numerator

The number of members who met the PDC threshold during the measurement year. Follow the steps below for each member to determine whether the member meets the PDC threshold.

Measure Calculation

Step 1 Determine the member's treatment period, defined as the IPSD to the end of the measurement year, disenrollment, or death.

Step 2 Within the treatment period, count the days the member was covered by at least one drug in the class (Medication Table; RASA: Renin Angiotensin System (RAS) Antagonists) based on the prescription fill date and days of supply. If the days' supply for prescription claims with the same target drug (generic ingredient) overlap, then adjust the prescription claim's start date to be the day after the last days' supply for the previous prescription claim. *

Step 3 Divide the number of covered days found in Step 2 by the number of days found in Step 1. Multiply this number by 100 to obtain the PDC (as a percentage) for each member. Then, round the PDC to the nearest hundredth (e.g., 79.996% is rounded to 80.00%, 79.992% is rounded to 79.99%).

Step 4 Count the number of members who had a PDC of 80% or greater and then divide by the total number of eligible members.

**Adjustment of overlap should also occur when there is overlap of a single drug product to a combination product containing the single drug or when there is an overlap of a combination product to another combination product where at least one of the target drugs is common.*

Rate 2: Diabetes All Class (PDC-DR)

Additional Eligible Population Criteria

Members who filled at least two prescriptions for any of the diabetes mediations listed in the Medication Tables BG: Biguanides, SFU: Sulfonylureas, TZD: Thiazolidinediones, DPP4: DPP-4 Inhibitors, GIP/GLP1: GIP/GLP-1 Receptor Agonists, MEG: Meglitinides, or SGLT2: SGLT2 Inhibitors on different dates of service in the treatment period. The prescriptions can be for the same or different medications and can be from any of these seven tables.

Denominator

The eligible population.

Required Exclusions

Any member with one or more of the following:

- Hospice: Any member who uses hospice services (See Value Sets, Hospice Encounter; Hospice Intervention) or elects to use a hospice benefit any time during the measurement year.
    - Organizations that use the Monthly Membership Detail Data File to identify these members must use only the run date of the file to determine if the member elected to use a hospice benefit during the measurement year.
- ESRD: An ESRD diagnosis is defined as having at least one claim with any of the listed ESRD diagnoses, including primary diagnosis or any other diagnosis fields during the measurement year. See PQA ESRD Value Set. Do not include diagnosis from laboratory claims (claims with POS code 81).
- Insulin: Any member with ≥1 prescription claim for insulin in the treatment period. See Medication Table, INSULINS: Insulin Exclusion.

Medication Tables

Table BG: Biguanides

Biguanide Medications and Combinations
• metformin (+/- alogliptin, canagliflozin, dapagliflozin, empagliflozin, ertugliflozin, glipizide, glyburide, linagliptin, pioglitazone, repaglinide, rosiglitazone, saxagliptin, sitagliptin)

Note: Active ingredients are limited to oral formulations only. Excludes nutritional supplement/dietary management combination products.

Table SFU: Sulfonylureas

Sulfonylurea Medications and Combinations		
• chlorpropamide [a]	• glipizide (+/- metformin)	• tolazamide
• glimepiride (+/- pioglitazone, rosiglitazone) [a]	• glyburide (+/- metformin)	• tolbutamide [b]

NOTE: Active ingredients are limited to oral formulations only.
[a] There are no active NDCs for chlorpropamide, glimepiride/rosiglitazone, or tolbutamide.

Table TZD: Thiazolidinediones

Thiazolidinedione Medications and Combinations	
• pioglitazone (+/- alogliptin, glimepiride, metformin)	• rosiglitazone (+/- glimepiride, metformin) [a]

NOTE: Active ingredients are limited to oral formulations only.
[a] There are no active NDCs for glimepiride/rosiglitazone.

Table DPP4: DPP-4 Inhibitors

DPP-4 Medications and Combinations		
• alogliptin (+/- metformin, pioglitazone)	• saxagliptin (+/- dapagliflozin, metformin)	• sitagliptin (+/-ertugliflozin, metformin
• linagliptin (+/- empagliflozin, metformin)		

NOTE: Active ingredients are limited to oral formulations only.

Table GIP/GLP1: GIP/GLP-1 Receptor Agonists

GIP/GLP-1 Receptor Agonists		
• albiglutide [b]	• liraglutide	• semaglutide
• dulaglutide	• lixisenatide	• tirzepatide
• exenatide		

NOTE: Excludes products indicated only for weight loss.
[b] There are no active NDCs for albiglutide.

Table MEG: Meglitinides

Meglitinides and Combinations	
• nateglinide	repaglinide (+/--metformin)

NOTE: Active ingredients are limited to oral formulations only.

