Integrated Healthcare Association Align. Measure. Perform. (AMP) Programs

Measurement Year 2021 Technical Specifications

Released June 1, 2021

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Measure Copyright Information

Abbreviation	Measure Name	Steward	Copyright
CBP	Controlling High Blood Pressure	NCQA	ii
SPC	Statin Therapy for Patients With Cardiovascular Disease	NCQA	ii
PDC	Proportion of Days Covered by Medications—(RAS) Antagonists	PQA	iii
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PDC	Proportion of Days Covered by Medications—Diabetes All Class	PQA	iii
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CDC	Comprehensive Diabetes Care—HbA1c Control (<8.0%)	NCQA	ii
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SPD	Statin Therapy for Patients With Diabetes	NCQA	ii
SUPD	Statin Use in Persons with Diabetes	PQA	iii
ART	Disease-Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis	NCQA	ii
OMW	Osteoporosis Management in Women Who Had a Fracture	NCQA	ii
CIS	Childhood Immunization Status	NCQA	ii
IMA	Immunizations for Adolescents	NCQA	ii
CHL	Chlamydia Screening in Women	NCQA	ii
CCS	Cervical Cancer Screening	NCQA	ii
CCO	Cervical Cancer Overscreening	NCQA/IHA	i
BCS	Breast Cancer Screening	NCQA	ii
COL	Colorectal Cancer Screening	NCQA	ii
PPC	Prenatal and Postpartum Care	NCQA	ii
WCV	Child and Adolescent Well-Care Visits	NCQA	ii
WCC	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents	NCQA	ii
AMR	Asthma Medication Ratio	NCQA	ii
CWP	Appropriate Testing for Pharyngitis	NCQA	ii
AAB	Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis	NCQA	ii
HDO	Use of Opioids at High Dosage	NCQA	ii
COB	Concurrent Use of Opioids and Benzodiazepines	PQA	iii

Abbreviation	Measure Name	Steward	Copyright
ENRST	Encounter Rate by Service Type	NCQA/IHA	i
ENFMT	Encounter Format	IHA	vi
ENLAG	Encounter Timeliness	IHA	vi
ECBP	Controlling High Blood Pressure (e-Measure)	NCQA	ii
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AMB	Ambulatory Care	NCQA	ii
*FSP**	Frequency of Selected Procedures	NCQA	ii
IPU	Inpatient Utilization—General Hospital/Acute Care	NCQA	ii
GRX	Generic Prescribing	IHA	vi
OSU	Outpatient Procedures Utilization—Percentage Done in Preferred Facility	NCQA/IHA	i
PCR[1]	All-Cause Readmissions	NCQA	ii
EDU	Emergency Department Utilization	NCQA	ii
AHU	Acute Hospital Utilization	NCQA	ii
HALOS	Hospital Average Length of Stay	NCQA/IHA	i
TCOC	Total Cost of Care	HealthPartners	vii
DSF-E	Depression Screening and Follow-Up for Adolescents and Adults	NCQA	ii
DMS-E	Utilization of the PHQ-9 to Monitor Depression Symptoms for Adolescents and Adults	NCQA	ii
DRR-E	Depression Remission or Response for Adolescents and Adults	NCQA	ii

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Overview

Background

IHA's Align. Measure. Perform. (AMP) Programs use a fair and transparent approach to measurement to generate comprehensive benchmarks and a reliable assessment of performance for medical groups, independent practice association (IPAs), and accountable care organizations (ACOs) across health plans. The AMP programs are recognized nationally for partnering with organizations across California and the nation to drive meaningful changes that reduce costs and improve healthcare quality and outcomes. Paired with the insights from IHA's California Regional Health Care Cost & Quality Atlas, the AMP programs help reduce reporting burden for payers and providers by using a standard measure set to deliver objective data and analysis that supports performance improvement. This document presents guidance and measure-level details needed to collect and report data for the AMP programs.

IHA provides detailed programmatic and technical information to its participants to support accurate and complete data collection for the AMP programs. Historically, this information has been presented in the AMP Program Manual, which contained programmatic updates, reporting guidance, and technical specifications. In 2020, IHA's Technical Measurement and Governance Committees recommended an improved AMP Program timeline beginning in measurement year (MY) 2021 that accelerates the release of measure specifications (in alignment with recent HEDIS timeline changes) and allows participating POs and health plans more time to apply specifications during the measurement year. In order to adapt to this new timeline and release relevant information on the AMP programs as soon as it is available, IHA has changed the presentation of programmatic guidelines (Program Guide) to be separate from measure specifications (Technical Specifications **[this document]**). The below table describes the changes in relation to the timeline.

	Previous Timeline (MY 2020 and prior)	Transition Timeline (MY 2021)	Future Timeline (MY 2022 and beyond)
Draft AMP Program Manual	September 1, 2020	September 1, 2020 (combined with MY 2020)	October 11, 2021 (*Now referred to as AMP Technical Specifications*)
Final AMP Program Manual	December 1, 2020	June 1, 2021 (*Now referred to as AMP Technical Specifications*)	June 1, 2022 (*Now referred to as AMP Technical Specifications*)
Preliminary AMP Program Guide (*New*)		June 1, 2021	June 1, 2022
Final AMP Program Guide (*New*)		December 15, 2021	December 15, 2022

Each document includes the following information:

- The *Draft MY 2020 and 2021 AMP Program Manual*, released on September 1, 2020, includes draft AMP programmatic information and draft technical specifications for all measures in the AMP program for MY 2020 and MY 2021, and reflects applicable changes in *HEDIS MY 2020 and 2021 Volume 2: Technical Specifications* (released in July 2020).
- The *MY 2020 Final AMP Program Manual,* released on December 1, 2020, includes final AMP programmatic information and final technical specifications for all measures in the AMP program for MY 2020, and reflects applicable changes in *HEDIS MY 2020 Volume 2: Technical Specifications Update* (released in October 2020).
- The *Final MY 2021 AMP Technical Specifications,* released on June 1, 2021, includes final technical specifications for all measures in the AMP program for MY 2021, and reflects

applicable changes in *HEDIS MY 2021 Volume 2: Technical Specifications Update* (released in March 2021).

- The *Preliminary MY 2021 AMP Program Guide,* released on June 1, 2021 includes AMP programmatic information such as background on AMP programs, reporting guidance, and timelines for data submission, and reflects applicable programmatic changes in *HEDIS MY 2021 Volume 2: Technical Specifications Update* (released in March 2021).
- The *Final MY 2021 AMP Program Guide,* to be released on December 15, 2021, includes all information previously included in the *Preliminary MY 2021 AMP Program Guide,* as well as additional AMP programmatic information which was not yet available in time for the release of the *Preliminary AMP Program Guide* on June 1, 2021.

Specifications in the *MY 2021 AMP Technical Specifications* that are posted to the IHA website on June 1, 2021, are frozen for MY 2021.

The HEDIS MY 2021 Medication List Directory (MLD) is available for free order on the NCQA Store page and for download in the "Download" section of My NCQA. Health plans and POs are accountable for all changes included in the corresponding *Final MY 2021 AMP Technical Specifications* and the MLD lists. Auditors assess compliance based on these.

The MY 2021 Risk Adjustment tables for the HEDIS Risk Adjusted Utilization Measures are available for free order on the NCQA Store page and for download in the "Download" section of My NCQA.

If You Have Questions About the Specifications

Policy Clarification Support

IHA partners with NCQA to maintain measure specifications used in the AMP programs. Participants who have questions regarding a measure specification should submit them through My NCQA at https://my.ncqa.org/.

Step 1 Go to the My NCQA page using the following link: https://my.ncqa.org/

Step 2 Complete the **Register** section.

Step 3 Log in and click **My Questions**.

- To ask a new question click **Ask a Question.**
- Click **PCS Policy/Program Clarification Support.**
- For *Product/Program Type,* click **IHA — AMP Programs** in the drop-down box.
- For *General Content Area,* select the appropriate category for your question.
- For *Specific Area,* scroll down and click the appropriate measure for your question, or click **Not Applicable** if your question type is not listed.
- For *Publication Year,* click **2021** for MY 2021 from the drop-down box.
- For *Subject*, enter a short subject for your question.
- Type your question (3,000 characters or less).

Step 4 Click **Submit Your Question**.

FAQs

The FAQs and Policy Updates clarify HEDIS and AMP uses and specifications, and are posted to the IHA website (www.iha.org), as needed.

Read the entire guidelines section and measure specifications before implementing MY 2021 measures.

General Guidelines for Data Collection and Reporting

For MY 2021
Health Plans and Self-Reporting POs

General Guidelines for Data Collection and Reporting

Reporting Options

1. Two Data Sources

Health plan reporting

Participating health plans produce administrative results for each of their contracted POs that have signed the Consent Agreement by submitting results related to all the clinical measures attributable to the PO's eligible population. This includes data derived from all encounters, fee-for-service claims, and in-network claims.

Health plans must follow the clinical specifications and submit results for all clinical measures on behalf of all contracted POs that have signed the Consent Agreement, regardless of PO eligibility for incentive payments from the health plan.

For Appropriate Resource Use (ARU) measures, health plans submit to the resource use data aggregator (Onpoint) member-level enrollment, claims and encounter files for all contracted POs that have signed the Consent Agreement, regardless of PO eligibility for incentive payments from the health plan. Onpoint applies the ARU measure specifications and produces PO results.

For AMP Commercial ACO reporting

For all Commercial ACO measures, participating health plans submit to Onpoint member-level enrollment, claims and encounter files for all Commercial ACO contracts, including an ACO ID, in the Member Identifier file. Onpoint applies measure specifications and produces contract-level results.

Self-reporting PO

A PO may self-report data, collecting and submitting administrative results directly to the data aggregator for any or all clinical measures.

A self-reporting PO submits clinical results based on all members belonging to a participating and contracted health plan.

IHA produces final PO rates using a combination of health plan-submitted results and PO-submitted results. For each measure, IHA determines the final rate by choosing the higher reportable rate from the aggregated health plan data or the self-reported PO data.

To begin self-reporting, a PO must contract with an organization licensed by NCQA to conduct HEDIS and compliance audits. A list of NCQA-Certified HEDIS Licensed Organizations is available here.

POs that intend to self-report in the coming year should indicate this in the annual Participation Confirmation period in November. POs can download the Provider Organization Clinical and Testing Measure File Layouts from the IHA website in the "Data Collection and Submission Resources" section.

For AMP Commercial ACO reporting

A PO may self-report data for the Commercial ACO population, collecting and submitting administrative results directly to the TransUnion for any or all clinical measures.

A self-reporting PO submits Commercial ACO results for all Commercial ACO members belonging to a participating health plan, based on the health plan Member Identifier file.

There will be no audit for MY 2021 AMP Commercial ACO reporting. An audit may be required in future reporting years.

POs can download the ACO Clinical Measure File Layout from the IHA website in the "Data Collection and Submission Resources" section, and submit unaudited data files to TransUnion according to the Data Collection and Reporting timeline in the AMP Program Guide.

Electronic data only

Regardless of data source, IHA requires that only electronic data (automated claims and encounter data and auditor-approved supplemental administrative databases) be used to calculate the measures. Sampling and the HEDIS Hybrid Methodology may not be used to collect data for the AMP programs. All reported clinical measure results must be validated through an audit review, described in *Audit Review*.

For AMP Commercial ACO reporting

Regardless of data source, IHA requires that only electronic data (automated claims and encounter data and auditor-approved supplemental administrative databases) be used to calculate the measures. Sampling and the HEDIS Hybrid Methodology may not be used to collect data for Commercial ACO reporting. For MY 2021, no audit review is required for Commercial ACO reporting.

2. Reporting Level

IHA aggregates data at the PO level. For IHA to report data at a more granular "subgroup" level for a PO (e.g., by region), all the PO's contracted health plans must be willing and able to report clinical data at the PO subgroup level. If even one health plan cannot report at the more subgroup level, all health plans must report the PO's data at the PO parent level (i.e., the "00" level). Additionally, to report final data at the PO subgroup level, the PO must have separate PAS surveys and Advancing Care Information submissions for each PO subgroup, if the PO participates in those domains.

Note: *Before enrollment in PAS, POs must decide if they can report at the PO subgroup level (most POs report at the parent level only).*

Encounter/Claims Submission

3. Submitting Data

All eligible POs—self-reporting or not—must submit encounter data to their contracted health plans throughout the year. POs should follow the dates in the Data Collection and Reporting timeline in the AMP Program Guide and other information communicated by contracted health plans to maximize the probability that their data are included in any health plan-generated PO results. Since complete encounter data is integral to accurately reflecting care provided to patients, and affects health plan and provider risk scores, full encounter submission is expected. Beginning in MY 2018, the *Encounter Rate by Service Type* measure was expanded to include facility encounters and claims.

Additionally, ENRST will again be factored into payments from health plans to POs in MY 2021 in order to place greater emphasis on the need for effective data sharing.

Although the AMP programs encourage data sharing between POs and health plans, IHA staff are not prescriptive about how this is done. POs and health plans are expected to work together early in the process to establish a data-sharing process and requirements. This may include an agreement on allowable data types, file formatting, timing, and confirmation of data received and of data use in health plan reports.

Reporting Policies

4. Handling Mergers and Acquisitions

There are a few PO acquisitions and mergers every year; each of these legal structural changes comes with its own set of complex circumstances. The IHA policy for handling mergers and acquisitions accommodates a variety of circumstances and ensures a consistent and fair process. POs undergoing a merger or acquisition should notify IHA by emailing amp@iha.org and/or make IHA aware of the merger/acquisition during the annual Participation Confirmation period each November.

5. Consent Agreement

POs must sign the Consent Agreement to confirm their participation in the appropriate AMP program(s). No data are collected or reported for POs that have not signed a Consent Agreement. IHA only makes AMP results available to POs that sign the Consent Agreement. Signed Consent Agreements are valid until such a time that a PO revokes its signed Consent Agreement.

6. Attribution to POs and Assignment to ACOs

IHA attributes patients to a PO in each of the following ways:

- Enrollment at the health plan level, communicated to the PO.
- Encounter data from the PO, including member identification or physician identification (so health plans can correctly attribute it), ***and***
- Continuous enrollment in the PO, enrollment in the PO on the anchor date, and required benefits, as specified for each measure.

For AMP Commercial ACO reporting:

IHA broadly defines ACOs to include any arrangement a participating health plan identifies as an ACO. IHA will document and use these definitions to inform subsequent discussions and decisions about standardizing Commercial ACO measurement.

All participating plans will use their own definitions of ACO, with the understanding that the models differ. Member assignment methodology varies by health plan using attribution algorithm, patient selection, plan assignment, or employer assignment.

There are three key distinguishing features of ACOs identified that are relevant to the interpretation and benchmarking of results:

- ACO participants (e.g., 2-way, 3-way or 4-way contract between health plans, POs, hospitals, pharmacy, and/or purchasers).
- Payment/incentive structure (e.g., financial risk arrangements).
- Product line (e.g., HMO, PPO, FFS).

The table below outlines the information that each participating plan will report to IHA.

Required ACO Documentation	Example
Product	• HMO • PPO • Other
Party	• 2-way (plan/PO) • 3-way (plan/PO/hospital) • 4-way (plan/PO/hospital/purchaser) • Other
Base Provider Risk Arrangement	• Global capitation • Dual capitation (separate institutional/facility payments) • Professional capitation • FFS • Other
Performance Payment	• Two-sided shared savings • One-sided shared savings • P4P quality bonus • Other
Member assignment	• Attribution algorithm • Patient selection • Plan assignment • Employer assignment
Timing	• Retrospective • Prospective
Attribution provider definition	• PCPs including OB-GYNs • PCPs excluding OB-GYNs • PCPs and specialists (non-surgical)
Attribution coverage	• All members are assigned (except HMO) • Some members left unassigned
Attribution provider exclusivity	• Member assigned to only one provider
Attribution methodology	• Plurality—provider with most visits • Temporal proximity—provider with most recent visit • Hybrid—mix of both
Attribution basis	• E&M visits • All visits
Attribution period	• 12 months • 18 months • 24 months
Attribution frequency	• Monthly • Quarterly

In addition to the information above, IHA will also collect information on the target population of the ACO in order to understand the potential impact on performance. For example, some ACOs may be formed to address specific populations or care models (e.g., high cost members, specialists managing chronic conditions). Documenting these methodologies and the rationale behind them will help inform any variation seen between ACOs for reporting. IHA will collect this information from both the plans and the ACOs. Information on attribution in ACOs can be found in *General Guideline 23: AMP Commercial ACO Continuous Enrollment & Attribution.*

7. Peer Groups

IHA defines **peer groups** as "all POs participating in a particular AMP program." POs eligible to participate in an AMP program have a valid contract with any participating health plan during the measurement year for the appropriate product. These POs have been delegated the responsibility of managing a patient population for both the primary and specialty care provided in ambulatory and inpatient settings.

8. Risk Adjustment

Clinical Quality	NCQA is the measure developer for most AMP Clinical Quality measures; therefore, IHA follows NCQA's risk adjustment protocol. NCQA's Committee on Performance Measurement (CPM) and its Board of Directors determined that risk adjustment would not be appropriate for the HEDIS Clinical Quality measures because the processes and outcomes being measured should be achieved regardless of the nature of the population. NCQA also creates or adapts the technical specifications for non-HEDIS Clinical Quality measures. Considering those measures are also process and outcome measures, NCQA determined that risk adjustment was not appropriate.
Data Quality	Data Quality measures are not risk adjusted.
Advancing Care Information	Advancing Care Information measures are not risk adjusted.
Patient Experience	For Patient Experience measures, each PO's results are adjusted for patient case-mix, to control for differences across populations. Characteristics controlled for in the case-mix adjustment model are included in the Patient Experience Specifications.
Appropriate Resource Use	Most Appropriate Resource Use measures are risk adjusted. The *Guidelines for HEDIS Risk Adjusted Utilization Measures* and individual measure specifications describe the type of risk adjustment used for each measure.
Cost	Cost is risk- and geography-adjusted. Risk adjustment is performed using the Johns Hopkins' Adjusted Clinical Grouper (ACG). Geographic adjustment is performed using the geographic adjustment factors published by CMS and based on the hospital wage index. Please see the Total Cost of Care domain for more detail on risk adjustment determination for cost.

9. Reliability Testing/Minimum Number of Observations

IHA considers measurement error and reliability for each of the two categories of measures:

- For Clinical Quality measures, the organization uses administrative data based on the PO member population. There is no sampling. Because statistical errors can result from small numbers, IHA requires a total eligible population of 30 or more for a particular measure and excludes any measure with a bias of 5 percent or more, as determined by the auditor.
- Patient Experience data are based on surveying a sample of eligible members and IHA does not use any results with reliability below 0.70.

10. Eligible Population

The **eligible population** for any measure is all members who satisfy all criteria specified in the measure, including age, continuous enrollment (including allowable gap), benefit, event, or anchor-date requirement. The rate is calculated using the eligible population after exclusions.

For AMP Commercial ACO reporting:

The **eligible population** for any measure is all members who satisfy all criteria specified in the measure, including age, continuous enrollment (including allowable gap), benefit, event, or anchor-date requirement. The rate is calculated using the eligible population after exclusions.

For MY 2021 AMP Commercial ACO reporting, participating plans will provide an ACO ID flag in the Member Identifier file provided to the IHA data aggregator. The participating plans will also provide additional information on the effective enrollment segment for the ACO flag. See *General Guideline 23: AMP Commercial ACO Continuous Enrollment & Member Attribution* for more information.

11. Optional Exclusions

Some measures allow the PO or health plan to exclude members from the eligible population who are identified as having a certain procedure or comorbidity (e.g., exclude women who have had a bilateral mastectomy from the *Breast Cancer Screening* measure).

The technical specifications contain instructions for optional exclusions, where applicable. Look for exclusions only where administrative data indicate that the specified numerator service or procedure did not occur. The PO or plan uses the eligible population to identify members for whom administrative data show the numerator services or procedures were rendered within the time frame specified in the measure, and then counts the members as having satisfied the measure (i.e., count these members in the numerator).

The PO or health plan verifies that the exclusions occurred by the time specified in the measure.

12. Product-Line Reporting

AMP clinical results must be collected and reported separately for four populations:

- The Commercial HMO population (including Exchange members).
- The Commercial ACO population.
- The Medicare Advantage population.
- The Medi-Cal Managed Care population.

Results should not include PPO members, except for Commercial ACO reporting if the ACO contract includes the PPO product line.

Note: *For AMP Commercial HMO reporting, Exchange HMO/POS members are reported with the Commercial HMO/POS population. This deviates from HEDIS health plan reporting to NCQA.*

For AMP Commercial ACO reporting:

Members are reported for each individual Commercial ACO contract, which may be in the HMO or PPO product line. If an ACO member is already included in the AMP Commercial HMO/POS population, also include that member in the applicable ACO population and report.

13. Members with Dual Enrollment

Dual enrollment is assessed using the continuous enrollment criteria in each measure. To meet criteria for dual enrollment, members must have dual enrollment at the end of the continuous enrollment period. Per *General Guideline 20: Members Who Switch Products/Product Lines*, if a measure allows a gap at the end of the continuous enrollment period, members must have dual enrollment as of the last enrollment segment.

This guideline must be used consistently across all measures.

For measures without a continuous enrollment requirement, members must have dual enrollment on the date of service or the date of discharge.

Dual Commercial/ Medi-Cal Managed Care enrollment	Members with dual Commercial HMO and Medi-Cal Managed Care enrollment must be reported in the AMP Commercial HMO reports. These members may be excluded from the AMP Medi-Cal Managed Care reports.
Dual Medi-Cal Managed Care enrollment	Members dually enrolled in two AMP Medi-Cal Managed Care plans must be reported in the primary AMP Medi-Cal Managed Care report. The secondary Medi-Cal Managed Care payer may exclude a member whose primary Medi-Cal Managed Care enrollment was offered through a different organization.
Dual Commercial enrollment	**Enrollment in different organizations:** Do not account for coordination of benefits with other insurance carriers. If members have Commercial enrollment in two organizations, both organizations must include the members in their AMP Commercial HMO reports, regardless of the primary insurer. For example, dependent children who are enrolled in one organization's Commercial product line under the Parent A's insurance and in another organization's Commercial product line under the Parent B's insurance, are included in both AMP Commercial HMO reports. **Enrollment in the same organization:** Adhere to the following criteria for members with dual Commercial enrollment (e.g., children enrolled under each parent): • *If members are enrolled twice in the same product and there is only one AMP Commercial HMO submission,* include them only once in the submission. • *If products are reported separately,* include members with dual enrollment in both products in both AMP Commercial HMO submissions. • *If the different product types are reported combined,* include members once in the combined submission.
Dual Commercial/ Medicare Advantage enrollment	Members with dual Commercial and Medicare Advantage enrollment must be included only in the product line that provides their primary enrollment (Commercial or Medicare Advantage).