Table SGLT2: Sodium Glucose Co-Transporter2 (SGLT2) Inhibitors

SGLT2 Inhibitors and Combinations		
• bexagliflozin	• dapagliflozin (+/- metformin, saxagliptin)	• ertugliflozin (+/- metformin sitagliptin)
• canagliflozin (+/- metformin)	• empagliflozin (+/-linagliptin, metformin)	

NOTE: Active ingredients are limited to oral formulations only.

Table INSULINS: Insulin Exclusion[a]

Insulin Medications and Combinations		
• insulin aspart (+/-insulin aspart protamine, niacinamide)	• insulin glargine (+/- lixisenatide)	• insulin lispro (+/- insulin lispro protamine)
• insulin degludec (+/- liraglutide)	• insulin glulisine	• insulin regular (including inhalation powder)
• insulin detemir	• insulin isophane (+/- regular insulin)	

NOTE: The active ingredients are limited to inhaled and injectable formulations only.
[a] For biologic reference products contained in the Medication Table, biosimilars associated with the reference product, regardless of interchangeable status, are also included in the associated value sets, unless otherwise noted.

Numerator The number of members who met the PDC threshold during the measurement year. Follow the steps below to determine whether the member meets the PDC threshold.

Measure Calculation

Step 1 Determine the member's treatment period, defined as the IPSD to the end of the measurement year, disenrollment, or death.

Step 2 Within the treatment period, count the days the member was covered by at least one diabetes medication (Medication Tables BG, SFU, TZD, DPP4, GIP/GLP1, MEG, or SGLT2) based on the date of service and days' supply on prescription claims. If the days' supply for prescription claims with the same target drug (generic ingredient) overlap, then adjust the prescription claim's start date to be the day after the last days' supply for the previous prescription claim.*

***Step* 3** Divide the number of covered days found in Step 2 by the number of days found in Step 1. Multiply this number by 100 to obtain the PDC (as a percentage) for each member. Then, round the PDC to the nearest hundredth (e.g., 79.996% is rounded to 80.00%, 79.992% is rounded to 79.99%).

Step 4 Count the number of members who had a PDC of 80% or greater and then divide by the total number of eligible members.

**Adjustment of overlap should also occur when there is overlap of a single drug product to a combination product containing the single drug or when there is an overlap of a combination product to another combination product where at least one of the target drugs is common.*

Rate 3: Statins (PDC-STA)

Additional Eligible Population Criteria Members with at least two prescription claims for any statin (Medication Table, STATINS) on different dates of service in the treatment period. The prescription claims can be for the same or different medications.

Denominator The eligible population.

Required Exclusions Any member with one or more of the following:

- Hospice: Any member who uses hospice services (See Value Sets, Hospice Encounter; Hospice Intervention) or elects to use a hospice benefit any time during the measurement year.
    - Organizations that use the Monthly Membership Detail Data File to identify these members must use only the run date of the file to determine if the member elected to use a hospice benefit during the measurement year.
- ESRD: An ESRD diagnosis is defined as having at least one claim with any of the listed ESRD diagnoses, including primary diagnosis or any other diagnosis fields during the measurement year. See PQA ESRD Value Set. Do not include diagnosis from laboratory claims (claims with POS code 81).

Table STATINS: Statins

Statin Medications		
• atorvastatin(+/-amlodipine, ezetimibe) • fluvastatin • lovastatin (+/- niacin)	• pitavastatin • pravastatin	• rosuvastatin (+/-ezetimibe) • simvastatin (+/-ezetimibe, niacin)

Note: The active ingredients are limited to oral formulations only.

Numerator The number of members who met the PDC threshold during the measurement year. Follow the steps below to determine whether the member meets the PDC threshold.

Measure Calculation

Step 1 Determine the member's treatment period, defined as the IPSD to the end of the measurement year, disenrollment, or death.

Step 2 Within the treatment period, count the days the member was covered by at least one drug in the class (Medication Table; STATIN: Statins) based on the date of service and days' supply on prescription claims. If the days' supply for prescription claims with the same target drug (generic ingredient) overlap, then adjust the prescription claim's start date to be the day after the last days' supply for the previous prescription claim.*

***Step* 3** Divide the number of covered days found in Step 2 by the number of days found in Step 1. Multiply this number by 100 to obtain the PDC (as a percentage) for each member. Then, round the PDC to the nearest hundredth (e.g., 79.996% is rounded to 80.00%, 79.992% is rounded to 79.99%).

Step 4 Count the number of members who had a PDC of 80% or greater and then divide by the total number of eligible members.