Self-reporting POs that are unable to identify the primary insurer should use their best judgment; the overall impact is expected to be minimal and equal across plans and POs.

Dual Medi-Cal Managed Care/ Medicare Advantage enrollment "dual eligible"

Include these members in *both* the AMP Medi-Cal Managed Care and AMP Medicare Advantage reports *only* if they are enrolled in the organization's Medicare contract required to report *and* in the organization's Medi-Cal Managed Care contract.

This decision must be applied consistently across all applicable measures.

Medicare Advantage-Medi-Cal Managed Care (MMP)

These members must be included in both the AMP Medi-Cal Managed Care and AMP Medicare Advantage reports.

Note: *The dual Medi-Cal Managed Care/Medicare Advantage enrollment "dual eligible" and MMP sections of this guideline apply to all measures, except for PCR. For PCR, remove these members from Medi-Cal Managed Care reporting and only include them in Medicare Advantage reporting.*

14. Reporting ASO and Self-Insured Members

Administrative Services Only (ASO) and self-insured members

Include ASO and self-insured members in the health plan/PO AMP Commercial HMO and ACO reports. Organizations may use different terms for these members, including, but not limited to, "no-touch," "self-funded" or "third party administrator (TPA)." Health plans/POs may exclude these members from AMP Commercial HMO and ACO reports in only either of the following situations and only with **auditor approval.**

- The contract prohibits the health plan/PO from contacting members for any reason.
- The **contractual agreement**, which is a contract or other written agreement between the organization (i.e., HMO, ACO) and the ASO client (e.g., employer), states that the health plan/PO may not contact these ASO and self-insured members under any circumstances or include them in reporting.
  Note: *Exclusion from disease management, case management or quality improvement projects does not meet criteria for exclusion from reporting.*
- The agreement to exclude members in the reporting year is in place (fully executed by both parties, in the case of a contract, or communicated, in the case of a written agreement) by January 1 of the measurement year.
- The health plan/PO is not responsible for administering both in-network and out-of-network claims for ASO and self-insured members (i.e., employer carve-out for both in-network and out-of-network claims).
  Note: *If claims are administered through a third party on behalf of the plan/PO (i.e., claims delegation arrangement), the plan/PO is considered responsible for administering claims and may not exclude members.*

A health plan/PO may not exclude members who cannot be reached (e.g., overseas military or Foreign Service members), unless one of the above situations applies. Non-ASO members may not be excluded under this

guideline. Federal government instructions and guidance supersede the requirements in this guideline.

Exclusion of these members must be reviewed with the auditor, and contracts should be provided to the auditor to review and approve the exclusion.

If the organization excludes these ASO and self-insured members, it must also exclude them from AMP Commercial HMO reporting.

15. Members in Hospice

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

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

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

Note

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

16. Members Who Refuse Services

It is AMP program policy that patient refusal of services is not a sufficient reason for exclusion from the denominator of any measure. The AMP measure set is continually monitored and vetted by the AMP Committees to ensure that measures are evidence-based, valid, and clinically relevant to the AMP population. The stakeholder-led committees governing the AMP programs agree that measures are developed based on clinical guidelines which are intended to apply for the majority of patients but are not intended to replace clinical judgment or patient choice. Further, no guideline is expected to be followed 100 percent of the time, and the impact of patient refusal of services is expected to be minimal and impact all POs equally.

17. Deceased Members

Members who die during the measurement year are treated as an optional exclusion. Refer to the *General Guideline 11: Optional Exclusions*. These members may be identified using various methods that include, but are not limited to, enrollment data, claims/encounter data, or supplemental data.

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

OSU and GRX).

The exclusion of deceased members is subject to auditor review.

Note

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

Membership Changes

18. Members Who Switch Health Plans or POs

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 for the entire period of continuous enrollment specified in the measure.

A health plan or PO that reports these members as continuously enrolled must follow the same definition of "continuous enrollment" as in *General Guideline 21: Continuous Enrollment and Allowable Gaps*, and all other guidelines affecting continuous enrollment (allow switching between products [HMO, POS, PPO, EPO] or product lines [Commercial HMO/POS, Commercial ACO, Medicare Advantage, Exchange, and Medi-Cal Managed Care]) consistently across all measures. For example, switching from a Commercial HMO/POS to an Exchange HMO/POS is not considered a gap in enrollment.

19. Members Who Switch Health Plans or POs as the 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.

20. Members Who Switch Products/Product Lines

Measures with a continuous enrollment requirement	Members enrolled in different **products** or **product lines** (Commercial HMO/POS, Commercial ACO, Medi-Cal Managed Care, Exchange, Medicare Advantage) in the time specified for continuous enrollment for a measure are continuously enrolled and are included in the product and product-line specific

AMP report in which they were enrolled as of the end of the continuous enrollment period. For example, a member enrolled in the Commercial product line who switches to the Medicare Advantage product line during the continuous enrollment period is reported in the AMP Medicare Advantage report. If a measure allows a gap at the end of the continuous enrollment period, report members in the product and product line-specific AMP report in which they were enrolled as of the last enrollment segment.

Members who "age in" to a Medicare Advantage product line mid-year are considered continuously enrolled if they were members of the organization through another product line (e.g., Commercial) during the continuous enrollment period and their enrollment did not exceed allowable gaps.

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

Enrollment in a Medicare Private Fee-for-Service (PFFS) plan is considered a gap in HMO/POS 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 AMP report in which they were enrolled on the date of service (outpatient, ED or observation visits) or date of discharge (inpatient stays).

Required Enrollment Periods and Benefits

21. Continuous Enrollment and Allowable Gaps

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

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

An **allowable gap** can occur at any time during continuous enrollment. For example, the *Comprehensive Diabetes Care* measure requires continuous enrollment from January 1–December 31 and allows one gap of up to 45 days. A member who enrolls for the first time on February 8 of the measurement year is considered continuously enrolled if there are no other gaps throughout the remainder of the measurement year (the member had a 38-day gap, January 1–February 7).

Enrollment in a Medicare Advantage Private Fee-for-Service (PFFS) plan is considered a gap in HMO/POS enrollment.

22. Medi-Cal Managed Care Continuous Enrollment

If the organization applies a full-month eligibility criterion to Medi-Cal Managed Care beneficiaries and verifies enrollment prospectively in monthly intervals (in 1-month increments), the one gap in enrollment

during the continuous enrollment period may not exceed 45 days. For example, a member whose coverage lapses for 2 months (60 days) is not considered continuously enrolled.

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

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

23. AMP Commercial ACO Continuous Enrollment & Member Attribution

IHA broadly defines ACOs to include any arrangement a participating health plan identifies as an ACO. As such, member assignment methodology varies by health plan using attribution algorithm, patient selection, plan assignment, or employer assignment. At the inception of the AMP ACO program, IHA reviewed Onpoint-generated ACO measure results based on health plan data and found that applying continuous enrollment and member attribution to an ACO contract using current measure specifications at the plan-PO level significantly decreased ACO members for reporting. Given the differences in Commercial HMO and Commercial ACO contracting arrangements, IHA has modified the approach in order to ensure reasonable and valid results for ACO reporting.

Continuous Enrollment

The AMP Commercial ACO program does not apply continuous enrollment at the plan-PO level for Onpoint-generated results using health plan data, as the AMP Commercial HMO program does. For Onpoint-generated AMP Commercial ACO results, continuous enrollment specifies the minimum amount of time a member must be enrolled in the *health plan* (not the specific ACO) before becoming eligible for a measure. The member must also be continuously enrolled in the benefit specified for each measure (e.g., medical and/or pharmacy), accounting for any allowable gaps, to be considered continuously enrolled. The continuous enrollment period, allowable gaps and anchor date are specified in each measure. For Commercial ACO attribution, participating plans' own attribution or assignment of members is leveraged. The attribution process detailed in the ***Member Attribution*** section below will be used throughout Commercial ACO reporting to attribute a member's measure results to the appropriate ACO for the measurement year.

For MY 2021 Commercial ACO reporting, participating plans will provide an ACO ID for each of their members in the Member Identifier file submitted to Onpoint. The ACO ID for each ACO-plan contract assigns members to an ACO at the member-month level. The Member Identifier file also includes detail around the effective time period, product line, risk type, etc., in addition to PO and ACO enrollment information. This information will be used to attribute members to an ACO using the process detailed below in the ***Member Attribution*** section. Continuous enrollment requirements for Onpoint-generated Commercial ACO results using health plan data will remain only at a health plan level and do not take ACO enrollment periods into consideration.

Participating plans will receive a layout for the Member Identifier file as part of the Data Submission Guide (DSG) from Onpoint. Health plans will provide member eligibility and enrollment segment information to any participating, contracted ACOs that will be self-reporting measures for the AMP Commercial ACO program, to use as reference in calculating their self-reported results. To note, results for self-reporting ACOs may differ from health plan results generated by Onpoint due to the differences in data capture and approach.

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

With the member month or other enrollment segment flags described above, the gaps will be translated from the enrollment segments provided by the plan. For example, if the plan identifies member month eligibility for January and February of the measurement year and April–December of the measurement year, the month of March—or 31 days—is considered a gap because the member was continuously enrolled from January 1–February 28 of the measurement year and again from April 1–December 31 of the measurement year.

An **allowable gap** (less than 45 days) can occur at any time during continuous enrollment. For example, the Comprehensive Diabetes Care measure requires continuous enrollment from January 1–December 31 and allows one gap of up to 45 days. A member who enrolls for the first time on February 1 of the measurement year is continuously enrolled if there are no other gaps throughout the remainder of the measurement year (the member had a 31-day gap, January 1–31).

See *General Guideline 27: Continuous Enrollment for Self-Reporting POs* for information on determining continuous enrollment for self-reported ACO results.

Member Attribution

Once continuous enrollment criteria have been met for a measure at the plan level, the "Frequency and Last Record Hierarchy" approach is used to attribute a member to an ACO. The ACOs are ranked based on length of enrollment for a member for the measurement year and then attributed to the ACO they are affiliated with for longest time. If a member belongs to more than one ACO for equal time, a tiebreaker is determined using the most recent ACO the member was associated with. To note, member assignment to an ACO contract is determined by the health plans in the Member Identifier file to Onpoint. Onpoint uses this data to attribute measure-eligible member for ACO reporting.

24. Continuous Enrollment Over Multiple Years

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

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

25. Anchor Dates

If a measure requires a member to be enrolled and to have a benefit on a specific date, the allowable gap must not include that date; the member must also have the benefit on that date. For example, a 55-year-old with only one gap in enrollment from November 30 of the measurement year through the remainder of the year is not eligible for the *Colorectal Cancer Screening* measure. Although the member meets the continuous enrollment criterion, the member does not meet the anchor date criterion, which requires enrollment as of December 31 of the measurement year.

26. Continuous Enrollment for Health Plans

For each measure, members are assessed for continuous enrollment in the health plan and continuous enrollment in the PO (parent level).

Plans that report AMP measures determine continuous enrollment using the following steps.

Step 1 Determine if the member was continuously enrolled in the plan, including allowable gaps.

Step 2 Determine if the member was continuously enrolled in the PO (parent level), including allowable gaps.

Step 3 Determine if the member was enrolled in the plan and the PO (parent level) on the anchor date.

Step 4 For POs eligible to report at the subgroup level, determine the subgroup to which the member was assigned on the anchor date.

27. Continuous Enrollment for Self-Reporting POs

The AMP measures require calculation of continuous enrollment at the PO parent level. POs that self-report AMP measures determine continuous enrollment using the following steps.

Step 1 Determine if the member was continuously enrolled in the PO (parent level), including allowable gaps.

Step 2 Determine if the member was enrolled in the PO (parent level) and a participating health plan on the anchor date.

Step 3 For POs eligible to report at the subgroup level, determine the subgroup to which the member was assigned on the anchor date.

For AMP Commercial ACO reporting:

For each measure, self-reporting ACOs assess members for continuous enrollment (attribution or assignment) in the Commercial ACO contract.

As described in *General Guideline 23*: *AMP Commercial ACO Continuous Enrollment*, health plans will provide a Member Identifier file to Onpoint, along with an ACO flag for enrollment segments, to establish continuous enrollment and attribution for Onpoint-generated Commercial ACO results. This information will also be shared with the POs that have ACO contracts with the participating plans, for use in identifying the eligible population in each ACO measure for ACO self-reporting. The continuous enrollment period, allowable gaps and anchor date are specified in each measure.

POs self-reporting ACO results should determine continuous enrollment using the following steps.

Step 1 Determine if the member was continuously enrolled (attributed or assigned) to the ACO contract, including allowable gaps.

Step 2 Determine if the member was enrolled (attributed or assigned) in the ACO on the anchor date.

Note

- *Each PO approved to self-report at the subgroup level must also ensure that all plans reporting data for its report at the subgroup level.*

- *Members assigned to a PO must be included, whether they sought services from the PO.*
- *Members who change subgroups within a PO during the continuous enrollment period are considered continuously enrolled as long as they meet the other continuous enrollment criteria.*

28. Required Benefits

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

Some measures require benefits in addition to medical (e.g., pharmacy) as part of the eligible population criteria. Health plans and POs must determine which benefits a member has before including the member in a measure.

…at the health plan/PO level

Health plans and POs must report AMP measures that require a specific benefit if the plan provides the benefit, either directly or through a contractor. Health plans and POs are not required to report measures that require a benefit that the plan 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 organization 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 the benefit specified in the measure should not be counted in that measure by health plans or POs. For example, the *Disease-Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis* measure requires a pharmacy benefit. Exclude members who do not have a pharmacy benefit. When members are dual enrolled, organizations must assess the benefit requirements based on the submission in which the member is included, refer to *General Guideline 13: Members With Dual Enrollment*.

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 example, in the *Generic Prescribing* measure, for a member whose pharmacy benefit is exhausted on November 1 of the measurement year, report only the selected procedures that occurred from January 1–October 31.

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 health plans and POs can obtain the necessary information from a carved-out entity and may include these members in the measures. For example, if an employer contracts directly with a pharmacy benefit manager (PBM) that shares pharmacy information, the health plan and PO may include the employer's members in the measure.

Organizations must apply the optional guidelines for exhausted and carved-out benefits consistently across all measures.

Data Collection

29. Administrative Method

The **Administrative Method** of data collection requires health plans and POs to use transaction or supplemental electronic clinical data from acceptable sources (e.g., administrative databases, registries, electronic health records [EHR]). The PO's reported rate is based on all members who meet the eligible population criteria (after optional exclusions, if applicable) and who are found, through administrative data, to have received the service identified in the numerator.

30. What Services Count?

For Clinical Quality measures, health plans and self-reporting POs should follow the *Guidelines for Clinical Quality Measures*. For ARU measures, Onpoint will generate measure results following the *Guidelines for HEDIS Utilization Measures* **and** *Guidelines for HEDIS Risk Adjusted Utilization Measures*. Health plans should submit to Onpoint all services for which the organization actually paid or expects to pay (i.e., claims incurred but not paid). Do not include services and days denied for any reason. In cases where a member is enrolled retroactively, count all services for which the organization has paid or expects to pay.

31. Supplemental Data

Supplemental data uses

To supplement claims data for calculating AMP measures, organizations may use sources other than claims and encounters to collect data about their members and about delivery of health services to their members. Validation and review of these data differ by the processes used to collect and report them.

Supplemental data may help determine:

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

Supplemental data may not be used for:

- Denominator events. Organizations *may not* create and use records to identify denominator events, other than for optional exclusions and required exclusions.

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

Supplemental Data Definitions

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

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

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

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, and how they are validated and used for AMP 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 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 EHRs.
  - State- or county-sponsored immunization registry records.

Proof-of-service documentation that is *not allowed:*

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

Continuity of Care Documents (CCD)

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

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

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

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 the 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 files must have all the data elements required to meet the 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 administrative measure specification.
- Evidence of provider accountability from the practitioner or practitioner group (signed contracts with accountability tied to passwords, e-signatures, or NPI/TIN 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 NPI/TIN is not required; however, documentation of NPI/TIN 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). Refer to *General Guideline 39: Member-Reported Services and Biometric Values* for more information about member-reported data.

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 33: Date Specificity* for date specificity requirements).

When pharmacy data are classified as supplemental data, all data elements from the NDC lists must be present: the generic name (or brand name), strength/dose, route, and date when the medication was dispensed to the member. A dispensed date is required; other dates (e.g., start date, shipped date) may not be used as a proxy. 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 exclusion must follow the requirements for exclusion in each measure.

Supplemental data sharing between POs and health plans

Health plans that use supplemental data collected for AMP measures must include all elements required by measure specifications and meet all requirements for standard and nonstandard supplemental data. Health plans that intend to use audited supplemental data from POs must complete *Roadmap Section 4* and submit it with the Roadmap that is due by January 31.

Supplemental Data Timeline

Supplemental data may be collected during the measurement year and into the beginning of the reporting year. All supplemental data must follow the Data Collection and Reporting timeline requirements.

Health plans that use audited PO supplemental data should receive the audited data files and PO auditor's final audit results from the PO by the deadline listed in the Data Collection and Reporting timeline in the AMP Program Guide. The health plan should receive all supporting documents for each supplemental data source (e.g., PO *Roadmap Section 4,* data file layouts, training materials) at the time the Roadmap is submitted to the auditor. The PO is responsible for sending the health plan all necessary documentation to support the use of supplemental data.

Refer to the Data Collection and Reporting timeline in the AMP Program Guide for all deadline requirements.

Identifying and Validating Supplemental Data

All supplemental data (standard and nonstandard) must be identifiable. Because supplemental data can affect reporting and incentives, POs, plans, or vendors that include supplemental data files for AMP reporting must mark the supplemental 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).

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

- A completed current year's *Supplemental Data* section of the PO *Roadmap Section 4,* including all attachments.
- Impact of supplemental data source, by measure (e.g., lists of numerator-positive hits from the supplemental data, by measure; year-to-year comparisons of percentage increases associated with supplemental data; proportion of numerator compliance from supplemental data).
- Primary source verification, where required or requested by the auditor.

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

For additional details about audit requirements for supplemental data, refer to the *MY 2021 Audit Review Guidelines,* released in November 2021.

Note: *Only health plans that participate in the AMP programs may use audited PO supplemental data for their NCQA HEDIS submission. The PO must provide the health plan with a completed Roadmap section for each supplemental data source, all applicable attachments, the auditor's review findings. Health plans are not required to also collect the proof-of-service documents for these audited and approved PO data. Refer to the MY 2021 Audit Review Guidelines, released in November 2021.*

32. Date of Service for Laboratory Tests

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

Order date and documented date are not eligible for use in AMP 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 as nonstandard supplemental data, the documentation must include the test date and the result (or evidence that the test was performed).The result/reported date can be used as the test date.

In addition, a health plan/PO may consider all events with dates no more than seven days apart to be the *same* test and may use the collected date for reporting. For example:

- If a test had a collection date of December 1 and a reported date of December 8, these dates are not more than seven 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 seven days apart and may not be considered the same test.
- If a member had an HbA1c test collected on December 28 of the measurement year and a HbA1c test result on January 2 of the year after the measurement year, the dates are within seven days and can be considered the same test. The result is present and the collection date is eligible for use.
- If a member had an HbA1c test collected on December 28 of the measurement year and a HbA1c test result on January 15 of the year after the measurement year, the dates are not within seven days and cannot be considered the same test. There is no result for the HbA1c test collected on December 28 and the member will not be numerator compliant for the *HbA1c Control <8%* if the HbA1c level is <8.0%.

33. Date Specificity

HEDIS requires that a date be specific enough to determine that an event occurred during the time established in the measure. IHA follows NCQA's date specificity protocol. For example, in the *Childhood Immunization Status* measure, members should receive three hepatitis B vaccines. For MY 2021, assume a member was born on February 5, 2019. 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 2021, 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; these include most optional exclusions and measures that look for events in the "measurement year or the year prior to the measurement year." Terms such as "recent," "most recent," or "at a prior visit" are not acceptable.

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

34. Collecting Data for Measures With Multiple Numerator Events

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

- Childhood Immunization Status.
- Immunizations for Adolescents.
- Cervical Cancer Overscreening.

For only the measures listed above, the organization may use a single data source or a combination of administrative data, which may include audited supplemental data to determine numerator compliance for members in the denominator. To avoid double-counting, 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.

35. Measures That Use Medication Lists

Some measures require the use of available clinical pharmacy data or pharmacy claims data to identify dispensed medications.

The specifications reference medication lists that must be used for AMP reporting for each pharmacy-dependent measure. In the specifications, medication list references are underlined (e.g., ACE Inhibitor/ ARB Medications List). Medication lists used for AMP reporting are included in the HEDIS 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.

36. Identifying Events/Diagnoses Using Laboratory or Pharmacy Data

Many organizations find a high rate of false positives when they use laboratory data to identify members with a disease or condition. Diagnosis codes are frequently reported on laboratory tests in cases where the condition is being ruled out. Use laboratory claims and data only for the Pregnancy Tests Value Set and the Sexual Activity Value Set (which do not contain LOINC[2] codes) and value sets that contain LOINC codes.

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

Diagnosis codes on pharmacy claims may not be used.

Note: *This guideline does not apply to the ENRST measure. POs and plans should include all encounters that meet the measure criteria based on the current ENRST measure specifications, even those that include POS code 81 on the claim.*

37. Facility Data

With the exception of ARU and certain maternity measures, AMP measures do not *require* facility data (e.g., inpatient, ED) for reporting rates, but facility data may be used as specified. Professional codes associated with facility-based events may help capture some services, such as ED care for asthmatics.

[2]LOINC® is a registered trademark of the Regenstrief Institute.

38. Member-Collected Samples

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

39. 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 2 for the definition of "PCP"), or by a specialist who 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.

Coding Conventions

40. Coding Systems Included in AMP[3] Reporting

AMP measures include codes from the following coding systems:

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

41. Presentation of Codes in AMP Value Sets

A **value set** is the complete set of codes used to identify the service or condition. Measure specifications reference value sets that must be used for AMP reporting. In the specifications, value set references are capitalized and underlined (e.g., Essential Hypertension Value Set). Only use the codes included in the value sets for AMP reporting.

Value sets used for AMP reporting are included in the Value Set Directory (VSD), which can be downloaded here.

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42. Telehealth

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

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

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

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

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

Many measures require that a visit code or procedure code be used in conjunction with a diagnosis code. Some measures (e.g., *Osteoporosis Management in Women Who Had a Fracture*) require that a visit code be used in conjunction with another procedure code (e.g., fracture fixation).

Except for inpatient stays (as described below) and unless otherwise stated 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 (health plan or PO) 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 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.

Note: *If sharing supplemental data between a PO and plan, the plan and PO should work together to ensure clear data submission processes between the PO and plan.*

44. Visits that Result in an Inpatient Stay

Some measures require exclusion of online assessments, telephone, outpatient, ED, or observation visits that result in an inpatient stay or observation stay.

When the visit and the stay are billed on separate claims, the 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). A visit billed on the same claim as a stay is considered a visit that resulted in a stay.

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45. Principal vs. Secondary Diagnosis

Principal and secondary diagnoses are mentioned throughout the specifications. Generally, a **principal diagnosis** or a **primary diagnosis** is the diagnosis given at discharge and is listed in the first position on a claim/encounter form. A **secondary diagnosis** is any diagnosis listed on a claim or encounter form that is not classified as the principal diagnosis. A claim or encounter can contain several secondary diagnoses. Organizations should follow the measure specifications to determine if a diagnosis must be the principal diagnosis or if it can be secondary. If the specification does not state that the principal or primary diagnosis must be used, any applicable diagnosis must be used.

Some measures require a specific principal diagnosis for a member to be in the eligible population; other measures allow any diagnosis (principal or secondary) for a member to be eligible. For example, the *Comprehensive Diabetes Care* measure specifies a member with any diagnosis of diabetes as eligible. If a member's claim lists the principal diagnosis as severe head injury trauma, but diabetes is listed as a second, third, fourth or fifth diagnosis on the same claim, the member should be included in the *Comprehensive Diabetes Care* measure. If the measure specifies that a principal diagnosis is required, health plans and POs should search for only the principal diagnosis (e.g., identifying the eligible population for the *Asthma Medication Ratio* measure*).*

The concept of "principal," "primary," 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.

46. Code Modifiers

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

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

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

47. 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).

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48. Uniform Bill Codes Specificity

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

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

Note: *Three-digit versions of the codes are not included in the Value Set Directory.*

49. Mapping Proprietary or Other Codes

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

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

For audit purposes, health plans and POs should document the method used to map codes. At a minimum, documentation should include a crosswalk containing the relevant codes, descriptions and clinical information.

Health plans and POs document the process for implementing codes. Auditors may request additional information.

50. Retiring Codes

NCQA annually tracks billing, diagnostic, procedure, and NDC codes that are designated obsolete. NCQA does not remove codes in the year in which they receive the designation of obsolete because of the look-back period in many HEDIS measures. Obsolete codes are deleted from the AMP specifications one year after the look-back period is exhausted. For example, since the *Asthma Medication Ratio* measure counts a principal diagnosis of asthma in the measurement year or the year prior to the measurement year, for this measure, asthma codes have a two-year look-back period.

A code that is designated obsolete effective January 1, 2019, is deleted from the specifications in MY 2021 after the two-year look-back period (2020, 2021) plus one additional year (2019) is exhausted.

51. Table Names

Measure specifications contain tables to present specification requirements. A standardized naming system is used to refer to the tables.

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

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Data Submission

52. Reporting Small Numbers

Health plans and POs must report all available denominators, numerators and rates to the data aggregator even if the denominators are small. Only measures with aggregated denominators (the total for all health plans) of 30 or more are recommended for payment and public reporting. Measures with denominators less than 30 will be publicly reported as "Too Few Patients in Sample to Report." This guideline only applies to measures in the Clinical Quality Domain. Please refer to the *AMP Program Guide* for more information on denominator requirements for payment and public reporting of measures in the AMP programs.

53. Reporting Date

The previous calendar year is the standard measurement year for AMP clinical data. IHA supplies the data submission file format to POs and health plans, and the Certified Auditor validates and locks the submission file before it is sent to TransUnion HealthCare. All health plan and PO-reported audited clinical data should be submitted to TransUnion HealthCare on or before the date specified in the Data Collection and Reporting timeline in the AMP Program Guide.

For AMP Commercial ACO reporting:

The previous calendar year is the standard measurement year for the ACO clinical data. All ACO-reported clinical data should be submitted to TransUnion HealthCare on or before the date specified in the Data Collection and Reporting timeline in the AMP Program Guide.

Note

- *POs that use TransUnion HealthCare as the encounter data intermediary must submit all Q1–Q4 2021 encounter data to TransUnion HealthCare by February 11, 2022. No new data will be accepted after this deadline. POs that use a different data intermediary or supply encounters directly to health plans should confirm the final acceptance date of encounter data to be included in AMP reporting.*
- *Self-reporting POs and health plans must submit auditor-locked AMP clinical results by May 6, 2022. Health plans must submit results for all clinical measures for each contracted PO with a signed Consent Agreement.*

54. Required Data Elements

Health plans and POs should report data based on all services delivered through December 31 of the measurement year, not encounters submitted or claims paid through that date. Data elements that must be submitted for each measure are listed below.

- Record type (Header—HDR, Detail—DTL, Trailer—TRL).
- PO ID (parent level, or subgroup level, for eligible POs).
- Enrollment (HMO and POS separately) with the PO as of December 31 of the measurement year.
- Measure ID.
- Numerator.
- Denominator.
- Rate.
- Audit result.
- Vendor ID (for NCQA-Certified vendors).

The Certified Auditor approves and locks the submission file before it is sent to TransUnion HealthCare.

For AMP Commercial ACO reporting:

ACOs should report data based on all services delivered through December 31 of the measurement year, not encounters submitted or claims paid through that date. Data elements that must be submitted for each measure are listed below.

- Record type (Header—HDR, Detail—DTL, Trailer—TRL).
- ACO ID (IHA will assign).
- ACO enrollment as of December 31 of the measurement year (must match plan-provided enrollment).
- Measure ID.
- Numerator.
- Denominator.
- Rate.

The Audit Review

55. Audit Review Principles

IHA requires health plans and self-reporting POs to undergo an audit review of clinical results conducted by an NCQA Certified Auditor. This review ensures that results are an accurate report of PO performance. The Audit Review incorporates relevant components of the HEDIS Compliance Audit described in the current volume, *HEDIS Compliance Audit™: Standards, Policies and Procedures*. A separate manual with Audit Specifications will be posted to the IHA website in November 2021. In MY 2021, audit is only required for AMP Commercial HMO/POS, Medicare Advantage and Medi-Cal Managed Care reporting. **Audit requirements do not apply to AMP Commercial ACOs for MY 2021.**

The underlying principles of the Audit Review are:

- Ensure accurate, reliable, publicly reportable data that can be used to compare POs.
- Verify that measure calculation processes conform to technical specifications, including, but not limited to, use of administrative only data, correct calculation of encounter rates, and appropriate application of continuous enrollment requirements.
- Assess information system capabilities and evaluate an organization's ability to process medical, member, and practitioner information to report clinical measures accurately.
- Ensure consistency across audit reviews by having the audit review conducted by an NCQA Licensed Organization and a Certified HEDIS Compliance Auditor using NCQA's standard audit methodology.

The audit review is conducted during the data collection process, allowing the auditor to detect errors while there is time to correct them and minimize the possibility of a *Biased Rate (BR).* The audit review process includes various tasks and requirements to ensure accurate data reporting. A PO that does not self-report clinical measures does not need an audit.

56. Audit Components

Audit review components depend on the reporting option.

Health plan reporting

A health plan that undergoes a HEDIS Compliance Audit and also reports AMP data on behalf of contracted POs must have a Certified Auditor review the PO results. The auditor reviews and confirms any additional activities required for calculating results at the PO level, including the following:

- The health plan's ability to attribute members to POs, including enrollment spans, and report the data at the PO level.
- The health plan's ability to produce AMP measures according to specifications.
- The algorithms and source code used to report rates by PO.

PO self-reporting

A PO that collects and reports clinical measures must undergo an audit review adapted from NCQA's HEDIS Compliance Audit. The review includes all PO-relevant HEDIS Compliance Audit standards and policies and procedures described in the *Audit Review Guidelines*.

Note: *Health plans that use supplemental data audited at the PO are not required to collect the proof-of-service documents also. Refer to the Audit Review Guidelines released in November 2021.*

57. Audit Results

In MY 2021, audit is only required for Commercial HMO, Medicare Advantage, and Medi-Cal Managed Care reporting. This section does not apply to Commercial ACOs.

Audit Reviews result in audited rates at the measure level and indicate if a measure can be publicly reported. All clinical and encounter rate measures where applicable, must have a final, audited rate/ result.

Health plan results

Audit reviews for health plans provide assessments for each of their contracted POs, indicating each measure's suitability for data aggregation. The auditor gives a designation for the rate of each measure included in the audit, as shown in the table below.

Rate/Result	Description	Notes
0–XXX	Reportable	A reportable rate was submitted for the measure. The rate of 0 includes instances when the health plan calculated the rate but found that no members met the criteria specified in the denominator.
BR	Biased Rate	The calculated rate was materially biased. The auditor determines a result is not reportable due to material bias.
NR	Not Reported	The health plan chose not to report the measure (may only be used for testing measures).
*NB**	No Benefit	The health plan did not offer the health benefit required by the measure (e.g., pharmacy).

*Benefits are assessed at the global level, not at the service level (refer to *General Guideline 28: Required Benefits*).

Note: *Small Denominator ("SD") is not a valid Rate/Result for health plan clinical data because IHA aggregates all health plan/PO data together for final PO clinical results. If a health plan reports a measure with a denominator of less than 30, the health plan should also report the numerical rate for that measure (i.e., do not report "SD" as the rate).*

PO results

For self-reporting POs, audit results indicate the suitability of each measure for public reporting. The auditor approves the rate or result of each measure included in the audit, as shown in the table below.

If the denominator for any measure is 0, the result should be 0, BR, NB, or NR. The rate of 0 indicates that the PO calculated the measure but no members met the criteria specified for the denominator.

Rate/Result	Description	Notes
0–XXX	Reportable	A reportable rate was submitted for the measure. The rate of 0 includes instances when the PO calculated the rate but found that no members met the criteria specified in the denominator.
BR	Biased Rate	The calculated rate was materially biased. The auditor determines a result is not reportable due to material bias.
SD	Small Denominator	The PO followed the specifications but the denominator was too small to report a valid rate.
*NB**	No Benefit	The health plan did not offer the health benefit required by the measure (e.g., pharmacy).
NR	Not Reported	The PO chose not to report the measure.

*Benefits are assessed at the global level, not the service level (refer to *General Guideline 28: Required Benefits*).

58. Multiple Audit Designations

Measures with multiple rates may have multiple audit results. For example, it is possible for the Childhood Immunization measure to be assigned a reportable rate for the MMR rate but BR for VZV.

59. Material Bias

Any error that causes a (+/-) 5 percentage point or greater difference in the reported rate is considered materially biased and receives *BR* for the affected measures.

60. Marketing

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

Organizations that refer to the audit or to data audited by a Certified HEDIS Compliance Auditor must adhere to the guidelines.

Clinical Quality Domain Technical Specifications

For AMP MY 2021
Health Plans and Self-Reporting POs

Overview

This section includes the AMP program technical specifications for use in collecting California PO clinical performance data in 2022 for MY 2021. The AMP program specifications are based on HEDIS measures and non-HEDIS measures. NCQA adapts measures for assessing performance at the PO level. All measures are collected using administrative data systems, including EHRs, registries and other clinical databases. The Hybrid Methodology or medical chart review *is not* permitted and hybrid specifications have been removed from respective HEDIS measures.

The following Clinical Quality Domain Technical Specifications apply to health plans and self-reporting POs. Differences between the native measure specifications and the Clinical Domain Technical Specifications are clearly noted under each measure's *Modifications From [HEDIS/PQA]* section. It is the policy of the AMP program to change native measure specifications only if the specifications are not possible for the program (e.g., they include manual chart review), or there is a very compelling reason to differ from the native specification.

Guidelines for Clinical Quality Measures

GUIDANCE UPDATES JUNE 2021 FOR AMP MY 2021

- Added clarifying language on which services count for the PDC, SUPD and COB measures.
- Added clarifying language on continuous enrollment for Commercial ACO.

GUIDANCE UPDATES SEPTEMBER 2020 FOR AMP MY 2021

- None.

Guidelines

Which services count?

Unless otherwise specified in a measure, report all services for the Clinical Quality 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 for the following measures in the Clinical Quality domain:*

- *Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis.*

Denied claims are not included when identifying the eligible population (except for required exclusions) or numerator events for the following measures in the Behavioral Health & Substance Use subdomain:

- *Use of Opioids at High Dosage.*

Organizations must include all claims (paid, suspended, pending, and denied) for required exclusions in all measures in the Behavioral Health & Substance Use subdomain.

Only paid, non-reversed prescription claims are included in the PDC, SUPD and COB measures. See definition of prescription claims in individual measure specifications.

Optional exclusions

Some measures in the Clinical Quality domain allow members to be excluded from the denominator if they are identified as having a certain procedure or comorbidity (e.g., exclude women who have had a bilateral mastectomy from the *Breast Cancer Screening* measure).

The technical specifications contain instructions for optional exclusions, where applicable. Look for exclusions only where administrative data indicate that the specified numerator service or procedure did not occur. The organization uses the eligible population to identify members for whom administrative data show the numerator services or procedures were rendered within the time frame specified in the measure, and then counts the members as having satisfied the measure (i.e., count these members in the numerator).

The organization verifies that the exclusion occurred by the time specified in the measure.

Measure format

There are 8 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. Exclusion.
8. Notes.

Eligible population criteria

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

1. **Product line** (Commercial HMO/POS, Commercial ACO, Medicare Advantage, Medi-Cal Managed Care) applicable to the measure.
2. **Age** group and gender requirements.
3. **Continuous enrollment** criteria for the measure.

   Note: *For measures reported in the Commercial ACO product line, continuous enrollment is determined in the health plan (not the ACO) for Onpoint-generated results using health plan data, and in the ACO contract for self-reporting ACOs. The criteria for continuous enrollment follows individual measure specifications. Refer to General Guideline 23 AMP Commercial ACO Continuous Enrollment & Member Attribution and General Guideline 27 Continuous Enrollment for Self-Reporting POs for additional guidance on continuous enrollment for Onpoint and self-reporting ACOs, respectively.*
4. **Allowable gap** in benefits during the continuous enrollment period. There are different allowable gap criteria for the Medi-Cal Managed Care product line.
5. **Anchor date** specifies the required enrollment date for the eligible population (e.g., children must be enrolled in the organization on their second birthday for inclusion in the *Childhood Immunization Status* measure).
6. **Benefit** a member must have during the continuous enrollment period to be included in the eligible population (e.g., members must have both medical and pharmacy benefits for inclusion in the *Asthma Medication Ratio* measure).
7. **Event/diagnosis** specifies the medical event or diagnosis requirements for the eligible population.

Administrative Specification

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

Controlling High Blood Pressure (CBP)

MEASURE UPDATES JUNE 2021 FOR AMP MY 2021

- None.

MEASURE UPDATES SEPTEMBER 2020 FOR AMP MY 2021

- Revised the time frame in the event/diagnosis criteria to look for two outpatient visits with a diagnosis of hypertension in the first six months of the measurement year and the year prior to the measurement year.
- Removed the restriction that only one of the two visits with a hypertension diagnosis be an outpatient telehealth, telephone visit, e-visit, or virtual check-in when identifying the event/diagnosis.
- Added palliative care as a required exclusion.
- Added telephone visits, e-visits, and virtual check-ins to the advanced illness exclusion.
- Added Donepezil-memantine to the "Dementia combinations" description in the Dementia Medications List.
- Added telephone visits, e-visits, and virtual check-ins to the Administrative Specification as appropriate settings for BP readings.

MODIFICATIONS FROM HEDIS

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

Description

The percentage of members 18–85 years of age who had a diagnosis of hypertension (HTN) and whose 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

Note: *Members in hospice are excluded from the eligible population. Refer to General Guideline 15: Members in Hospice.*

Product lines	Commercial HMO/POS, Commercial ACO, Medicare Advantage, Medi-Cal Managed Care (report each product line separately).
Ages	18–85 years as of December 31 of the measurement year.

Continuous enrollment	The measurement year.
…for self-reporting POs	The measurement year in the PO (parent level).
…for health plans	The measurement year in the health plan and the PO (parent level).
Allowable gap	No more than one gap in continuous enrollment of up to 45 days during the measurement year. To determine continuous enrollment for a Medi-Cal Managed Care beneficiary for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage (e.g., a member whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).
Anchor date	December 31 of the measurement year.
…for self-reporting POs	Enrolled in the PO (parent level, or subgroup level, for eligible POs) and in an AMP plan on December 31 of the measurement year.
…for health plans	Enrolled in the health plan and the PO (parent level, or, for eligible POs, subgroup level) on December 31 of the measurement year.
Benefit	Medical.
Event/diagnosis	Members who had at least two visits on different dates of service with a diagnosis of hypertension on or between January 1 of the year prior to the measurement year and June 30 of the measurement year. Visit type need not be the same for the two visits. Any of the following code combinations meet criteria: • Outpatient visit (Outpatient Without UBREV Value Set) with any diagnosis of hypertension (Essential Hypertension Value Set). • A telephone visit (Telephone Visits Value Set) with any diagnosis of hypertension (Essential Hypertension Value Set). • An e-visit or virtual check-in (Online Assessments Value Set) with any diagnosis of hypertension (Essential Hypertension Value Set).
Required exclusion	Members receiving palliative care (Palliative Care Assessment Value Set; Palliative Care Encounter Value Set; Palliative Care Intervention Value Set) during the measurement year.
Exclusions	Exclude members who meet any of the following criteria: ***Note:*** *Supplemental data may not be used for these exclusions.* • Medicare Advantage members 66 years of age and older as of December 31 of the measurement year who meet either of the following: – Enrolled in an Institutional SNP (I-SNP) any time during the measurement year. – Living long-term in an institution any time during the measurement year as identified by the LTI flag in the Monthly Membership Detail Data File. Use the run date of the file to determine if a member had an LTI flag during the measurement year.*

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

- Members 66–80 years of age as of December 31 of the measurement year (all product lines) with frailty ***and*** advanced illness. Members must meet ***both*** of the following frailty and advanced illness criteria to be excluded:
  1. At least one claim/encounter for frailty (Frailty Device Value Set; Frailty Diagnosis Value Set; Frailty Encounter Value Set; Frailty Symptom Value Set) during the measurement year.
  2. Any of the following during the measurement year or the year prior to the measurement year (count services that occur over both years):
     - At least two outpatient visits (Outpatient Value Set), observation visits (Observation Value Set), ED visits (ED Value Set), telephone visits (Telephone Visits Value Set), e-visits, or virtual check-ins (Online Assessments Value Set), nonacute inpatient encounters (Nonacute Inpatient Value Set), or nonacute inpatient discharges (instructions below; the diagnosis must be on the discharge claim) on different dates of service, with an advanced illness diagnosis (Advanced Illness Value Set). Visit type need not be the same for the two visits. To identify a nonacute inpatient discharge:
       1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
       2. Confirm the stay was for nonacute care based on the presence of a nonacute code (Nonacute Inpatient Stay Value Set) on the claim.
       3. Identify the discharge date for the stay.
     - At least one acute inpatient encounter (Acute Inpatient Value Set) with an advanced illness diagnosis (Advanced Illness Value Set).
     - At least one acute inpatient discharge with an advanced illness diagnosis (Advanced Illness Value Set) on the discharge claim. To identify an acute inpatient discharge:
       1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
       2. Exclude nonacute inpatient stays (Nonacute Inpatient Stay Value Set).
       3. Identify the discharge date for the stay.
     - A dispensed dementia medication (Dementia Medications List).
- Members 81 years of age and older as of December 31 of the measurement year (all product lines) with frailty (Frailty Device Value Set; Frailty Diagnosis Value Set; Frailty Encounter Value Set; Frailty Symptom Value Set) during the measurement year.

Dementia Medications

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

Administrative Specification

Denominator The eligible population.

Numerator Identify the most recent BP reading (Systolic Blood Pressure Value Set; Diastolic Blood Pressure Value Set) taken during an outpatient visit (Outpatient Without UBREV Value Set), telephone visit (Telephone Visits Value Set), e-visit, or virtual check-in (Online Assessments Value Set), a nonacute inpatient encounter (Nonacute Inpatient Value Set), or remote monitoring event (Remote Blood Pressure Monitoring Value Set) during the measurement year.

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

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

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

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

Exclusions *(optional)*

- Exclude from the eligible population all members with evidence of end-stage renal disease (ESRD) (ESRD Diagnosis Value Set), dialysis (Dialysis Procedure Value Set), nephrectomy (Nephrectomy Value Set), or kidney transplant (Kidney Transplant Value Set; History of Kidney Transplant Value Set) on or prior to December 31 of the measurement year.
- Exclude from the eligible population female members with a diagnosis of pregnancy (Pregnancy Value Set) during the measurement year.
- Exclude from the eligible population all 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.

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Statin Therapy for Patients With Cardiovascular Disease (SPC)

MEASURE UPDATES JUNE 2021 FOR AMP MY 2021

- Removed reference to reporting two age/gender stratifications in the Eligible Population 'Age' section for each indicator (i.e., AMP reports one total rate for each indicator).

MEASURE UPDATES SEPTEMBER 2020 FOR AMP MY 2021

- Updated rules for allowable gap for the Medi-Cal Managed Care product line.
- Removed the restriction that only one of two visits with an IVD diagnosis may be an outpatient telehealth, telephone visit, e-visit, or virtual check-in when identifying the event/diagnosis.
- Added telephone visits, e-visits, and virtual check-ins to the advanced illness exclusion.
- Added palliative care as a required exclusion.
- Added Donepezil-memantine to the "Dementia combinations" description in the Dementia Medications List.

MODIFICATIONS FROM HEDIS

- The gender and age stratifications for each indicator are not reported for AMP (i.e., AMP reports one total rate for each indicator).
- The exclusion for members living long-term in an institution is optional for POs that do not have access to the LTI flag in the Monthly Membership Detail Data File.

Description

The percentage of males 21–75 years of age and females 40–75 years of age during the measurement year, who were identified as having clinical atherosclerotic cardiovascular disease (ASCVD) and met the following criteria. The following rates are reported:

1. *Received Statin Therapy.* Members who were dispensed at least one high-intensity or moderate-intensity statin medication during the measurement year.
2. *Statin Adherence 80%.* Members who remained on a high-intensity or moderate-intensity statin medication for at least 80% of the treatment period.