**Adjustment of overlap should also occur when there is overlap of a single drug product to a combination product containing the single drug or when there is an overlap of a combination product to another combination product where at least one of the target drugs is common.*

Data Elements for Reporting

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

Table PDC: Data Elements for Proportion of Days Covered

Metric	Data Element	Reporting Instructions
RASAntagonists	Benefit	Metadata
Diabetes	EligiblePopulation	For each Metric
Statins	ExclusionAdminRequired	For each Metric
	NumeratorByAdmin	For each Metric
	Rate	(Percent)

4. QRS Survey Measure Specifications

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QRS Survey Measure Descriptions

Overview

This section includes descriptions for the QRS survey measures[1] that will be collected as part of the 2026 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 2026 QHP Enrollee Survey item(s), refer to the annual QRS and QHP Enrollee Survey: Technical Guidance.

Additional details related to the 2026 QHP Enrollee Survey and data collection protocols are included on the CMS QHP Enrollee Survey page of the CMS Marketplace Quality Initiatives website at https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityInitiativesGenInfo/ACA-MQI/Consumer-Experience-Surveys/Surveys-page.html.

QRS Survey Measure Descriptions

Access to Care

The *Access to Care* measure includes data from the following three questions from the 2026 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 as soon as you needed? Include in-person, telephone, or video appointments. *(Question #21)*
- In the last 6 months, how often did you get an appointment for a check-up or routine care at a doctor's office or clinic as soon as you needed? Include in-person, telephone, or video appointments. *(Question #22)*
- In the last 6 months, how often was it easy to get the care, tests, or treatment you needed? Include in-person, telephone, or video appointments. *(Question #24)*
- In the last 6 months, how often did you get an appointment to see a specialist as soon as you needed? Include in-person, telephone, or video appointments. *(Question #40)*

Access to Information

The *Access to Information* measure includes data from the following three questions from the 2026 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)*

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[1] The following QRS survey measure is a HEDIS® measure and is addressed in NCQA's Measure Specifications: Medical Assistance with Smoking Cessation.

Care Coordination

The *Care Coordination* measure includes data from the following six questions from the 2026 QHP Enrollee Survey:

- When you visited your personal doctor for a scheduled appointment in the last 6 months, how often did he or she have your medical records or other information about your care? Include in-person, telephone, or video appointments. *(Question #32)*
- In the last 6 months, when your personal doctor ordered a blood test, x-ray, or other test for you, how often did someone from your personal doctor's office follow up to give you those results? *(Question #33)*
- In the last 6 months, when your personal doctor ordered a blood test, x-ray, or other test for you, how often did you get those results as soon as you needed them? *(Question #34)*
- In the last 6 months, how often did you and your personal doctor talk about all the prescription medicines you were taking? *(Question #35)*
- In the last 6 months, how often did you get the help that you needed from your personal doctor's office to manage your care among these different providers and services?[2] *(Question #38)*
- In the last 6 months, how often did your personal doctor seem informed and up-to-date about the care you got from specialists? *(Question #42)*

Enrollee Experience with Cost

The *Enrollee Experience with Cost* measure includes data from the following four questions from the 2026 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 #13)*
- 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 #14)*
- In the last 6 months, how often did you have to delay visiting or not visit a doctor because you were worried about the cost? *(Question #15)*
- In the last 6 months, how often did you delay filling or not fill a prescription because you were worried about the cost? *(Question #16)*

Plan Administration

The *Plan Administration* measure includes data from the following five questions from the 2026 QHP Enrollee Survey:

- In the last 6 months, how often did your health plan's customer service give you the information or help you needed? *(Question #6)*
- In the last 6 months, how often did your health plan's customer service staff treat you with courtesy and respect? *(Question #7)*
- In the last 6 months, how often did the time that you waited to talk to your health plan's customer service staff take longer than you expected? *(Question #8)*
- In the last 6 months, how often were the forms from your health plan easy to fill out? *(Question #9)*

[2] Enrollees must answer affirmatively to the screener question: "In the last 6 months, did you need help from anyone in your personal doctor's office to manage your care among these different providers and services?" in order to respond to this question.

- In the last 6 months, how often did the health plan explain the purpose of a form before you filled it out? *(Question #10)*

Rating of All Health Care

The *Rating of All Health Care* measure includes data from the following question from the 2026 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? Include in-person, telephone, or video appointments. *(Question #26)*

Rating of Health Plan

The *Rating of Health Plan* measure includes data from the following question from the 2026 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 #19)*

Rating of Personal Doctor

The *Rating of Personal Doctor* measure includes data from the following question from the 2026 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 #39)*

Rating of Specialist

The *Rating of Specialist* measure includes data from the following question from the 2026 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 #43)*