Definitions

IPSD	Index prescription start date. The earliest prescription dispensing date for any statin medication of at least moderate intensity during the measurement year.
Treatment period	The period of time beginning on the IPSD through the last day of the measurement year.
PDC	Proportion of days covered. The number of days the member is covered by at least one statin medication prescription of appropriate intensity, divided by the number of days in the treatment period.
Calculating number of days covered for	If multiple prescriptions for different medications are dispensed on the same day, calculate the number of days covered by a statin medication (for the numerator) using the prescriptions with the longest days supply. For multiple

multiple prescriptions	different prescriptions dispensed on different days with overlapping days supply, count each day in the treatment period only once toward the numerator. If multiple prescriptions for the same medication are dispensed on the same day or on different days, sum the days supply and use the total to calculate the number of days covered by a statin medication (for the numerator). For example, three prescriptions for the same medication are dispensed on the same day, each with a 30-day supply. Sum the days supply for a total of 90 days covered by a statin. Subtract any days supply that extends beyond December 31 of the measurement year. Use the medication lists to determine if drugs are the same or different. Drugs in different medication lists are considered different drugs. For example, a dispensing event from the Amlodipine Atorvastatin High Intensity Medications List and a dispensing event from the Amlodipine Atorvastatin Moderate Intensity Medications List are dispensing events for different medications.

Eligible Population: Rate 1—Received Statin Therapy

Note: *Members in hospice are excluded from the eligible population. Refer to General Guideline 15: Members in Hospice.*

Product line	Commercial HMO/POS, Commercial ACO, Medicare Advantage, Medi-Cal Managed Care (report each product line separately).
Age	Report a total rate of: • Males 21–75 years as of December 31 of the measurement year. • Females 40–75 years as of December 31 of the measurement year.
Continuous enrollment	
...for self-reporting POs	The measurement year and the year prior to the measurement year in the PO (parent level).
…for health plans	The measurement year and the year prior to the measurement year in the health plan and PO (parent level).
Allowable gap	No more than one gap in enrollment of up to 45 days during each year of continuous enrollment. To determine continuous enrollment for a Medi-Cal Managed Care beneficiary for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage (e.g., a member whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).
Anchor date	
…for self-reporting POs	Enrolled in the PO (parent level, or subgroup level, for eligible POs) and in an AMP plan on December 31 of the measurement year.
…for health plans	Enrolled in the health plan and the PO (parent level, or, for eligible POs, subgroup level) on December 31 of the measurement year.
Benefit	Medical. Pharmacy during the measurement year.

Event/diagnosis

Follow the steps below to identify the eligible population.

Step 1

Members are identified for the eligible population in two ways: by event or by diagnosis. 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.

Event. Any of the following during the year prior to the measurement year meet criteria:

- *MI.* Discharged from an inpatient setting with an MI (MI Value Set) on the discharge claim. To identify discharges:
  1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
  2. Identify the discharge date for the stay.
- *CABG*. Members who had CABG (CABG Value Set) in any setting.
- *PCI*. Members who had PCI (PCI Value Set) in any setting.
- *Other revascularization*. Members who had any other revascularization procedures (Other Revascularization Value Set) in any setting.

Diagnosis. Identify members as having ischemic vascular disease (IVD) 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 outpatient visit (Outpatient Value Set) with an IVD diagnosis (IVD Value Set),
- A telephone visit (Telephone Visits Value Set) with an IVD diagnosis (IVD Value Set).
- An e-visit or virtual check-in (Online Assessments Value Set) with an IVD diagnosis (IVD Value Set).
- At least one acute inpatient encounter (Acute Inpatient Value Set) with an IVD diagnosis (IVD Value Set) ***without*** telehealth (Telehealth Modifier Value Set; Telehealth POS Value Set).
- At least one acute inpatient discharge with an IVD diagnosis (IVD 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.

Step 2: Required exclusions

Exclude members who meet any of the following criteria:

- Female members with a diagnosis of pregnancy (Pregnancy Value Set) during the measurement year or the year prior to the measurement year.
- In vitro fertilization (IVF Value Set) in the measurement year or the year prior to the measurement year.
- Dispensed at least one prescription for clomiphene (Estrogen Agonists Medications List) during the measurement year or the year prior to the measurement year.

- ESRD (ESRD Diagnosis Value Set) or dialysis (Dialysis Procedure Value Set) during the measurement year or the year prior to the measurement year.
- Cirrhosis (Cirrhosis Value Set) during the measurement year or the year prior to the measurement year.
- Myalgia, myositis, myopathy, or rhabdomyolysis (Muscular Pain and Disease Value Set) 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.

Estrogen Agonists Medications

Description	Prescription
Estrogen agonists	• Clomiphene

Step 3: Exclusions Exclude members who meet any of the following criteria:

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

- Members 66 years of age and older as of December 31 of the measurement year who meet either of the following:
  - Enrolled in an Institutional SNP (I-SNP) any time during the measurement year.
  - *Living long-term in an institution any time during the measurement year as identified by the LTI flag in the Monthly Membership Detail Data File. Use the run date of the file to determine if a member had an LTI flag during the measurement year.
- Members 66 years of age and older as of December 31 of the measurement year (all product lines) with frailty ***and*** advanced illness. Members must meet ***both*** of the following frailty and advanced illness criteria to be excluded:
  1. At least one claim/encounter for frailty (Frailty Device Value Set; Frailty Diagnosis Value Set; Frailty Encounter Value Set; Frailty Symptom Value Set) during the measurement year.
  2. Any of the following during the measurement year or the year prior to the measurement year (count services that occur over both years):
     - At least two outpatient visits (Outpatient Value Set), observation visits (Observation Value Set), ED visits (ED Value Set), telephone visits (Telephone Visits Value Set), e-visits, or virtual check-ins (Online Assessments Value Set), nonacute inpatient encounters (Nonacute Inpatient Value Set), or nonacute inpatient discharges (instructions below; the diagnosis must be on the discharge claim) on different dates of service, with an advanced illness diagnosis (Advanced Illness Value Set). Visit type need not be the same for the two visits. To identify a nonacute inpatient discharge:
       1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).

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

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

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

Dementia Medications

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

Administrative Specification: *Rate 1*—Received Statin Therapy

Denominator The Rate 1 eligible population.

Numerator The number of members who had at least one dispensing event for a high-intensity or moderate-intensity statin medication during the measurement year. Use all the medication lists below to identify statin medication dispensing events.

High and Moderate-Intensity Statin Medications

Description	Prescription	Medication Lists
High-intensity statin therapy	• Atorvastatin 40-80 mg	Atorvastatin High Intensity Medications List
High-intensity statin therapy	• Amlodipine-atorvastatin 40-80 mg	Amlodipine Atorvastatin High Intensity Medications List
High-intensity statin therapy	• Rosuvastatin 20-40 mg	Rosuvastatin High Intensity Medications List
High-intensity statin therapy	• Simvastatin 80 mg	Simvastatin High Intensity Medications List
High-intensity statin therapy	• Ezetimibe-simvastatin 80 mg	Ezetimibe Simvastatin High Intensity Medications List
Moderate-intensity statin therapy	• Atorvastatin 10-20 mg	Atorvastatin Moderate Intensity Medications List
Moderate-intensity statin therapy	• Amlodipine-atorvastatin 10-20 mg	Amlodipine Atorvastatin Moderate Intensity Medications List

Description	Prescription	Medication Lists
Moderate-intensity statin therapy	• Rosuvastatin 5-10 mg	Rosuvastatin Moderate Intensity Medications List
Moderate-intensity statin therapy	• Simvastatin 20-40 mg	Simvastatin Moderate Intensity Medications List
Moderate-intensity statin therapy	• Ezetimibe-simvastatin 20-40 mg	Ezetimibe Simvastatin Moderate Intensity Medications List
Moderate-intensity statin therapy	• Pravastatin 40-80 mg	Pravastatin Moderate Intensity Medications List
Moderate-intensity statin therapy	• Lovastatin 40 mg	Lovastatin Moderate Intensity Medications List
Moderate-intensity statin therapy	• Fluvastatin 40-80 mg	Fluvastatin Moderate Intensity Medications List
Moderate-intensity statin therapy	• Pitavastatin 1–4 mg	Pitavastatin Moderate Intensity Medications List

Eligible Population: *Rate 2*—Statin Adherence 80%

Note: *Members in hospice are excluded from the eligible population. Refer to General Guideline 15: Members in Hospice.*

Product line Commercial HMO/POS, Commercial ACO, Medicare Advantage, Medi-Cal Managed Care (report each product line separately).

Age Report a total rate of:

- Males 21–75 years as of December 31 of the measurement year.
- Females 40–75 years as of December 31 of the measurement year.

Continuous enrollment

...for self-reporting POs The measurement year and the year prior to the measurement year in the PO (parent level).

…for health plans The measurement year and the year prior to the measurement year in the health plan and PO (parent level).

Allowable gap No more than one gap in enrollment of up to 45 days during each year of continuous enrollment. To determine continuous enrollment for a Medi-Cal Managed Care beneficiary for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage (e.g., a member whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).

Anchor date

…for self-reporting POs Enrolled in the PO (parent level, or subgroup level, for eligible POs) and in an AMP plan on December 31 of the measurement year.

…for health plans Enrolled in the health plan and the PO (parent level, or, for eligible POs, subgroup level) on December 31 of the measurement year.

Benefit Medical. Pharmacy during the measurement year.

Event/diagnosis All members who meet the numerator criteria for Rate 1.

Administrative Specification: *Rate 2*—Statin Adherence 80%

Denominator The Rate 2 eligible population.

Numerator The number of members who achieved a PDC of at least 80% during the treatment period.

Follow the steps below to identify numerator compliance.

Step 1 Identify the IPSD. The IPSD is the earliest dispensing event for any high-intensity or moderate-intensity statin medication during the measurement year. Use all the medications lists above to identify statin medication dispensing events.

Step 2 To determine the treatment period, calculate the number of days beginning on the IPSD through the end of the measurement year.

Step 3 Count the days covered by at least one prescription for any high-intensity or moderate-intensity statin medication during the treatment period. To ensure that days supply that extends beyond the measurement year is not counted, subtract any days supply that extends beyond December 31 of the measurement year.

Step 4 Calculate the member's PDC using the following equation. Multiply the equation by 100 and round (using the .5 rule) to the nearest whole number. For example, if a member has 291 total days covered by a medication during a 365-day treatment period, this calculates to 0.7972. Multiply this number by 100, convert it to 79.72% and round it to 80%, the nearest whole number.

$$\frac{\text{Total Days Covered by a Statin Medication in the Treatment Period (step 3)}}{\text{Total Days in Treatment Period (step 2)}}$$

Step 5 Sum the number of members whose PDC is ≥80% for the treatment period.

Note

- *All members who are numerator compliant for Rate 1 must be used as the eligible population for Rate 2 (regardless of the data source used to capture the Rate 1 numerator). For example, if supplemental data were used to identify compliance for the Rate 1 numerator, then supplemental data will be included in identifying the Rate 2 eligible population.*

Proportion of Days Covered by Medications (PDC)

MEASURE UPDATES JUNE 2021 FOR AMP MY 2021

- Changed Diabetic Medication class name from Incretin Mimetic Agents to GLP-1 Receptor Agonists.
- Updated language for Index Prescription Start Date (IPSD) definition.
- Updated language for Treatment Period.
- Added clarifying language for the PDC Threshold definition.
- Added clarifying language in Step 2 of the numerator calculation for PDC-RASA, PDC-STA & PDC-DR.
- Added clarifying language for the additional eligible population criteria for PDC-STA, PDC-STA & PDC-DR.
- Added note about exclusion of products only for weight loss to Table GLP1: GLP-1 Receptor Agonists.

MEASURE UPDATES SEPTEMBER 2020 FOR AMP MY 2021

- Updated language in "Treatment period."
- Updated language in Continuous Enrollment criteria to include a 1-day allowable gap.
- Added "Prescription claims" definition.
- Clarified step 3 of the numerator calculation.
- Changed Medication table names.
- Added niacinamide to insulin medications.

MODIFICATIONS FROM PQA

- None.

Description

The percentage of members ≥18 years of age who met the proportion of days covered (PDC) threshold of 80 percent for select medications during the measurement year. Members must have filled at least two prescriptions in a given medication category on different dates of service during the treatment period to be included in the measure.

Report a performance rate for each of the following:

Cardiovascular

- *Proportion of Days Covered by Medications:* RAS antagonists (PDC-RASA) (i.e., ACEI, ARB, direct renin inhibitors).
- *Proportion of Days Covered by Medications:* Statins (PDC-STA).

Diabetes

- *Proportion of Days Covered by Medications*: Diabetes (PDC-DR) (i.e., biguanides, sulfonylureas, thiazolidinediones, or DPP-IV inhibitors, GLP-1 receptor agonists, meglitinides, and sodium glucose co-transporter 2 [SGLT2] inhibitors).

Note: *Refer to the AMP Value Set Directory download for a comprehensive list of PQA medications and associated codes (PQA NDC Code List and PQA ICD Code List). Do not distribute NDC lists outside your organization.*

Definitions

Index prescription start date (IPSD)	The earliest date of service for a target medication during the measurement year.
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.
Prescription claims	Only paid, non-reversed prescription claims are included in the data set to calculate the measure.
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 level of PDC above which the medication has a reasonable likelihood of achieving most of the potential clinical benefit (i.e., 80% for diabetes and cardiovascular drugs, and many chronic conditions).
Hospice exclusion	For ommercial HMO and Medi-Cal Managed Care reporting, refer *to General Guideline 15: Members in Hospice*. For health plans reporting for Medicare Advantage, identify any member with a hospice indicator from the Monthly Membership Detail File. POs reporting for Medicare Advantage have the option of using the Monthly Membership Detail File or the HEDIS Hospice Encounter Value Set and Hospice Intervention Value Set to identify members in Hospice. Refer *to General Guideline 15: Members in Hospice*.
End-stage renal disease diagnosis exclusion	Applies to PDC-DR, PDC-RASA and PDC-STA. Any members with an ESRD diagnosis at any time during the measurement year. Refer to *PQA Value Set, ESRD.* An ESRD diagnosis is defined as having ≥1 claim with ESRD in the primary diagnosis or any other diagnosis fields during the measurement year. Medicare Data (if ICD codes not available): RxHCC 261—(Dialysis Status) or 262 (Chronic Kidney Disease Stage 5) for Payment Year 2020 or 2021. Available at: https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Risk-Adjustors.html ***Note:*** *Use the most current information for the ESRD exclusion; using diagnosis codes is the preferred method. The RxHCC code can be found in the CMS Medicare Advantage and Prescription Drug System (MARx), which provides a monthly report of members' RxHCCs to plan sponsors. If the MARx System output is used, then the most recent version applies. Although the time frames are not consistent between diagnosis codes and the MARx System, using the most recent version provides the most current information to identify members with ESRD.*

Insulin exclusion	Applies to PDC-DR. Any member with ≥1 prescription claim for insulin in the treatment period. Refer to Medication Table INSULINS: Insulin Exclusion.
Sacubitril/ Valsartan exclusion	Applies to PDC-RASA. Any member with ≥1 prescription claim for the medication sacubitril/ valsartan during the treatment period. Refer to Medication Table SAC-VAL: Sacubitril/Valsartan Exclusion.

Eligible Population

Product lines	Commercial HMO/POS, Medicare Advantage, Medi-Cal Managed Care (report each product line separately).
Age	18 years and older as of the first day of the measurement year.
Continuous enrollment	
…for self-reporting POs	*Treatment period:* The IPSD through the end of the measurement year or until death or disenrollment from the PO (parent level).
…for health plans	*Treatment period:* The IPSD through the end of the measurement year or until death or disenrollment from the health plan and from the PO (parent level).
Allowable gap	1 day. Exclude members with >1-day gap in enrollment during the treatment period. ***Note:*** *This allows a 1-day gap to compensate for discrepancies in the enrollment data. For example, a member eligible from January 1–April 1 and April 3–December 31 is continuously enrolled despite the 1-day gap (April 2) in eligibility.*
Anchor date	
…for self-reporting POs	None.
…for health plans	None.
Benefit	Medical, pharmacy.
Event/diagnosis	Refer to Additional Eligible Population Criteria for each rate.

Note

- *If a PO receives pharmacy claim information for a member, the PO can assume the member has a pharmacy benefit and that the pharmacy benefit dates align with the medical benefit dates.*
- *Do not include members who disenroll and reenroll more than one day later at any time during the measurement year, after the treatment period.*

Administrative Specification

Report each rate 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.

PDC for Renin Angiotensin System (RAS) Antagonists

Additional eligible population criteria

Members with at least two prescription claims for any RAS antagonist: (Medication Table RASA: Renin Angiotensin System [RAS] Antagonist Medications) on different dates of service during the treatment period. The prescriptions may be for the same or different medications.

Denominator

The eligible population.

Denominator exclusion *(required)*

Any members with one or more of the following:

- *Hospice:* A hospice indicator at any time during the measurement year.
- *ESRD:* An ESRD diagnosis at any time during the measurement year.
- *Sacubitril/valsartan:* A prescription claim for sacubitril/valsartan during the treatment period. Refer to Table SAC-VAL.

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)
ACE Inhibitor Medications and Combination Products		
• Benazepril (+/- amlodipine, hydrochlorothiazide) • Captopril (+/- hydrochlorothiazide) • Enalapril (+/- hydrochlorothiazide) • Fosinopril (+/- hydrochlorothiazide)	• Lisinopril (+/- hydrochlorothiazide) • Moexipril (+/- hydrochlorothiazide) • Perindopril (+/- amlodipine)	• Quinapril (+/- hydrochlorothiazide) • Ramipril • Trandolapril (+/- verapamil)

Note: *Active ingredients are limited to oral formulations only. Excludes nutritional supplement/dietary management combination products.*

Table SAC-VAL: Sacubitril/Valsartan

ARB/Neprilysin Inhibitor Combination Medication
• Sacubitril/valsartan

Numerator The number of members who met the PDC threshold during the measurement year. Follow the steps below for each member to determine whether the member meets the PDC threshold.

Step 1 Determine the treatment period, defined as the index prescription date (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 RAS antagonist medication (Medication Table RASA) based on the date of service and days' supply on the prescription claims. If the days' supply for prescription claims with the same target drug (generic ingredient) overlap, then adjust the prescription claim's start date to be the day after the last days' supply for the previous prescription claim.*

**Adjustment of overlap should also occur when there is overlap of a single drug product to a combination product containing the single target drug or when there is an overlap of a combination product to another combination product where at least one of the target drugs is common.*

Step 3 Divide the number of covered days found in step 2 by the number of days found in step 1. Multiply this number by 100 to obtain the PDC (as a percentage) for each member, then round the PDC to the nearest hundredth (e.g., 79.996% is rounded to 80.00%, 79.992% is rounded to 79.99%).

Step 4 Count the number of members who had a PDC of 80.00% or greater.

Calculate performance rate Divide the number of members from step 4 by the total number of eligible members.

An example of SAS code for steps 1–3 is available from PQA upon request and at http://www2.sas.com/proceedings/forum2007/043-2007.pdf

PDC for Statin Medications

Additional eligible population criteria Members with at least two prescription claims for a statin or statin combination (Medication Table STATINS) on different dates of service during the treatment period. The prescriptions may be for the same or different medications.

Denominator The eligible population.

Denominator exclusion *(required)* Any members with the following:

- *Hospice:* A hospice indicator at any time during the measurement year.
- *ESRD:* An ESRD diagnosis at any time during the measurement year.

Table STATINS: Statins

Statin Medications		
• Atorvastatin (+/- amlodipine)	• Pitavastatin	• Simvastatin (+/-ezetimibe, niacin)
• Fluvastatin	• Pravastatin	
• Lovastatin (+/- niacin)	• Rosuvastatin	

Note: *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 for each member to determine whether the member meets the PDC threshold.

Step 1 Determine the 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 statin medication (Medication Table STATINS) based on the date of service and days' supply on the prescription claims. If the days' supply for the presciption claims with the same target drug (generic ingredient) overlap, then adjust the prescription claim's start date to be the day after the last days' supply for the previous prescription claim.*

**Adjustment of overlap should also occur when there is overlap of a single drug product to a combination product containing the single target drug or when there is an overlap of a combination product to another combination product where at least one of the target drugs is common.*

Step 3 Divide the number of covered days found in step 2 by the number of days found in step 1. Multiply this number by 100 to obtain the PDC (as a percentage) for each individual, then round the PDC to the nearest hundredth (e.g., 79.996% is rounded to 80.00%, 79.992% is rounded to 79.99%).

Step 4 Count the number of members who had a PDC of 80.00% or greater.

Calculate performance rate Divide the number of members from step 4 by the total number of eligible members.

An example of SAS code for steps 1–3 is available from PQA upon request and at http://www2.sas.com/proceedings/forum2007/043-2007.pdf

PDC Diabetes All-Class Medications

Additional eligible population criteria Members with at least two prescription claims for any diabetes medication (Medication Tables BG, SFU, TZD, DPP4, GLP1, MEG, or SGLT2) on different dates of service during the treatment period. The prescriptions may be for the same or different medications and from any of the seven tables.

Denominator The eligible population.

Denominator exclusion *(required)* Any members with one or more of the following:

- *Hospice:* A hospice indicator at any time during the measurement year.
- *ESRD:* An ESRD diagnosis at any time during the measurement year.
- *Insulin:* A prescription claim for insulin during the treatment period (Refer to Medication Table INSULINS).

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 • Glimepiride (+/- pioglitazone)	• Glipizide (+/- metformin) • Glyburide (+/- metformin)	• Tolazamide • Tolbutamide

Note: *Active ingredients are limited to oral formulations only (includes all salts and dosage forms).*

Table TZD: Thiazolidinediones

Thiazolidinedione Medications and Combinations	
• Pioglitazone (+/- alogliptin, glimepiride, metformin)	• Rosiglitazone (+/- metformin)

Note: *Active ingredients are limited to oral formulations only.*

Table DPP4: DPP-4 Inhibitors

DPP-4 Medications and Combinations	
• Alogliptin (+/- metformin, pioglitazone) • Linagliptin (+/- empagliflozin, metformin)	• Saxagliptin (+/- metformin, dapagliflozin) • Sitagliptin (+/- metformin, ertugliflozin)

Note: *Active ingredients are limited to oral formulations only.*

Table GLP1: GLP-1 Receptor Agonists

GLP-1 Receptor Agonist Medications		
• Albiglutide • Dulaglutide	• Exenatide • Liraglutide	• Lixisenatide • Semaglutide

Note: *Active ingredients are limited to oral formulations only. Excludes products indicated only for weight loss.*

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	
• Canagliflozin (+/-- metformin) • Dapagliflozin (+/- metformin, saxagliptin)	• Empagliflozin (+/- metformin, linagliptin) • Ertugliflozin (+/- sitagliptin, metformin)

Note: Active ingredients are limited to oral formulations only.

Table INSULINS: Insulin Exclusion
Refer to the Insulins tab in the PQA NDC Code list.

Insulins		
• Insulin aspart (+/-insulin aspart protamine, niacinamide) • Insulin degludec (+/- liraglutide) • Insulin detemir	• Insulin glargine (+/- lixisenatide) • Insulin glulisine • Insulin isophane (+/- regular insulin)	• Insulin lispro (+/- insulin lispro protamine) • Insulin regular (including inhalation powder)

Note: *The active ingredients are limited to inhaled and injectable formulations only.*

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.

Step 1 Determine the treatment period, defined as the index prescription date (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, GLP1, MEG, or SGLT2) based on the date of service and days' supply on the prescription claims. If the days' supply for prescription claims with the same target drug (generic ingredient) overlap, then adjust the prescription claim's start date to be the day after the last days' supply for the previous prescription claim.*

** Adjustment of overlap should also occur when there is overlap of a single drug product to a combination product containing the target single drug or when there is an overlap of a combination product to another combination product where at least one of the drugs is common.*

Step 3 Divide the number of covered days found in step 2 by the number of days found in step 1. Multiply this number by 100 to obtain the PDC (as a percentage) for each individual, then round the PDC to the nearest hundredth (e.g., 79.996% is rounded to 80.00%, 79.992% is rounded to 79.99%).

Step 4 Count the number of members who had a PDC of 80.00% or greater.

Calculate performance rate Divide the number of members from step 4 by the total number of eligible members.

An example of SAS code for steps 1–3 is available from PQA upon request and at http://www2.sas.com/proceedings/forum2007/043-2007.pdf

Comprehensive Diabetes Care (CDC)
HbA1c Testing (One Test), HbA1c Poor Control (>9.0%), HbA1c Control (<8.0%), Eye Exam, Medical Attention for Nephropathy, Blood Pressure Control (<140/90), Optimal Diabetes Care

MEASURE UPDATES JUNE 2021 FOR AMP MY 2021

- Removed the following bullet from the Eye Exam numerator: "Any code in the Diabetic Retinal Screening Value Set billed by an eye care professional (optometrist or ophthalmologist) during the year prior to the measurement year, with a negative result (negative for retinopathy)."
- Added "or Automated Eye Exam Value Set" to the following bullet in the Eye Exam numerator: "Any code in the Eye Exam With Evidence of Retinopathy Value Set or Eye Exam Without Evidence of Retinopathy Value Set billed by any provider type during the measurement year."

MEASURE UPDATES SEPTEMBER 2020 FOR AMP MY 2021

- Updated rules for allowable gap for the Medi-Cal Managed Care product line.
- Removed the restriction that only one of two visits with a diabetes diagnosis may be an outpatient telehealth, telephone visit, e-visit, or virtual check-in when identifying the event/diagnosis.
- Added telephone visits, e-visits, and virtual check-ins to the advanced illness exclusion.
- Added palliative care as a required exclusion.
- Deleted the HbA1c Level 7.0-9.0 Value Set.
- Updated the Administrative Specification logic and value sets for the Eye Exam indicator.
- Added telephone visits, e-visits, and virtual check-ins to the Administrative Specification as appropriate settings for BP readings.
- Added Nebivolol-valsartan to the "Antihypertensive combinations" description in the ACE inhibitor and ARB Medications List.
- Added Donepezil-memantine to the "Dementia combinations" description in the Dementia Medications List.
- Added polycystic ovary syndrome to the optional exclusions.

MODIFICATIONS FROM HEDIS

- Optimal Diabetes Care Combination Rate is a non-HEDIS measure that is an "all or none" combination rate composed of four indicators.
- AMP does not include Medicare SES Stratifications for the Eye Exam indicator.
- The exclusion for members living long-term in an institution is optional for POs that do not have access to the LTI flag in the Monthly Membership Detail Data File.

Description

The percentage of members 18–75 years of age with diabetes (type 1 and type 2) who had each of the following:

- Hemoglobin A1c (HbA1c) Testing (One Test)
- HbA1c poor control (>9.0%).
- HbA1c control (<8.0%).
- Eye exam (retinal) performed.
- Medical attention for nephropathy.
- BP control (<140/90 mm Hg).

Also report the following measure: Optimal Diabetes Care Combination Rate. *

- HbA1c Control (<8.0%).
- BP Control (<140/90 mm Hg).
- Medical Attention for Nephropathy.
- Eye Exam (Retinal) Performed.

**The Optimal Diabetes Care Combination Rate measure comprises four process and outcome indicators; "all or none" criterion is used to qualify for each combination rate.*

Eligible Population

Note: *Members in hospice are excluded from the eligible population. Refer to General Guideline 15: Members in Hospice.*

Product line Report each product line separately.

Clinical Measures	Commercial HMO	Commercial ACO	Medicare Advantage	Medi-Cal Managed Care	Non-HEDIS
Comprehensive Diabetes Care—HbA1c Testing (One Test)				✓	
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)	✓	✓	✓	✓	
Comprehensive Diabetes Care—HbA1c Control (<8.0%)	✓			✓	
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	✓	✓	✓	✓	
Comprehensive Diabetes Care—Medical Attention for Nephropathy	✓	✓	✓	✓	
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	✓	✓		✓	
Comprehensive Diabetes Care—Optimal Diabetes Care	✓			✓	✓

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

Continuous enrollment

…for self-reporting POs The measurement year in the PO (parent level).

…for health plans The measurement year in the health plan and the PO (parent level).

Allowable gap No more than one gap in enrollment of up to 45 days during the measurement year. To determine continuous enrollment for a Medi-Cal Managed Care beneficiary for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage (e.g., a member whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).

Anchor date

…for self-reporting POs Enrolled in the PO (parent level, or, for eligible POs, subgroup level) and in an AMP plan on December 31 of the measurement year.

…for health plans Enrolled in the health plan and the PO (parent level, or, for eligible POs, subgroup level) on December 31 of the measurement year.

Benefit Medical.

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

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

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

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

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

Diabetes Medications

Description	Prescription		
Alpha-glucosidase inhibitors	• Acarbose	• Miglitol	
Amylin analogs	• Pramlintide		
Antidiabetic combinations	• Alogliptin-metformin • Alogliptin-pioglitazone • Canagliflozin-metformin • Dapagliflozin-metformin • Empaglifozin-linagliptin • Empagliflozin-metformin • 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 detemir • Insulin glargine	• Insulin glulisine • Insulin isophane human • Insulin isophane-insulin regular	• Insulin lispro • Insulin lispro-insulin lispro protamine • Insulin regular human • Insulin human inhaled
Meglitinides	• Nateglinide	• Repaglinide	
Glucagon-like peptide-1 (GLP1) agonists	• Dulaglutide • Exenatide • Semaglutide	• Albiglutide • Liraglutide (excluding *Saxenda*®)	
Sodium glucose cotransporter 2 (SGLT2) inhibitor	• Canagliflozin • Dapagliflozin (excluding *Farxiga*®)	• Empagliflozin	
Sulfonylureas	• Chlorpropamide • Glimepiride • Glipizide	• Glyburide • Tolazamide • Tolbutamide	
Thiazolidinediones	• Pioglitazone	• Rosiglitazone	
Dipeptidyl peptidase-4 (DDP-4) inhibitors	• Alogliptin • Linagliptin	• Saxagliptin • Sitagliptin	

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

Required exclusion Exclude members receiving palliative care (Palliative Care Assessment Value Set; Palliative Care Encounter Value Set; Palliative Care Intervention Value Set) during the measurement year.

Exclusions Exclude members who meet any of the following criteria:

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

- Medicare Advantage members 66 years of age and older as of December 31 of the measurement year who meet either of the following:

  - Enrolled in an Institutional SNP (I-SNP) any time during the measurement year.
  - Living long-term in an institution any time during the measurement year as identified by the LTI flag in the Monthly Membership Detail Data File. Use the run date of the file to determine if a member had an LTI flag during the measurement year.*

- Members 66 years of age and older as of December 31 of the measurement year (all product lines) with frailty ***and*** advanced illness. Members must meet **BOTH** of the following frailty and advanced illness criteria to be excluded:
  1. At least one claim/encounter for frailty (Frailty Device Value Set; Frailty Diagnosis Value Set; Frailty Encounter Value Set; Frailty Symptom Value Set) during the measurement year.
  2. Any of the following during the measurement year or the year prior to the measurement year (count services that occur over both years):
     - At least two outpatient visits (Outpatient Value Set), observation visits (Observation Value Set), ED visits (ED Value Set), telephone visits (Telephone Visits Value Set), e-visits, or virtual check-ins (Online Assessments Value Set), nonacute inpatient encounters (Nonacute Inpatient Value Set), or nonacute inpatient discharges (instructions below; the diagnosis must be on the discharge claim) on different dates of service, with an advanced illness diagnosis (Advanced Illness Value Set). Visit type need not be the same for the two visits. To identify a nonacute inpatient discharge:
       1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
       2. Confirm the stay was for nonacute care based on the presence of a nonacute code (Nonacute Inpatient Stay Value Set) on the claim.
       3. Identify the discharge date for the stay.
     - At least one acute inpatient encounter (Acute Inpatient Value Set) with an advanced illness diagnosis (Advanced Illness Value Set).
     - At least one acute inpatient discharge with an advanced illness diagnosis (Advanced Illness Value Set) on the discharge claim. To identify an acute inpatient discharge:
       1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
       2. Exclude nonacute inpatient stays (Nonacute Inpatient Stay Value Set).
       3. Identify the discharge date for the stay.
     - A dispensed dementia medication (Dementia Medications List).

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

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.

Numerators

HbA1c Testing One HbA1c test (HbA1c Lab Test Value Set; HbA1c Test Result or Finding Value Set) performed during the measurement year.

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

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

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

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

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

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

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

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

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

Any of the following meet criteria:

- Any code in the Diabetic Retinal Screening Value Set billed by an eye care professional (optometrist or ophthalmologist) during the measurement year.
- Any code in the Diabetic Retinal Screening Value Set billed by an eye care professional (optometrist or ophthalmologist) during the year prior to the measurement year, with a diagnosis of diabetes without complications (Diabetes Mellitus Without Complications Value Set).
- Any code in the Eye Exam With Evidence of Retinopathy Value Set, Eye Exam Without Evidence of Retinopathy Value Set or Automated Eye Exam Value Set billed by any provider type during the measurement year.
- Any code in the Eye Exam Without Evidence of Retinopathy Value Set billed by any provider type during the year prior to the measurement year.
- Any code in the Diabetic Retinal Screening Negative In Prior Year Value Set billed by any provider type during the measurement year.
- Unilateral eye enucleation (Unilateral Eye Enucleation Value Set) ***with*** a bilateral modifier (Bilateral Modifier Value Set).

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- Two unilateral eye enucleations (Unilateral Eye Enucleation Value Set) with service dates 14 days or more apart. For example, if the service date for the first unilateral eye enucleation was February 1 of the measurement year, the service date for the second unilateral eye enucleation must be on or after February 15.
- Left unilateral eye enucleation (Unilateral Eye Enucleation Left Value Set) and right unilateral eye enucleation (Unilateral Eye Enucleation Right Value Set) on the same or different dates of service.
- A unilateral eye enucleation (Unilateral Eye Enucleation Value Set) and a left unilateral eye enucleation (Unilateral Eye Enucleation Left Value Set) with service dates 14 days or more apart.
- A unilateral eye enucleation (Unilateral Eye Enucleation Value Set) and a right unilateral eye enucleation (Unilateral Eye Enucleation Right Value Set) with service dates 14 days or more apart.

Medical Attention for Nephropathy

A nephropathy screening or monitoring test ***or*** evidence of nephropathy, as documented through administrative data. This includes diabetics who had one of the following during the measurement year:

- A nephropathy screening or monitoring test (Urine Protein Tests Value Set).
- Evidence of treatment for nephropathy or ACE/ARB therapy (Nephropathy Treatment Value Set).
- Evidence of stage 4 chronic kidney disease (CKD Stage 4 Value Set).
- Evidence of ESRD (ESRD Diagnosis Value Set) or dialysis (Dialysis Procedure Value Set).
- Evidence of nephrectomy (Nephrectomy Value Set) or kidney transplant (Kidney Transplant Value Set).
- A visit with a nephrologist, as identified by the organization's specialty provider codes (no restriction on the diagnosis or procedure code submitted).
- At least one ACE inhibitor or ARB dispensing event (ACE Inhibitor and ARB Medications List).

ACE Inhibitor and ARB Medications

Description	Prescription		
Angiotensin converting enzyme inhibitors	• Benazepril • Captopril • Enalapril • Fosinopril	• Lisinopril • Moexipril • Perindopril • Quinapril	• Ramipril • Trandolapril
Angiotensin II inhibitors	• Azilsartan • Candesartan • Eprosartan	• Irbesartan • Losartan • Olmesartan	• Telmisartan • Valsartan
Antihypertensive combinations	• Amlodipine-benazepril • Amlodipine-hydrochlorothiazide-valsartan	• Benazepril-hydrochlorothiazide • Candesartan-hydrochlorothiazide	• Hydrochlorothiazide-losartan • Hydrochlorothiazide-moexipril • Hydrochlorothiazide-olmesartan

Description	Prescription		
	• Amlodipine-hydrochlorothiazide-olmesartan • Amlodipine-olmesartan • Amlodipine-perindopril • Amlodipine-telmisartan • Amlodipine-valsartan • Azilsartan-chlorthalidone	• Captopril-hydrochlorothiazide • Enalapril-hydrochlorothiazide • Fosinopril-hydrochlorothiazide • Hydrochlorothiazide-irbesartan • Hydrochlorothiazide-lisinopril • Hydrochlorothiazide-quinapril	• Hydrochlorothiazide-telmisartan • Hydrochlorothiazide-valsartan • Nebivolol-valsartan • Sacubitril-valsartan • Trandolapril-verapamil

BP Control <140/90 mm Hg

Identify the most recent BP reading (Systolic Blood Pressure Value Set; Diastolic Blood Pressure Value Set) taken during an outpatient visit (Outpatient Value Set), telephone visit (Telephone Visits Value Set), e-visit, or virtual check-in (Online Assessments Value Set), or a nonacute inpatient encounter (Nonacute Inpatient Value Set), or remote monitoring event (Remote Blood Pressure Monitoring Value Set) during the measurement year.

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

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

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

Optimal Diabetes Care Combination rate

Calculate the following combination rate:

- HbA1c Control (<8.0%).
- BP Control (<140/90 mm Hg).
- Medical Attention for Nephropathy.
- Eye exam (retinal) performed.

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Exclusions *(optional)*

- Members who do not have a diagnosis of diabetes (Diabetes Value Set), in any setting, during the measurement year or the year prior to the measurement year ***and*** who had a diagnosis of polycystic ovary syndrome (PCOS), gestational diabetes, or steroid-induced diabetes (Diabetes Exclusions Value Set), in any setting, during the measurement year or the year prior to the measurement year.
- Organizations that apply optional exclusions must exclude members from the denominator for all indicators. The denominator for all rates must be the same.
- If the member was included in the measure based on claim or encounter data, as described in the event/diagnosis criteria, the optional exclusions do not apply because the member had a diagnosis of diabetes.

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.*
- *To facilitate AMP reporting the denominator for all rates must be the same. While an eye exam is not possible, services measured in the other indicators are important for members with bilateral eye enucleation. For these reasons bilateral eye enucleation is considered a numerator hit (rather than an optional exclusion).*
- *Hypertensive retinopathy is not handled differently from diabetic retinopathy when reporting the Eye Exam indicator; for example, an eye exam documented as positive for hypertensive retinopathy is counted as positive for diabetic retinopathy and an eye exam documented as negative for hypertensive retinopathy is counted as negative for diabetic retinopathy. The intent of the Eye Exam indicator is to ensure that members with evidence of any type of retinopathy have an eye exam annually, while members who remain free of retinopathy (i.e., the retinal exam was negative for retinopathy) are screened every other year.*
- *If a combination of administrative and supplemental data is used, the most recent result must be used, regardless of data source, for the indicators that require use of the most recent result.*
- *If an organization chooses to apply the optional exclusions, members must be numerator negative for at least one indicator, with the exception of HbA1c Poor Control (>9%). Remove members from the eligible population who are numerator negative for any indicator (other than for HbA1c Poor Control [>9%]). Do not exclude members who are numerator compliant for all indicators except HbA1c Poor Control (>9%), because a lower rate indicates better performance for this indicator.*

Statin Therapy for Patients With Diabetes (SPD)

MEASURE UPDATES JUNE 2021 FOR AMP MY 2021

- None.

MEASURE UPDATES SEPTEMBER 2020 FOR AMP MY 2021

- Updated rules for allowable gap for the Medi-Cal Managed Care product line.
- Added polycystic ovary syndrome to the optional exclusions.
- Removed the restriction that only one of two visits with a diabetes diagnosis may be an outpatient telehealth, telephone visit, e-visit, or virtual check-in when identifying the event/diagnosis.
- Removed the restriction that only one of two visits with an IVD diagnosis may be an outpatient telehealth, telephone visit, e-visit, or virtual check-in when identifying the event/diagnosis, step 2 required exclusions.
- Added telephone visits, e-visits, and virtual check-ins to the advanced illness exclusion.
- Added palliative care as a required exclusion.
- Added Donepezil-memantine to the "Dementia combinations" description in the Dementia Medications List.
- Added Pitavastatin 1 mg to the Pitavastatin Moderate Intensity Medications List and deleted the Pitavastatin Low Intensity Medications List.

MODIFICATIONS FROM HEDIS

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

Description

The percentage of members 40–75 years of age during the measurement year with diabetes who do not have clinical atherosclerotic cardiovascular disease (ASCVD) and met the following criteria. Two rates are reported:

1. *Received Statin Therapy.* Members who were dispensed at least one statin medication of any intensity during the measurement year.
2. *Statin Adherence 80%.* Members who remained on a statin medication of any intensity for at least 80% of the treatment period.

Definitions

IPSD	Index prescription start date. The earliest prescription dispensing date for any statin medication of any intensity during the measurement year.
Treatment period	The period beginning on the IPSD through the last day of the measurement year.

PDC	Proportion of days covered. The number of days the member is covered by at least one statin medication prescription of appropriate intensity, divided by the number of days in the treatment period.
Calculating number of days covered for multiple prescriptions	If multiple prescriptions for different medications are dispensed on the same day, calculate number of days covered by a statin medication (for the numerator) using the prescriptions with the longest days supply. For multiple different prescriptions dispensed on different days with overlapping days supply, count each day within the treatment period only once toward the numerator. If multiple prescriptions for the same medication are dispensed on the same or different day, sum the days supply and use the total to calculate the number of days covered by a statin medication (for the numerator). For example, if three prescriptions for the same medication are dispensed on the same day, each with a 30-day supply, sum the days supply for a total of 90 days covered by a statin. Subtract any days supply that extends beyond December 31 of the measurement year. Use the medication lists to determine if drugs are the same or different. Drugs in different lists are considered different drugs. For example, a dispensing event from the Amlodipine Atorvastatin High Intensity Medications List and a dispensing event from the Amlodipine Atorvastatin Moderate Intensity Medications List are dispensing events for different medications.

Eligible Population: *Rate 1*—Received Statin Therapy

Note: *Members in hospice are excluded from the eligible population. Refer to General Guideline 15: Members in Hospice.*

Product lines	Commercial HMO/POS, Commercial ACO, Medi-Cal Managed Care (report each product line separately).
Ages	40–75 years as of December 31 of the measurement year.
Continuous enrollment	
...for self-reporting POs	The measurement year and the year prior to the measurement year in the PO (parent level).
…for health plans	The measurement year and the year prior to the measurement year in the health plan and in the PO (parent level).
Allowable gap	No more than one gap in enrollment of up to 45 days during each year of continuous enrollment. To determine continuous enrollment for a Medi-Cal Managed Care beneficiary for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage (e.g., a member whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).
Anchor date	
…for self-reporting POs	Enrolled in the PO (parent level, or subgroup level, for eligible POs) and in an AMP plan on December 31 of the measurement year.
…for health plans	Enrolled in the health plan and the PO (parent level, or, for eligible POs, subgroup level) on December 31 of the measurement year.

Benefit Medical. Pharmacy during the measurement year.

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

Step 1 There are two ways to identify members with diabetes: by claim/encounter data and by pharmacy data. The organization must use both methods to identify the eligible population, but a member only needs to be identified by one method to be included in the measure. Members may be identified as having diabetes during the measurement year or the year prior to the measurement year.

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

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

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

Pharmacy data. Members who were dispensed insulin or hypoglycemics/ anti-hyperglycemics on an ambulatory basis during the measurement year or the year prior to the measurement year (Diabetes Medications List).

Diabetes Medications

Description	Prescription
Alpha-glucosidase inhibitors	• Acarbose • Miglitol
Amylin analogs	• Pramlintide
Antidiabetic combinations	• Alogliptin-metformin • Alogliptin-pioglitazone • Canagliflozin-metformin • Dapagliflozin-metformin • Empaglifozin-linagliptin • Empagliflozin-metformin • 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 detemir • Insulin glargine • Insulin glulisine • Insulin isophane human • Insulin isophane-insulin regular • Insulin lispro • Insulin lispro-insulin lispro protamine • Insulin regular human • Insulin human inhaled
Meglitinides	• Nateglinide • Repaglinide
Glucagon-like peptide-1 (GLP1) agonists	• Albiglutide • Dulaglutide • Exenatide • Liraglutide (excluding *Saxenda*®) • Semaglutide
Sodium glucose cotransporter 2 (SGLT2) inhibitor	• Canagliflozin • Dapagliflozin (excluding *Farxiga*®) • Empagliflozin
Sulfonylureas	• Chlorpropamide • Glimepiride • Glipizide • Glyburide • Tolazamide • Tolbutamide
Thiazolidinediones	• Pioglitazone • Rosiglitazone
Dipeptidyl peptidase-4 (DDP-4) inhibitors	• Alogliptin • Linagliptin • Saxagliptin • Sitaglipin

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

Step 2: Required exclusions

Exclude members who meet any of the following criteria:

- Members with cardiovascular disease are identified in two ways: by event or by diagnosis. The organization must use *both* methods to identify this population, but a member only needs to be identified by one method to be excluded from the measure.
  - *Event.* Any of the following during the year prior to the measurement year meet criteria:
    - *MI*. Discharged from an inpatient setting with an MI (MI Value Set) on the discharge claim. To identify discharges:
      1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
      2. Identify the discharge date for the stay.
    - *CABG.* Members who had CABG (CABG Value Set) in any setting.
    - *PCI.* Members who had PCI (PCI Value Set) in any setting.
    - *Other revascularization.* Members who had any other revascularization procedure (Other Revascularization Value Set) in any setting.
  - *Diagnosis.* Identify members as having ischemic vascular disease (IVD) 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 outpatient visit (Outpatient Value Set) with an IVD diagnosis (IVD Value Set).
    - A telephone visit (Telephone Visits Value Set) with an IVD diagnosis (IVD Value Set).
    - An e-visit or virtual check-in (Online Assessments Value Set) with an IVD diagnosis (IVD Value Set).
    - At least one acute inpatient encounter (Acute Inpatient Value Set) with an IVD diagnosis (IVD Value Set) ***without*** telehealth (Telehealth Modifier Value Set; Telehealth POS Value Set).
    - At least one acute inpatient discharge with an IVD diagnosis (IVD 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.
- Female members with a diagnosis of pregnancy (Pregnancy Value Set) during the measurement year or the year prior to the measurement year.
- In vitro fertilization (IVF Value Set) in the measurement year or the year prior to the measurement year.
- Dispensed at least one prescription for clomiphene (Estrogen Agonists Medications List) during the measurement year or the year prior to the measurement year.
- ESRD (ESRD Diagnosis Value Set) or dialysis (Dialysis Procedure Value Set) during the measurement year or the year prior to the measurement year.
- Cirrhosis (Cirrhosis Value Set) during the measurement year or the year prior to the measurement year.

- Myalgia, myositis, myopathy, or rhabdomyolysis (Muscular Pain and Disease Value Set) 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.

Estrogen Agonists Medications

Description	Prescription
Estrogen agonists	• Clomiphene

Step 3: Exclusions Exclude members who meet any of the following criteria:

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

- Members 66 years of age and older as of December 31 of the measurement year who meet either of the following:
  - Enrolled in an Institutional SNP (I-SNP) any time during the measurement year.
  - Living long-term in an institution any time during the measurement year as identified by the LTI flag in the Monthly Membership Detail Data File. Use the run date of the file to determine if a member had an LTI flag during the measurement year.*
- Members 66 years of age and older as of December 31 of the measurement year (all product lines) with frailty and advanced illness. Members must meet BOTH of the following frailty and advanced illness criteria to be excluded:
  1. At least one claim/encounter for frailty (Frailty Device Value Set; Frailty Diagnosis Value Set; Frailty Encounter Value Set; Frailty Symptom Value Set) during the measurement year.
  2. Any of the following during the measurement year or the year prior to the measurement year (count services that occur over both years):
  - At least two outpatient visits (Outpatient Value Set), observation visits (Observation Value Set), ED visits (ED Value Set), telephone visits (Telephone Visits Value Set), e-visits, or virtual check-ins (Online Assessments Value Set), nonacute inpatient encounters (Nonacute Inpatient Value Set), or nonacute inpatient discharges (instructions below; the diagnosis must be on the discharge claim) on different dates of service, with an advanced illness diagnosis (Advanced Illness Value Set). Visit type need not be the same for the two visits. To identify a nonacute inpatient discharge:
    1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
    2. Confirm the stay was for nonacute care based on the presence of a nonacute code (Nonacute Inpatient Stay Value Set) on the claim.
    3. Identify the discharge date for the stay.
  - At least one acute inpatient encounter (Acute Inpatient Value Set) with an advanced illness diagnosis (Advanced Illness Value Set).

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

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

Dementia Medications

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

Administrative Specification: *Rate 1*—Received Statin Therapy

Denominator The Rate 1 eligible population.

Numerator The number of members who had at least one dispensing event for a high-intensity, moderate-intensity, or low-intensity statin medication during the measurement year. Use all the medication lists below to identify statin medication dispensing events.

High, Moderate, and Low-Intensity Statin Medications

Description	Prescription	Medication Lists
High-intensity statin therapy	• Atorvastatin 40-80 mg	Atorvastatin High Intensity Medications List
High-intensity statin therapy	• Amlodipine-atorvastatin 40-80 mg	Amlodipine Atorvastatin High Intensity Medications List
High-intensity statin therapy	• Rosuvastatin 20-40 mg	Rosuvastatin High Intensity Medications List
High-intensity statin therapy	• Simvastatin 80 mg	Simvastatin High Intensity Medications List
High-intensity statin therapy	• Ezetimibe-simvastatin 80 mg	Ezetimibe Simvastatin High Intensity Medications List
Moderate-intensity statin therapy	• Atorvastatin 10-20 mg	Atorvastatin Moderate Intensity Medications List
Moderate-intensity statin therapy	• Amlodipine-atorvastatin 10-20 mg	Amlodipine Atorvastatin Moderate Intensity Medications List
Moderate-intensity statin therapy	• Rosuvastatin 5-10 mg	Rosuvastatin Moderate Intensity Medications List
Moderate-intensity statin therapy	• Simvastatin 20-40 mg	Simvastatin Moderate Intensity Medications List
Moderate-intensity statin therapy	• Ezetimibe-simvastatin 20-40 mg	Ezetimibe Simvastatin Moderate Intensity Medications List

Description	Prescription	Medication Lists
Moderate-intensity statin therapy	• Pravastatin 40-80 mg	Pravastatin Moderate Intensity Medications List
Moderate-intensity statin therapy	• Lovastatin 40 mg	Lovastatin Moderate Intensity Medications List
Moderate-intensity statin therapy	• Fluvastatin 40-80 mg	Fluvastatin Moderate Intensity Medications List
Moderate-intensity statin therapy	• Pitavastatin 1–4 mg	Pitavastatin Moderate Intensity Medications List
Low-intensity statin therapy	• Ezetimibe-simvastatin 10 mg	Ezetimibe Simvastatin Low Intensity Medications List
Low-intensity statin therapy	• Fluvastatin 20 mg	Fluvastatin Low Intensity Medications List
Low-intensity statin therapy	• Lovastatin 10-20 mg	Lovastatin Low Intensity Medications List
Low-intensity statin therapy	• Pravastatin 10–20 mg	Pravastatin Low Intensity Medications List
Low-intensity statin therapy	• Simvastatin 5-10 mg	Simvastatin Low Intensity Medications List

Eligible Population: *Rate 2*—Statin Adherence 80%

Note: *Members in hospice are excluded from the eligible population. Refer to General Guideline 15: Members in Hospice.*

Product lines Commercial HMO/POS, Commercial ACO, Medi-Cal Managed Care (report each product line separately).

Age 40–75 years as of December 31 of the measurement year.

Continuous enrollment

...for self-reporting POs The measurement year and the year prior to the measurement year in the PO (parent level).

…for health plans The measurement year and the year prior to the measurement year in the health plan and in the PO (parent level).

Allowable gap No more than one gap in enrollment of up to 45 days during each year of continuous enrollment. To determine continuous enrollment for a Medi-Cal Managed Care beneficiary for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage (e.g., a member whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).

Anchor date

…for self-reporting POs Enrolled in the PO (parent level, or subgroup level, for eligible POs) and in an AMP plan on December 31 of the measurement year.

…for health plans Enrolled in the health plan and the PO (parent level, or, for eligible POs, subgroup level) on December 31 of the measurement year.

Benefit Medical. Pharmacy during the measurement year.

Event/diagnosis All members who meet the numerator criteria for Rate 1.

Administrative Specification: *Rate 2*—Statin Adherence 80%

Denominator The Rate 2 eligible population.

Numerator The number of members who achieved a PDC of at least 80% during the treatment period.

Follow the steps below to identify numerator compliance.

Step 1 Identify the IPSD. The IPSD is the earliest dispensing event for any high-intensity, moderate-intensity, or low-intensity statin medication during the measurement year. Use all the medication lists above to identify statin medication dispensing events.

Step 2 To determine the treatment period, calculate the number of days on the IPSD to the end of the measurement year.

Step 3 Count the days covered by at least one prescription for any high-intensity, moderate-intensity, or low-intensity statin medication during the treatment period. To ensure the measure does not give credit for supply that extends beyond the measurement year, subtract any days supply that extends beyond December 31 of the measurement year.

Step 4 Calculate the member's PDC using the following equation. Multiply the equation by 100 and round (using the.5 rule) to the nearest whole number. For example, if a member has 291 total days covered by a medication during a 365-day treatment period, this calculates to 0.7972. Multiply this number by 100, convert it to 79.72% and round it to 80%, the nearest whole number.

$$\frac{\text{Total Days Covered by a Statin Medication in the Treatment Period (step 3)}}{\text{Total Days in Treatment Period (step 2)}}$$

Step 5 Sum the number of members whose PDC is ≥80% for the treatment period.

Exclusion *(optional)*

Members who do not have a diagnosis of diabetes (Diabetes Value Set), in any setting, during the measurement year or the year prior to the measurement year ***and*** who had a diagnosis of polycystic ovary syndrome (PCOS), gestational diabetes, or steroid-induced diabetes (Diabetes Exclusions Value Set), in any setting, during the measurement year or the year prior to the measurement year.

Organizations that apply optional exclusions must exclude members from the denominator for both rates.

If the member was included in the measure based on claim or encounter data, as described in the event/ diagnosis criteria, the optional exclusions do not apply because the member had a diagnosis of diabetes.

Note

- *All members who are numerator compliant for Rate 1 must be used as the eligible population for Rate 2 (regardless of the data source used to capture the Rate 1 numerator). For example, if supplemental data were used to identify compliance for the Rate 1 numerator, then supplemental data will be included in identifying the Rate 2 eligible population.*

Statin Use in Persons with Diabetes (SUPD)

MEASURE UPDATES JUNE 2021 FOR AMP MY 2021

- Added definition for Index Prescription Start Date (IPSD).
- Added clarifying language for Exclusions.
- Added clarifying language to "Event/Diagnosis."
- Added clarifying language to Numerator.
- Added clarifying language to the note on exclusion of products only approved for weight loss to Table DIABETES: Diabetes Medications.

MEASURE UPDATES SEPTEMBER 2020 FOR AMP MY 2021

- Added FERTILITY: Fertility Medications to the Medication Table.
- Changed Medication Table to Table SUPD-A: Diabetes Medications to DIABETES: Diabetes Medications and Table SUPD-B: Statin Medications to STATINS: Statin Medications.
- Added insulin aspart and niacinamide (DIABETES) to statins medications.
- Added requirement that IPSD occurs ≥ 90 days prior to the end of the measurement year.
- Added exclusions for rhabdomyolysis or myopathy, pregnancy, lactation, or fertility, liver disease, pre-diabetes, and polycystic ovary syndrome.

MODIFICATIONS FROM PQA

- None.

Description

The percentage of members ages 40–75 years who were dispensed a medication for diabetes that receive a statin medication.

Note: *Refer to the AMP Value Set Directory download for a comprehensive list of PQA medications and associated codes (PQA NDC Code List and PQA ICD Code List). Do not distribute NDC lists outside your organization.*

Onpoint will run this measure for health plans in MY 2021. Health plans are not expected to report the measure. POs may self-report this measure.

Definitions

Diabetes medications	Refer to Medication Table DIABETES: Diabetes Medications.
Statin medications	Refer to Medication Table STATINS: Statin Medications.
Measurement year	The calendar year (January 1 through December 31) when the measure is assessed.
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 a diabetes medication during the measurement year.
Hospice exclusion	Health plans reporting for Medicare Advantage, identify any member with a hospice indicator from the Monthly Membership Detail File. POs reporting for Medicare Advantage have the option of using the Monthly Membership Detail File or the HEDIS Hospice Encounter Value Set and Hospice Intervention Value Set to identify members in Hospice, refer *to General Guideline 15: Members in Hospice*.
ESRD diagnosis exclusion	Any member with a diagnosis of ESRD at any time during the measurement year. Refer to the PQA Value Set, 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. Medicare Data (if ICD codes not available): RxHCC 261 (Dialysis Status) or 262 (Chronic Kidney Disease Stage 5) for Payment Year 2020 or 2021. Available at: https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Risk-Adjustors.html. ***Note:*** *Use the most current information for the ESRD exclusion; using diagnosis codes is the preferred method. The RxHCC code can be found in the CMS Medicare Advantage and Prescription Drug System (MARx), which provides a monthly report of members' RxHCCs to plan sponsors. If the MARx System output is used, then the most recent version applies. Although the time frames are not consistent between diagnosis codes and the MARx System, using the most recent version provides the most current information to identify members with ESRD*.
Rhabdomyolysis and myopathy exclusions	Any member with a diagnosis of rhabdomyolysis or myopathy at any time during the measurement year Refer to the PQA Value Set, RHABDO-MYOPATHY. A rhabdomyolysis or myopathy diagnosis is defined as having at least one claim with rhabdomyolysis or myopathy in the primary diagnosis or any other diagnosis fields during the measurement year.
Pregnancy, lactation, and fertility exclusions	Any member with a diagnosis of pregnancy or lactation at any time during the measurement year or with fertility treatment during the measurement year. • A pregnancy diagnosis is defined as having at least one claim with pregnancy in the primary diagnosis or any other diagnosis fields during the measurement year. Refer to the PQA ICD Value Set, *PREGNANCY; or* • A lactation diagnosis is defined as having at least one claim with lactation in the primary diagnosis or any other diagnosis fields during the measurement year. Refer to the PQA ICD Value Set, *LACTATION; or*

- Fertility treatment is defined as having at least one claim for a medication indicated for fertility during the measurement year. Refer to Medication Table FERTILITY: Fertility Medications.

Liver disease exclusion	Any member with a diagnosis of liver disease at any time during the measurement year. Refer to the PQA Value Set, LIVER DISEASE. A liver disease diagnosis is defined as having at least one claim with liver disease in the primary diagnosis or any other diagnosis fields during the measurement year.
Pre-diabetes exclusion	Any member with a diagnosis of pre-diabetes at any time during the measurement year. Refer to the PQA Value Set, PRE-DIABETES. A pre-diabetes diagnosis is defined as having at least one claim with pre-diabetes in the primary diagnosis or any other diagnosis fields during the measurement year.
Polycystic Ovary Syndrome (PCOS) Exclusion	Any member with a diagnosis of polycystic ovary syndrome (PCOS) at any time during the measurement year. Refer to the PQA Value Set, PCOS. A PCOS diagnosis is defined as having at least one claim with PCOS in the primary diagnosis or any other diagnosis fields during the measurement year.

Eligible Population

Product line	Medicare Advantage.
Ages	40–75 years as of January 1 of the measurement year.
Continuous enrollment	
…for self-reporting POs	The measurement year in the PO (parent level).
…for health plans	The measurement year in the health plan and the PO (parent level).
Allowable gap	No more than one gap in 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).
Anchor date	
…for self-reporting POs	None.
...for health plans	None.

Benefit Medical, pharmacy.

Event/diagnosis Members with ≥2 prescription claims on different dates of service for any diabetes medication (see Medication Table DIABETES) during the measurement year.

Use the steps below to determine the eligible population.

Step 1 Identify members aged 40–75 years as of the first day of the measurement year.

Step 2 Identify members meeting the continuous enrollment criteria.

Step 3 Identify members with ≥2 prescription claims on different dates of service for a diabetes medication during the measurement year.

Step 4 Identify members with an IPSD that occurs ≥90 days prior to the end of the measurement year.

Step 5: Exclude members who met any of the following:

Required Exclusions

- *Hospice:* A hospice indicator at any time during the measurement year.
- *ESRD:* An ESRD diagnosis at any time during the measurement year.
- *Rhabdomyolysis or Myopathy:* A rhabdomyolysis or myopathy diagnosis at any time during the measurement year.
- *Pregnancy, Lactation, or Fertility*: A pregnancy or lactation diagnosis or fertility treatment at any time during the measurement year.
- *Liver Disease:* A liver disease diagnosis at any time during the measurement year.
- *Pre-Diabetes:* A pre-diabetes diagnosis at any time during the measurement year.

Polycystic Ovary Syndrome (PCOS): A PCOS diagnosis at any time during the measurement year.

Note

- *If a PO receives pharmacy claim information for a member, the PO can assume the member has a pharmacy benefit, and that the pharmacy benefit dates align with the medical benefit dates.*

Administrative Specification

Denominator The eligible population.

Numerator The number of members from the denominator with ≥1 prescription claim for a statin medication (Medication Table STATINS) during the measurement year.

Table DIABETES: Diabetes Medications

Biguanides		
• Metformin (+/- alogliptin, canagliflozin, dapagliflozin, empagliflozin, ertugliflozin, glipizide, glyburide, linagliptin, pioglitazone, repaglinide, rosiglitazone, saxagliptin, sitagliptin)		
Sulfonylureas		
• Chlorpropamide • Glipizide (+/- metformin)	• Glimepiride (+/- pioglitazone) • Glyburide (+/- metformin)	• Tolazamide • Tolbutamide
Meglitinides		
• Nateglinide	• Repaglinide (+/- metformin)	
Alpha-Glucosidase Inhibitors		
• Acarbose	• Miglitol	
Thiazolidinediones		
• Pioglitazone (+/- alogliptin, glimepiride, metformin)	• Rosiglitazone (+/- metformin)	
GLP-1 Receptor Agonists		
• Albiglutide • Dulaglutide	• Exenatide • Liraglutide (+/- insulin degludec)	• Lixisenatide (+/- insulin glargine) • Semaglutide
Amylin Analogs		
• Pramlintide		
DPP-4 Inhibitors		
• Alogliptin (+/- metformin, pioglitazone) • Linagliptin (+/- empagliflozin, metformin)	• Saxagliptin (+/-dapagliflozin, metformin) • Sitagliptin (+/- metformin, ertugliflozin)	
Insulins		
• Insulin aspart (+/-insulin aspart protamine, niacinamide) • Insulin degludec (+/- liraglutide) • Insulin detemir	• Insulin glargine (+/- lixisenatide) • Insulin glulisine • Insulin isophane (+/- regular insulin)	• Insulin lispro (+/- insulin lispro protamine) • Insulin regular (including inhalation powder)
Sodium Glucose Co-transporter2 (SGLT2) Inhibitors		
• Canagliflozin (+/- metformin) • Dapagliflozin (+/- metformin, saxagliptin)	• Empagliflozin (+/- linagliptin, metformin) • Ertugliflozin (+/- sitagliptin, metformin)	

Note: *The active ingredients are limited to oral, inhalation and injectable formulations only (excludes nutritional supplement/dietary management combination products, and products indicated only for weight loss).*

Table STATINS: Statin Medications

Statin Medications		
• Atorvastatin (+/- amlodipine) • Fluvastatin • Lovastatin (+/- niacin)	• Pitavastatin • Pravastatin • Rosuvastatin	• Simvastatin (+/-ezetimibe, niacin)

Note: *The active ingredients are limited to oral formulations only.*

Table FERTILITY: Fertility Medications

Fertility Medications
• Clomiphene

Note: *The active ingredients are limited to oral formulations only.*

Disease-Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis (ART)

MEASURE UPDATES JUNE 2021 FOR AMP MY 2021

- None – this measure was retired from HEDIS MY 2021.

  ***Note:** Organizations are expected to reference the "AMP MY 2021 Value Set Directory" and "HEDIS MY2020 Medication List Directory" for data collection and reporting.*

MEASURE UPDATES SEPTEMBER 2020 FOR AMP MY 2021

- Removed the restriction that only one of two visits with a rheumatoid arthritis diagnosis may be an outpatient telehealth, telephone visit, e-visit, or virtual check-in when identifying the event/diagnosis.
- Added telephone visits, e-visits, and virtual check-ins to the advanced illness exclusion.
- Added Upadacitinib to the "Janus kinase (JAK)" description in the DMARD Medications List.
- Added Donepezil-memantine to the "Dementia combinations" description in the Dementia Medications List.
- Added Mycophenolic acid to the "Immunosuppressive agents" description in the DMARD Medications List.

MODIFICATIONS FROM HEDIS

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

Description

The percentage of Medicare Advantage members 18 years of age and older who were diagnosed with rheumatoid arthritis and who were dispensed at least one ambulatory prescription for a disease modifying anti-rheumatic drug (DMARD).

Eligible Population

***Note:** Members in hospice are excluded from the eligible population. Refer to General Guideline 15: Members in Hospice.*

Product line	Medicare Advantage.
Ages	18 years and older as of December 31 of the measurement year.
Continuous enrollment	
...for self-reporting POs	The measurement year in the PO (parent level).
…for health plans	The measurement year in the health plan and PO (parent level).
Allowable gap	No more than one gap in enrollment of up to 45 days during the measurement year.

Anchor date

...for self-reporting POs Enrolled in the PO (parent level, or, for eligible POs, subgroup level) and in an AMP plan on December 31 of the measurement year.

…for health plans Enrolled in the health plan and PO (parent level, or, for eligible POs, subgroup level) and in an AMP plan on December 31 of the measurement year.

Benefit Medical and pharmacy.

Event/diagnosis Two of the following with different dates of service on or between January 1 and November 30 of the measurement year. Visit type need not be the same for the two visits.

- An outpatient visit (Outpatient Value Set), with any diagnosis of rheumatoid arthritis (Rheumatoid Arthritis Value Set).
- A telephone visit (Telephone Visits Value Set) with any diagnosis of rheumatoid arthritis (Rheumatoid Arthritis Value Set).
- An e-visit or virtual check-in (Online Assessments Value Set) with any diagnosis of rheumatoid arthritis (Rheumatoid Arthritis Value Set).
- A nonacute inpatient discharge, with any diagnosis of rheumatoid arthritis (Rheumatoid Arthritis Value Set) on the discharge claim. To identify nonacute inpatient discharges:
  1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
  2. Confirm the stay was for nonacute care based on the presence of a nonacute code (Nonacute Inpatient Stay Value Set) on the claim.
  3. Identify the discharge date for the stay.

Count a nonacute-to-nonacute direct transfer as two discharges only if both discharges have a diagnosis of rheumatoid arthritis and different discharge dates.

Exclusions Exclude members who meet any of the following criteria:

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

- Members 66 years of age and older as of December 31 of the measurement year who meet either of the following:
  - Enrolled in an Institutional SNP (I-SNP) any time during the measurement year.
  - Living long-term in an institution any time during the measurement year as identified by the LTI flag in the Monthly Membership Detail Data File. Use the run date of the file to determine if a member had an LTI flag during the measurement year.*
- Members 66–80 years of age as of December 31 of the measurement year (all product lines) with frailty ***and*** advanced illness. Members must meet **BOTH** of the following frailty and advanced illness criteria to be excluded:
  1. At least one claim/encounter for frailty (Frailty Device Value Set; Frailty Diagnosis Value Set; Frailty Encounter Value Set; Frailty Symptom Value Set) during the measurement year.

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

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

- Members 81 years of age and older as of December 31 of the measurement year (all product lines) with frailty (Frailty Device Value Set; Frailty Diagnosis Value Set; Frailty Encounter Value Set; Frailty Symptom Value Set) during the measurement year.

Dementia Medications

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

Administrative Specification

Denominator The eligible population.

Numerator Members who had at least one ambulatory prescription dispensed for a DMARD during the measurement year. There are two ways to identify members who received a DMARD: by claim/encounter data and by pharmacy data. The organization may use both methods to identify the numerator, but a member need only be identified by one method to be included in the numerator.

Claim/encounter data. A DMARD prescription (DMARD Value Set) during the measurement year.

Pharmacy data. Members who were dispensed a DMARD during the measurement year on an ambulatory basis (DMARD Medications List).

DMARD Medications

Description	Prescription		
5-Aminosalicylates	• Sulfasalazine		
Alkylating agents	• Cyclophosphamide		
Aminoquinolines	• Hydroxychloroquine		
Anti-rheumatics	• Auranofin • Leflunomide	• Methotrexate • Penicillamine	
Immunomodulators	• Abatacept • Adalimumab • Anakinra • Etanercept	• Golimumab • Certolizumab pegol • Infliximab • Rituximab	• Sarilumab • Tocilizumab
Immunosuppressive agents	• Azathioprine • Cyclosporine	• Mycophenolate mofetil • Mycophenolic acid	
Janus kinase (JAK) inhibitor	• Baricitinib	• Tofacitinib	• Upadacitinib
Tetracyclines	• Minocycline		

Exclusions *(optional)*

- A diagnosis of HIV (HIV Value Set; HIV Type 2 Value Set) any time during the member's history through December 31 of the measurement year.
- Female members with a diagnosis of pregnancy (Pregnancy Value Set) any time during the measurement year.

Note

- *This measure is administrative only; therefore, the use of valid data errors is not permitted, nor may supplemental data be used as a substitute for claims data for the event/diagnosis criteria (to correct billing errors) or to identify valid data errors.*

Osteoporosis Management in Women Who Had a Fracture (OMW)

MEASURE UPDATES JUNE 2021 FOR AMP MY 2021

- None.

MEASURE UPDATES SEPTEMBER 2020 FOR AMP MY 2021

- Updated the instructions for excluding visits that result in an inpatient stay (steps 1 and 2).
- Added telephone visits, e-visits, and virtual check-ins to the advanced illness exclusion.
- Added palliative care as a required exclusion.
- Added Donepezil-memantine to the "Dementia combinations" description in the Dementia Medications List.
- Added Romosozumab to the "Other agents" description in the Osteoporosis Medications List.

MODIFICATIONS FROM HEDIS

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

Description

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

Definitions

Intake Period — A 12-month (1 year) window that begins on July 1 of the year prior to the measurement year and ends on June 30 of the measurement year. The Intake Period is used to capture the first fracture.

Episode Date — The date of service for an eligible encounter during the Intake Period with a diagnosis of fracture.

For an outpatient, observation, or ED visit, the Episode Date is the date of service.

For an inpatient stay, the Episode Date is the date of discharge.

For direct transfers, the Episode Date is the discharge date from the last admission.

IESD — Index Episode Start Date. The earliest Episode Date during the Intake Period that meets all eligible population criteria.

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.

Note: *The direct transfer does not require a fracture diagnosis.*

Active prescription A prescription is considered active if the "days supply" indicated on the date the member filled the prescription is the number of days or more between that date and the relevant service date.

Eligible Population

Note: *Members in hospice are excluded from the eligible population. Refer to General Guideline 15: Members in Hospice.*

Product line Medicare Advantage.

Ages Women 67–85 years as of December 31 of the measurement year.

Continuous enrollment

...for self-reporting POs 12 months (1 year) before the Episode Date through 180 days (6 months) after the Episode Date in the PO (parent level).

…for health plans 12 months (1 year) before the Episode Date through 180 days (6 months) after the Episode Date in the health plan and PO (parent level).

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

Anchor date

...for self-reporting POs Episode Date in the PO (parent level, or, for eligible POs, subgroup level) and in an AMP plan.

…for health plans Episode Date in the health plan and the PO (parent level, or, for eligible POs, subgroup level).

Benefit Medical and pharmacy.

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

Step 1 Identify all members who had either of the following during the Intake Period.

- An outpatient visit (Outpatient Value Set), an observation visit (Observation Value Set), or an ED visit (ED Value Set), for a fracture (Fractures Value Set) ***without*** (Telehealth Modifier Value Set; Telehealth POS Value Set).

- Do not include visits that result in an inpatient stay (Inpatient Stay Value Set).

- An acute or nonacute inpatient discharge with a fracture (Fractures Value Set) on the discharge claim. 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.

If the member had more than one fracture, identify all fractures and assess eligibility in steps 2-4 below.

Step 2 Test for Negative Diagnosis History. Exclude fractures where either of the following occurred during the 60-day (2 months) period prior to the Episode Date.

- An outpatient visit (Outpatient Value Set), a telephone visit (Telephone Visits Value Set), an e-visit or virtual check-in (Online Assessments Value Set), an observation visit (Observation Value Set), or an ED visit (ED Value Set) for a fracture (Fractures Value Set).
  - Do not include visits that result in an inpatient stay (Inpatient Stay Value Set).
- An acute or nonacute inpatient discharge with a fracture (Fractures Value Set) on the discharge claim. 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.

For an acute or nonacute inpatient episode, use the date of admission to determine the 60-day period.

For episodes that were direct transfers, use the first admission to determine the Negative Diagnosis History.

For inpatient stay episodes that were a result of an outpatient, ED, or observation visit, use the date of the outpatient, ED, or observation visit to determine negative diagnosis history.

Step 3 Calculate continuous enrollment. Members must be continuously enrolled during the 12 months prior to the Episode Date through 180 days (6 months) post-Episode Date.

Step 4: Required exclusions Exclude Episode Dates where any of the following are met:

- Members who had a BMD test (Bone Mineral Density Tests Value Set) during the 730 days (24 months) prior to the Episode Date.
- Members who had a claim/encounter for osteoporosis therapy (Osteoporosis Medication Therapy Value Set) during the 365 days (12 months) prior to the Episode Date.
- Members who received a dispensed prescription or had an active prescription to treat osteoporosis (Osteoporosis Medications List) during the 365 days (12 months) prior to the Episode Date.

- Members who received palliative care (Palliative Care Assessment Value Set; Palliative Care Encounter Value Set; Palliative Care Intervention Value Set) during the intake period through the end of the measurement year.

For an acute or nonacute inpatient event, use the date of admission to identify the number of days prior to the Episode Date.

For direct transfers, use the first admission date to identify the number of days prior to the Episode Date.

For outpatient, ED, and observation visits that result in an inpatient stay, use the date of the outpatient, ED, or observation visit to identify the days prior to the Episode Date.

Step 5 Select the Episode Date. The measure examines the earliest eligible episode per member that meets the criteria above.

Step 6: Exclusions Exclude members who meet any of the following criteria:

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

- Members 67 years of age and older as of December 31 of the measurement year who meet either of the following:
  - Enrolled in an Institutional SNP (I-SNP) any time during the intake period through the end of the measurement year.
  - Living long-term in an institution any time during the intake period through the end of the measurement year as identified by the LTI flag in the Monthly Membership Detail Data File. Use the run date of the file to determine if a member had an LTI flag during the intake period through the end of the measurement year.*
- Members 67–80 years of age as of December 31 of the measurement year (all product lines) with frailty ***and*** advanced illness. Members must meet ***BOTH*** of the following frailty and advanced illness criteria to be excluded:
  1. At least one claim/encounter for frailty (Frailty Device Value Set; Frailty Diagnosis Value Set; Frailty Encounter Value Set; Frailty Symptom Value Set) during the intake period through the end of during the measurement year.
  2. Any of the following during the measurement year or the year prior to the measurement year (count services that occur over both years):
     - At least two outpatient visits (Outpatient Value Set), observation visits (Observation Value Set), ED visits (ED Value Set), telephone visits (Telephone Visits Value Set), e-visits, or virtual check-ins (Online Assessments Value Set), nonacute inpatient encounters (Nonacute Inpatient Value Set), or nonacute inpatient discharges (instructions below; the diagnosis must be on the discharge claim) on different dates of service, with an advanced illness diagnosis (Advanced Illness Value Set). Visit type need not be the same for the two visits. To identify a nonacute inpatient discharge:

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

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

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

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

- Members 81 years of age and older as of December 31 of the measurement year (all product lines) with frailty (Frailty Device Value Set; Frailty Diagnosis Value Set; Frailty Encounter Value Set; Frailty Symptom Value Set) during the intake period through the end of the measurement year.

Dementia Medications

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

Administrative Specification

Denominator The eligible population.

Numerator Appropriate testing or treatment for osteoporosis after the fracture defined by any of the following criteria:

- A BMD test (Bone Mineral Density Tests Value Set), in any setting, on the IESD or in the 180-day (6-month) period after the IESD.
- If the IESD was an inpatient stay, a BMD test (Bone Mineral Density Tests Value Set) during the inpatient stay.
- Osteoporosis therapy (Osteoporosis Medication Therapy Value Set) on the IESD or in the 180-day (6-month) period after the IESD.
- If the IESD was an inpatient stay, long-acting osteoporosis therapy (Long-Acting Osteoporosis Medications Value Set) during the inpatient stay.
- A dispensed prescription to treat osteoporosis (Osteoporosis Medications List) on the IESD or in the 180-day (6-month) period after the IESD.

Osteoporosis Medications

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

Note

- *Fractures of finger, toe, face, and skull are not included in this measure.*

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

MEASURE UPDATES JUNE 2021 FOR AMP MY 2021

- None.

MEASURE UPDATES SEPTEMBER 2020 FOR AMP MY 2021

- None.

MODIFICATIONS FROM HEDIS

- The AMP WCC measure only includes the BMI percentile indicator.

Description

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

- BMI percentile documentation*.

**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

***Note:** Members in hospice are excluded from the eligible population. Refer to General Guideline 15: Members in Hospice.*

Product line Medi-Cal Managed Care.

Ages 3–17 years as of December 31 of the measurement year. Report two age stratifications and a total for each of the three indicators:

- 3–11 years.
- 12–17 years.
- Total.

The total is the sum of the age stratifications.

Continuous enrollment

…for self-reporting POs The measurement year in the PO (parent level).

…. for health plans	The measurement year in the health plan and the PO (parent level).
Allowable gap	No more than one gap in continuous enrollment of up to 45 days during the measurement year. To determine continuous enrollment for a Medi-Cal Managed Care beneficiary for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage (e.g., a member whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).
Anchor date	
…for self-reporting POs	Enrolled in the PO (parent level, or subgroup level, for eligible POs) and in a AMP plan on December 31 of the measurement year.
…. for health plans	Enrolled in the health plan and the PO (parent level, or, for eligible POs, subgroup level) on 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.

Administrative Specification

Denominator	The eligible population.
Numerators	
BMI Percentile	BMI percentile (BMI Percentile Value Set) during the measurement year.

Exclusions *(optional)*

Female members who have a diagnosis of pregnancy (Pregnancy Value Set) during the measurement year. The denominator for all rates must be the same. An organization that excludes these members must do so for all rates.

Note

- *Refer to Appendix 2 for the definition of PCP and OB/GYN practitioner.*

Child and Adolescent Well-Care Visits (WCV)

MEASURE UPDATES JUNE 2021 FOR AMP MY 2021

- None.

MEASURE UPDATES SEPTEMBER 2020 FOR AMP MY 2021

- This measure is a combination measure that replaces the former Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life and Adolescent Well-Care Visits HEDIS measures.
- Added members age 7–11 years.
- Added age stratifications.
- Removed the telehealth exclusion.

MODIFICATIONS FROM HEDIS

- None.

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 Clinical Measures domain. The organization must follow the Guidelines for Clinical Quality measures when calculating this measure.*

Eligible Population

Note: *Members in hospice are excluded from the eligible population. Refer to General Guideline 15: Members in Hospice.*

Product line Medi-Cal Managed Care.

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

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

The total is the sum of the age stratifications for each product line.

Continuous enrollment

...for self-reporting POs The measurement year in the PO (parent level).

...for health plans	The measurement year in the health plan and the PO (parent level).
Allowable gap	No more than one gap in enrollment of up to 45 days during the continuous enrollment period. To determine continuous enrollment for a Medi-Cal Managed Care beneficiary for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage (e.g., a member whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).
Anchor date	
...for self-reporting POs	Enrolled in the PO (parent level, or subgroup level, for eligible POs) and in a AMP plan on December 31 of the measurement year.
...for health plans	Enrolled in the health plan and the PO (parent level, or, for eligible POs, subgroup level) on December 31 of the measurement year.
Benefit	Medical.
Event/diagnosis	None.

Administrative Specification

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

Note

- *Refer to* Appendix 2 *for the definition of* PCP and OB/GYN and other prenatal care practitioners.
- This measure is based on the American Academy of Pediatrics *Bright Futures: Guidelines for Health Supervision of Infants, Children and Adolescents* (published by the National Center for Education in Maternal and Child Health). Visit the Bright Futures website for more information about well-child visits (https://brightfutures.aap.org/materials-and-tools/guidelines-and-pocket-guide/).

Childhood Immunization Status (CIS)

MEASURE UPDATES JUNE 2021 FOR AMP MY 2021

- None.

MEASURE UPDATES SEPTEMBER 2020 FOR AMP MY 2021

- Updated rules for allowable gap for the Medi-Cal Managed Care product line.
- Added a requirement that LAIV (influenza) vaccination must occur on the child's second birthday.

MODIFICATIONS FROM HEDIS

- The AMP CIS measure only includes one combination rate (Combination 10).

Description

The percentage of enrolled children 2 years of age who were identified as having completed the following antigen series by their second birthday. The measure calculates a rate for each vaccine and one separate combination rate.

- Four diphtheria, tetanus, and acellular pertussis (DTaP).
- Three polio (IPV).
- One measles, mumps, 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).
- Two influenza (flu) vaccinations.
- Combination 10.

Eligible Population

Note: *Members in hospice are excluded from the eligible population. Refer to General Guideline 15: Members in Hospice.*

Product line	Commercial HMO/POS, Commercial ACO, Medi-Cal Managed Care (report each product line separately).
Age	Children who turn 2 years of age during the measurement year.
Continuous enrollment	
…for self-reporting POs	12 months prior to the child's second birthday in the PO (parent level).
…for health plans	12 months prior to the child's second birthday in the health plan and in the PO (parent level).
Allowable gap	No more than one gap in enrollment of up to 45 days during the 12 months prior to the child's second birthday. To determine continuous enrollment for a Medi-Cal Managed Care beneficiary for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage (e.g., a member whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).

Anchor date

…for self-reporting POs Enrolled in the PO (parent level, or subgroup level, for eligible POs) and in an AMP plan on the child's second birthday.

…for health plans Enrolled in the health plan and the PO (parent level, or subgroup level, for eligible POs) on the child's second birthday.

Benefit Medical.

Event/diagnosis None.

Administrative Specification

Denominator The eligible population.

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

- Evidence of the antigen or combination vaccine, ***or***
- Documented history of the illness, ***or***
- A seropositive test result for each antigen.

For DTaP, IPV, HiB, pneumococcal conjugate, rotavirus, and influenza, count *only:*

- Evidence of the antigen or combination vaccine.

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

DTaP At least four DTaP vaccinations (DTaP Immunization Value Set; DTaP Vaccine Procedure Value Set) with different dates of service on or before the child's second birthday. Do not count a vaccination administered prior to 42 days after birth.

IPV At least three IPV vaccinations (Inactivated Polio Vaccine (IPV) Immunization Value Set; Inactivated Polio Vaccine (IPV) Procedure Value Set), with different dates of service on or before the child's second birthday. Do not count a vaccination administered prior to 42 days after birth.

MMR Any of the following meet criteria:

- At least one MMR vaccination (Measles, Mumps and Rubella (MMR) Immunization Value Set; Measles, Mumps and Rubella (MMR) Vaccine Procedure Value Set) on or between the child's first and second birthdays.
- At least one measles and rubella vaccination (Measles Rubella Immunization Value Set; Measles Rubella Vaccine Procedure Value Set) on or between the child's first and second birthdays ***and*** one of the following:
  - At least one mumps vaccination (Mumps Immunization Value Set; Mumps Vaccine Procedure Value Set) on or between the child's first and second birthdays.
  - History of mumps illness (Mumps Value Set) any time on or before the child's second birthday.

- Any combination of codes from the table below that indicates evidence of all three antigens (on the same or different date of service).

Measles (any of the following)	Mumps (any of the following)	Rubella (any of the following)
• At least one measles vaccination (Measles Immunization Value Set; Measles Vaccine Procedure Value Set) administered on or between the child's first and second birthdays.	• At least one mumps vaccination (Mumps Immunization Value Set; Mumps Vaccine Procedure Value Set) administered on or between the child's first and second birthdays.	• At least one rubella vaccination (Rubella Immunization Value Set; Rubella Vaccine Procedure Value Set) administered on or between the child's first and second birthdays.
• History of measles (Measles Value Set) illness any time on or before the child's second birthday.	• History of mumps (Mumps Value Set) illness any time on or before the child's second birthday.	• History of rubella (Rubella Value Set) illness any time on or before the child's second birthday.

Note: *General Guideline 34: Collecting Data for Measures With Multiple Numerator Events (i.e., the 14-day rule) does not apply to MMR.*

HiB 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 on or before the child's second birthday. Do not count a vaccination administered prior to 42 days after birth.

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

- At least three hepatitis B vaccinations (Hepatitis B Immunization Value Set; Hepatitis B Vaccine Procedure Value Set), with different dates of service.
  - One of the three vaccinations may be a newborn hepatitis B vaccination (Newborn Hepatitis B Vaccine Administered Value Set) during the eight-day period that begins on the date of birth and ends seven 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 (Hepatitis B Value Set).

VZV Either 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.

Pneumococcal conjugate At least four pneumococcal conjugate vaccinations (Pneumococcal Conjugate Immunization Value Set; Pneumococcal Conjugate Vaccine Procedure Value Set), with different dates of service on or before the child's second birthday. Do not count a vaccination administered prior to 42 days after birth.

Hepatitis A Either 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.

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

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

Influenza At least two influenza vaccinations (Influenza Immunization Value Set; Influenza Vaccine Procedure Value Set), with different dates of service on or before the child's second birthday. Do not count a vaccination administered prior to 6 months (180 days) after birth.

One of the two vaccinations may be an LAIV vaccination (Influenza Virus LAIV Immunization Value Set; Influenza Virus LAIV Vaccine Procedure Value Set) administered on the child's second birthday. Do not count an LAIV vaccination administered before the child's second birthday.

Combination rate Calculate the following rates for Combination 10.

Combination Vaccination for Childhood Immunization Status

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

Exclusions *(optional)*

- Exclude children who had a contraindication for a specific vaccine from the denominator for all antigen rates and the combination rate. The denominator for all rates must be the same.
- Exclude contraindicated children only if administrative data do not indicate that the contraindicated immunization was rendered in its entirety.

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

Any particular vaccine

- Anaphylactic reaction to the vaccine or its components (Anaphylactic Reaction Due To Vaccination Value Set).

DTaP

- Encephalopathy (Encephalopathy Due To Vaccination Value Set) ***with*** a vaccine adverse-effect code (Vaccine Causing Adverse Effect Value Set).

MMR and VZV and influenza

- Immunodeficiency (Disorders of the Immune System Value Set).
- HIV (HIV Value Set; HIV Type 2 Value Set).
- Lymphoreticular cancer, multiple myeloma, or leukemia (Malignant Neoplasm of Lymphatic Tissue Value Set).
- Anaphylactic reaction to neomycin.

Rotavirus

- Severe combined immunodeficiency (Severe Combined Immunodeficiency Value Set).
- History of intussusception (Intussusception Value Set).

IPV

- Anaphylactic reaction to streptomycin, polymyxin B, or neomycin.

Hepatitis B

- Anaphylactic reaction to common baker's yeast.

Immunizations for Adolescents (IMA)

MEASURE UPDATES JUNE 2021 FOR AMP MY 2021

- None.

MEASURE UPDATES SEPTEMBER 2020 FOR AMP MY 2021

- Updated rules for allowable gap for the Medi-Cal Managed Care product line.

MODIFICATIONS FROM HEDIS

- None.

Description

The percentage of adolescents 13 years of age who had one dose of meningococcal vaccine, one tetanus, diphtheria toxoids, and acellular pertussis vaccine (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.

Eligible Population

Note: *Members in hospice are excluded from the eligible population. Refer to General Guideline 15: Members in Hospice.*

Product lines	Commercial HMO/POS, Commercial ACO, Medi-Cal Managed Care (report each product line separately).
Age	Adolescents who turn 13 years of age during the measurement year.
Continuous enrollment	
…for self-reporting POs	12 months prior to the member's 13th birthday in the PO (parent level).
…for health plans	12 months prior to the member's 13th birthday in the health plan and in the PO (parent level).
Allowable gap	No more than one gap in enrollment of up to 45 days during the 12 months prior to the 13th birthday. To determine continuous enrollment for a Medi-Cal Managed Care beneficiary for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage (e.g., a member whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).
Anchor date	
…for self-reporting POs	Enrolled in the PO (parent level, or subgroup level, for eligible POs) and in a AMP plan on the member's 13th birthday.
…for health plans	Enrolled in the health plan and the PO (parent level, or subgroup level, for eligible POs) on the member's 13th birthday.

Benefit Medical.

Event/diagnosis None.

Administrative Specification

Denominator The eligible population.

Numerators For meningococcal, Tdap, and HPV count *only* evidence of the antigen or combination vaccine.

Meningococcal serogroups A, C, W, Y At least one meningococcal serogroups A, C, W, Y vaccine (Meningococcal Immunization Value Set; Meningococcal Vaccine Procedure Value Set), with a date of service on or between the member's 11th and 13th birthdays.

Tdap At least one tetanus, diphtheria toxoids and acellular pertussis (Tdap) vaccine (Tdap Immunization Value Set; Tdap Vaccine Procedure Value Set), with a date of service on or between the member's 10th and 13th birthdays.

HPV

- At least two HPV vaccines (HPV Immunization Value Set; HPV Vaccine Procedure Value Set), with dates of service at least 146 days apart on or between the member's 9th and 13th birthdays. For example, if the service date for the first vaccine was March 1, then the service date for the second vaccine must be after July 25.

OR

- 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.

Combination 1 (Meningococcal, Tdap) Adolescents who are numerator compliant for both the meningococcal conjugate and Tdap indicators.

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

Exclusion *(optional)*

Exclude adolescents who had a contraindication for a specific vaccine from the denominator for all antigen rates and the combination rates. The denominator for all rates must be the same. Contraindicated adolescents may be excluded only if administrative data do not indicate that the contraindicated immunization was rendered.

Any of the following meet optional exclusion criteria:

Any particular vaccine

- Anaphylactic reaction to the vaccine or its components (Anaphylactic Reaction Due To Vaccination Value Set) any time on or before the member's 13th birthday.
- Anaphylactic reaction to the vaccine or its components (Anaphylactic Reaction Due To Serum Value Set), with a date of service prior to October 1, 2011.

Tdap

- Encephalopathy (Encephalopathy Due To Vaccination Value Set) with a vaccine adverse-effect code (Vaccine Causing Adverse Effect Value Set) anytime on or before the member's 13th birthday.

Chlamydia Screening in Women (CHL)

MEASURE UPDATES JUNE 2021 FOR AMP MY 2021

- None.

MEASURE UPDATES SEPTEMBER 2020 FOR AMP MY 2021

- Added Dienogest-estradiol (multiphasic) and removed Estradiol-medroxyprogesterone and Ethinyl estradiol-folic acid-levonorgestrel from the "Contraceptives" description in the Contraceptive Medications List.

MODIFICATIONS FROM HEDIS

- None.

Description

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

Eligible Population

Note: *Members in hospice are excluded from the eligible population. Refer to General Guideline 15: Members in Hospice.*

Product line Commercial HMO/POS, Commercial ACO, Medi-Cal Managed Care (report each product line separately).

Ages Women 16–24 years as of December 31 of the measurement year. Report two age stratifications and a total rate:

- 16–20 years.
- 21–24 years.
- Total.

The total is the sum of the age stratifications.

Continuous enrollment

…for self-reporting POs The measurement year in the PO (parent level).

…for health plans The measurement year in the health plan and in the PO (parent level).

Allowable gap No more than one gap in enrollment of up to 45 days during the measurement year. To determine continuous enrollment for a Medi-Cal Managed Care beneficiary for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage (e.g., a member whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).

Anchor date

…for self-reporting POs Enrolled in the PO (parent level, or subgroup level, for eligible POs) and in a AMP plan on December 31 of the measurement year.

…for health plans Enrolled in the health plan and the PO (parent level, or subgroup level, for eligible POs) on December 31 of the measurement year.

Benefit Medical.

Event/diagnosis *Sexually active*. Two methods identify sexually active women: pharmacy data and claim/encounter data. The organization must use both methods to identify the eligible population; however, a member only needs to be identified in one method to be eligible for the measure.

Claim/encounter data. Members who had a claim or encounter indicating sexual activity during the measurement year. A code from any of the following meets criteria:

- Pregnancy Value Set.
- Sexual Activity Value Set.
- Pregnancy Tests Value Set.

Pharmacy data. Members who were dispensed prescription contraceptives during the measurement year (Contraceptive Medications List).

Contraceptive Medications

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

Administrative Specification

Denominator The eligible population.

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

Exclusion *(optional)*

Exclude members who qualified for the denominator based on a *pregnancy test* (Pregnancy Tests Value Set) *alone* **and** who meet either of the following criteria:

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

Retinoid Medications

Description	Prescription
Retinoid	• Isotretinoin

Cervical Cancer Screening (CCS)

MEASURE UPDATES JUNE 2021 FOR AMP MY 2021

- None.

MEASURE UPDATES SEPTEMBER 2020 FOR AMP MY 2021

- Added palliative care as a required exclusion.

MODIFICATIONS FROM HEDIS

- The measure exclusion is required.

Description

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

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

Eligible Population

Note: *Members in hospice are excluded from the eligible population. Refer to General Guideline 15: Members in Hospice.*

Product lines	Commercial HMO/POS, Commercial ACO, Medi-Cal Managed Care (report each product line separately).
Ages	Women 24–64 years as of December 31 of the measurement year.
Continuous enrollment	
…for self-reporting POs	The measurement year and the two years prior to the measurement year in the PO (parent level). *For Medi-Cal Managed Care reporting:* The measurement year in the PO (parent level).
…for health plans	The measurement year and the two years prior to the measurement year in the health plan and in the PO (parent level). *For Medi-Cal Managed Care reporting:* The measurement year in the health plan and in the PO (parent level).

Allowable gap No more than one gap in enrollment of up to 45 days during each year of continuous enrollment. To determine continuous enrollment for a Medi-Cal Managed Care beneficiary for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage (e.g.., a member whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).

Anchor date

…for self-reporting POs Enrolled in the PO (parent level, or subgroup level, for eligible POs) and in a AMP plan on December 31 of the measurement year.

…for health plans Enrolled in the health plan and the PO (parent level, or, for eligible POs, subgroup level) on December 31 of the measurement year.

Benefit Medical.

Event/diagnosis None.

Administrative Specification

Denominator The eligible population.

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

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

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

Exclusions *(required)*

- Members receiving palliative care (Palliative Care Assessment Value Set; Palliative Care Encounter Value Set; Palliative Care Intervention Value Set) during the measurement year.
- Hysterectomy with no residual cervix, cervical agenesis or acquired absence of cervix (Absence of Cervix Diagnosis Value Set; Hysterectomy With No Residual Cervix Value Set) any time during the member's history through December 31 of the measurement year.

Cervical Cancer Overscreening (CCO)

MEASURE UPDATES JUNE 2021 FOR AMP MY 2021

- None.

MEASURE UPDATES SEPTEMBER 2020 FOR AMP MY 2021

- Added palliative care as a required exclusion.

MODIFICATIONS FROM HEDIS

- None (this is a non-HEDIS measure based on a HEDIS measure).

Description

The percentage of women 21–64 years of age who received more cervical cancer screenings than necessary according to evidence-based guidelines, using either of the following criteria:

- Women 21–64 who had more than one cervical cytology performed within the last 3 years.
- Women 30–64 who had more than one cervical high-risk human papillomavirus (hrHPV) testing performed within the last 5 years.
- Women 30–64 who had more than one cervical cytology/high-risk human papillomavirus (hrHPV) co-testing within the last 5 years.

Report one total rate.

Because this measure assesses overscreening, a lower rate indicates better performance.

Eligible Population

Note: *Members in hospice are excluded from the eligible population. Refer to General Guideline 15: Members in Hospice.*

Product lines	Commercial HMO/POS, Commercial ACO, Medi-Cal Managed Care (report each product line separately).
Ages	Women 24–64 years as of December 31 of the measurement year.
Continuous enrollment	
…for self-reporting POs	The measurement year and the two years prior to the measurement year in the PO (parent level). *For Medi-Cal Managed Care reporting:* The measurement year in the PO (parent level).
…for health-plans	The measurement year and the two years prior to the measurement year in the health plan and in the PO (parent level). For Medi-Cal Managed Care reporting: The measurement year in the health plan and in the PO (parent level).

Allowable gap	No more than one gap in enrollment of up to 45 days during each year of continuous enrollment. To determine continuous enrollment for a Medi-Cal Managed Care beneficiary for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage (e.g., a member whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).
Anchor date	
…for self-reporting POs	Enrolled in the PO (parent level, or subgroup level, for eligible POs) and in an AMP plan on December 31 of the measurement year.
…for health plans	Enrolled in the health plan and the PO (parent level, or, for eligible POs, subgroup level) on December 31 of the measurement year.
Benefit	Medical.
Event/ diagnosis	None.

Administrative Specification

Denominator	The eligible population.
Numerator	The number of women who were screened too frequently for cervical cancer. Either of the following meet criteria: • Women 24–64 years of age as of December 31 of the measurement year who had more than one cervical cytology (Cervical Cytology Lab Test Value Set; Cervical Cytology Result or Finding Value Set) during the measurement year or the two years prior to the measurement year. • Women 30–64 years of age as of December 31 of the measurement year who had more than one cervical high-risk human papillomavirus (hrHPV) testing (High Risk HPV Lab Test Value Set; High Risk HPV Test Result or Finding Value Set) during the measurement year or the four years prior to the measurement year ***and*** who were 30 years or older on the date of both tests. ***Note:*** *Evidence of more than one hrHPV testing within the last 5 years also captures patients who had cotesting; therefore, additional methods to identify cotesting are not necessary.* *If two or more claims/encounters with qualifying numerator codes for cervical cytology occur within 14 days of each other, count only the first one. Refer to General Guideline 34.*

Exclusions *(required)*

- Members receiving palliative care (Palliative Care Assessment Value Set; Palliative Care Encounter Value Set; Palliative Care Intervention Value Set) during the measurement year.
- Hysterectomy with no residual cervix, cervical agenesis, or acquired absence of cervix (Absence of Cervix Diagnosis Value Set; Hysterectomy With No Residual Cervix Value Set) any time during the member's history through December 31 of the measurement year.
- A diagnosis of dysplasia, HPV codes, or an abnormal cervical cytology screening (CCO Exclusions Group 1 Value Set) during the measurement year or four years prior to the measurement year.

- A history of cervical cancer, DES exposure, HIV, or immunodeficiency, including genetic (congenital) immunodeficiency syndromes (CCO Exclusions Group 2 Value Set) any time during the member's history through December 31 of the measurement year.

Note: *Current cervical cancer screening guidelines for average-risk women do not state that women 30–64 years of age with a "cervical cytology" in 3 years and a "cervical cytology and HPV co-test" in 5 years are considered overscreened. For AMP reporting, we look only at cases of overscreening as explicitly outlined by the guidelines. AMP staff and committees will continue to review clinical practices and cervical cancer screening guidelines.*

Breast Cancer Screening (BCS)

MEASURE UPDATES JUNE 2021 FOR AMP MY 2021

- None.

MEASURE UPDATES SEPTEMBER 2020 FOR AMP MY 2021

- Added palliative care as a required exclusion.
- Added telephone visits, e-visits, and virtual check-ins to the advanced illness exclusion.
- Added Donepezil-memantine to the "Dementia combinations" description in the Dementia Medications List.

MODIFICATIONS FROM HEDIS

- AMP does not include the Medicare SES Stratifications.
- The exclusion for members living long-term in an institution is optional for POs that do not have access to the LTI flag in the Monthly Membership Detail Data File.

Description

The percentage of women 50–74 years of age who had a mammogram to screen for breast cancer. The eligible population starts at 52 years of age to account for the look-back period.

Eligible Population

Note: *Members in hospice are excluded from the eligible population. Refer to General Guideline 15: Members in Hospice.*

Product lines	Commercial HMO/POS, Commercial ACO, Medicare Advantage, Medi-Cal Managed Care (report each product line separately).
Ages	Women 52–74 years as of December 31 of the measurement year.
Continuous enrollment	
…for self-reporting POs	October 1 two years prior to the measurement year through December 31 of the measurement year in the PO (parent level).
…for health plans	October 1 two years prior to the measurement year through December 31 of the measurement year in the health plan and in the PO (parent level).
Allowable gap	No more than one gap in enrollment of up to 45 days for each full calendar year of continuous enrollment (the measurement year and the year prior to the measurement year). To determine continuous enrollment for a Medi-Cal Managed Care beneficiary for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage (e.g., a member whose coverage lapses for 2 months [60 days] is not considered continuously enrolled) during each year of continuous enrollment. No gaps in enrollment are allowed from October 1 two years prior to the measurement year through December 31 two years prior to the measurement year.

Anchor date

…for self-reporting POs Enrolled in the PO (parent level, or subgroup level, for eligible POs) and in an AMP plan on December 31 of the measurement year.

…for health plans Enrolled in the health plan and the PO (parent level, or subgroup level, for eligible POs) on December 31 of the measurement year.

Benefit Medical.

Event/diagnosis None.

Required exclusion Members receiving palliative care (Palliative Care Assessment Value Set; Palliative Care Encounter Value Set; Palliative Care Intervention Value Set) during the measurement year.

Exclusions Exclude members who meet any of the following criteria:

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

- Medicare Advantage members 66 years of age and older as of December 31 of the measurement year who meet either of the following:
  - Enrolled in an Institutional SNP (I-SNP) any time during the measurement year.
  - Living long-term in an institution any time during the measurement year as identified by the LTI flag in the Monthly Membership Detail Data File. Use the run date of the file to determine if a member had an LTI flag during the measurement year.*
- Members 66 years of age and older as of December 31 of the measurement year (all product lines) with frailty ***and*** advanced illness. Members must meet ***BOTH*** of the following frailty and advanced illness criteria to be excluded:
  1. At least one claim/encounter for frailty (Frailty Device Value Set; Frailty Diagnosis Value Set; Frailty Encounter Value Set; Frailty Symptom Value Set) during the measurement year.
  2. Any of the following during the measurement year or the year prior to the measurement year (count services that occur over both years):
     - At least two outpatient visits (Outpatient Value Set), observation visits (Observation Value Set), ED visits (ED Value Set), telephone visits (Telephone Visits Value Set), e-visits or virtual check-ins (Online Assessments Value Set), nonacute inpatient encounters (Nonacute Inpatient Value Set), or nonacute inpatient discharges (instructions below; the diagnosis must be on the discharge claim) on different dates of service, with an advanced illness diagnosis (Advanced Illness Value Set). Visit type need not be the same for the two visits. To identify a nonacute inpatient discharge:
       1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
       2. Confirm the stay was for nonacute care based on the presence of a nonacute code (Nonacute Inpatient Stay Value Set) on the claim.
       3. Identify the discharge date for the stay.
     - At least one acute inpatient encounter (Acute Inpatient Value Set) with an advanced illness diagnosis (Advanced Illness Value Set).

- At least one acute inpatient discharge with an advanced illness diagnosis (Advanced Illness Value Set). To identify an acute inpatient discharge:
  1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
  2. Exclude nonacute inpatient stays (Nonacute Inpatient Stay Value Set).
  3. Identify the discharge date for the stay.
- A dispensed dementia medication (Dementia Medications List).

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

Dementia Medications

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

Administrative Specification

Denominator The eligible population.

Numerator One or more mammograms (Mammography Value Set) any time on or between October 1 two years prior to the measurement year and December 31 of the measurement year.

Exclusion *(optional)*

Bilateral mastectomy any time during the member's history through December 31 of the measurement year. Any of the following meet criteria for bilateral mastectomy:

- Bilateral mastectomy (Bilateral Mastectomy Value Set).
- Unilateral mastectomy (Unilateral Mastectomy Value Set) ***with*** a bilateral modifier (Bilateral Modifier Value Set). Codes must be on the same claim.
- Unilateral mastectomy found in clinical data (Clinical Unilateral Mastectomy Value Set) with a bilateral modifier (Clinical Bilateral Modifier Value Set).

  Note: *The "clinical" mastectomy value sets identify mastectomy; the word "clinical" refers to the data source, not to the type of mastectomy.*
- History of bilateral mastectomy (History of Bilateral Mastectomy Value Set).
- Any combination of codes from the table below that indicate a mastectomy on ***both*** the left ***and*** right side on the same or different dates of service.

Left Mastectomy (any of the following)	Right Mastectomy (any of the following)
• Unilateral mastectomy (Unilateral Mastectomy Value Set) ***with*** a left-side modifier (Left Modifier Value Set) (same procedure)	• Unilateral mastectomy (Unilateral Mastectomy Value Set) ***with*** a right-side modifier (Right Modifier Value Set) (same procedure)

• Unilateral mastectomy found in clinical data (Clinical Unilateral Mastectomy Value Set) ***with*** a left-side modifier (Clinical Left Modifier Value Set) (same procedure)	• Unilateral mastectomy found in clinical data (Clinical Unilateral Mastectomy Value Set) ***with*** a right-side modifier (Clinical Right Modifier Value Set) (same procedure)
• Absence of the left breast (Absence of Left Breast Value Set)	• Absence of the right breast (Absence of Right Breast Value Set)
• Left unilateral mastectomy (Unilateral Mastectomy Left Value Set)	• Right unilateral mastectomy (Unilateral Mastectomy Right Value Set)

Note

- *This measure assesses the use of imaging to detect early breast cancer in women. Because the measure denominator does not remove women at higher risk of breast cancer, all types and methods of mammograms (screening, diagnostic, film, digital, or digital breast tomosynthesis) qualify for numerator compliance. Do not count MRIs, ultrasounds, or biopsies toward the numerator. Although these procedures may be indicated for evaluating women at higher risk for breast cancer or for diagnostic purposes, they are performed as an adjunct to mammography and do not alone count toward the numerator.*

Colorectal Cancer Screening (COL)

MEASURE UPDATES JUNE 2021 FOR AMP MY 2021

- None.

MEASURE UPDATES SEPTEMBER 2020 FOR AMP MY 2021

- Added palliative care as a required exclusion.
- Added telephone visits, e-visits, and virtual check-ins to the advanced illness exclusion.
- Added Donepezil-memantine to the "Dementia combinations" description in the Dementia Medications List.

MODIFICATIONS FROM HEDIS

- AMP does not include the Medicare SES Stratifications.
- AMP specifies the Continuous enrollment separately for the Medi-Cal Managed Care product line.
- The exclusion for members living long-term in an institution is optional for POs that do not have access to the LTI flag in the Monthly Membership Detail Data File.

Description

The percentage of adults 50–75 years of age who had appropriate screening for colorectal cancer. The eligible population starts at 51 years of age to account for the look-back period.

Eligible Population

Note: *Members in hospice are excluded from the eligible population. Refer to General Guideline 15: Members in Hospice.*

Product lines	Commercial HMO/POS, Commercial ACO, Medicare Advantage, Medi-Cal Managed Care (report each product line separately).
Ages	51–75 years as of December 31 of the measurement year.
Continuous enrollment	
…for self-reporting POs	The measurement year and the year prior to the measurement year in the PO (parent level). *For Medi-Cal Managed Care reporting:* The measurement year in the PO (parent level).
…for health plans	The measurement year and the year prior to the measurement year in the health plan and in the PO (parent level). *For Medi-Cal Managed Care reporting:* The measurement year in the health plan and in the PO (parent level).
Allowable gap	No more than one gap in enrollment of up to 45 days during each year of continuous enrollment.

To determine continuous enrollment for a Medi-Cal Managed Care beneficiary for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage (e.g., a member whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).

Anchor date

…for self-reporting POs Enrolled in the PO (parent level, or subgroup level, for eligible POs) and in an AMP plan on December 31 of the measurement year.

…for health plans Enrolled in the health plan and the PO (parent level, or subgroup level, for eligible POs) on December 31 of the measurement year.

Benefit Medical.

Event/diagnosis None.

Required exclusion Members receiving palliative care (Palliative Care Assessment Value Set; Palliative Care Encounter Value Set; Palliative Care Intervention Value Set) during the measurement year.

Exclusions Exclude members who meet any of the following criteria:

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

- Medicare Advantage members 66 years of age and older as of December 31 of the measurement year who meet either of the following:
  - Enrolled in an Institutional SNP (I-SNP) any time during the measurement year.
  - Living long-term in an institution any time during the measurement year as identified by the LTI flag in the Monthly Membership Detail Data File. Use the run date of the file to determine if a member had an LTI flag during the measurement year.*
- Members 66 years of age and older as of December 31 of the measurement year (all product lines) with frailty ***and*** advanced illness. Members must meet **BOTH** of the following frailty and advanced illness criteria to be excluded:
  1. At least one claim/encounter for frailty (Frailty Device Value Set; Frailty Diagnosis Value Set; Frailty Encounter Value Set; Frailty Symptom Value Set) during the measurement year.
  2. Any of the following during the measurement year or the year prior to the measurement year (count services that occur over both years):
     - At least two outpatient visits (Outpatient Value Set), observation visits (Observation Value Set), ED visits (ED Value Set), telephone visits (Telephone Visits Value Set), e-visits, or virtual check-ins (Online Assessments Value Set), nonacute inpatient encounters (Nonacute Inpatient Value Set), or nonacute inpatient discharges (instructions below; the diagnosis must be on the discharge claim) on different dates of service, with an advanced illness diagnosis (Advanced Illness Value Set). Visit type need not be the same for the two visits. To identify a nonacute inpatient discharge:

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

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

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

Dementia Medications

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

Administrative Specification

Denominator The eligible population.

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

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

Exclusion *(optional)*

Either of the following any time during the member's history through December 31 of the measurement year:

- Colorectal cancer (Colorectal Cancer Value Set).
- Total colectomy (Total Colectomy Value Set; History of Total Colectomy Value Set).

Prenatal and Postpartum Care (PPC)

MEASURE UPDATES JUNE 2021 FOR AMP MY 2021

- None.

MEASURE UPDATES SEPTEMBER 2020 FOR AMP MY 2021

- Revised the definition of "last enrollment segment."
- Clarified that visits that occur prior to the enrollment start date (during the pregnancy) meet criteria.
- Added telephone visits (Telephone Visits Value Set) e-visits and virtual check-ins (Online Assessments Value Set) to the Timeliness of Prenatal Care rate (administrative specification) and clarified in the *Notes* that services provided via telephone, e-visit, or virtual check-in are eligible for use in reporting both rates.

MODIFICATIONS FROM HEDIS

- None.

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 women, 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 EDD).
Last enrollment segment	The period of continuous enrollment (with no gaps in enrollment) during the pregnancy with the start date that is closest to the delivery date. Refer to *General Guideline 20: Members Who Switch Products/Product Lines* to determine continuous enrollment.

Eligible Population

Note: *Members in hospice are excluded from the eligible population. Refer to General Guideline 15: Members in Hospice.*

Product line	Medi-Cal Managed Care.
Age	None specified.

Continuous enrollment

...for self-reporting POs 43 days prior to delivery through 60 days after delivery in the PO (parent level).

...for health plans 43 days prior to delivery through 60 days after delivery in the health plan and the PO (parent level).

Allowable gap No allowable gap during the continuous enrollment period.

Anchor date

...for self-reporting POs Enrolled in the PO (parent level, or subgroup level, for eligible POs) and in an AMP plan on the date of delivery.

...for health plans Enrolled in the health plan and the PO (parent level, or subgroup level, for eligible POs) on the date of delivery.

Benefit Medical.

Event/diagnosis *Delivered a live birth on or between October 8 of the year prior to the measurement year and October 7 of the measurement year.* Include women who delivered in any setting.

Multiple births. Women who had two separate deliveries (different dates of service) between October 8 of the year prior to the measurement year and October 7 of the measurement year count twice. Women who had multiple live births during one pregnancy count once.

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

Step 1 Identify deliveries. Identify all women 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 Exclude 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.

Note: *If a member has multiple enrollment segments with no gaps in enrollment leading up to delivery, use the beginning of the first segment as the start of the last segment (i.e., treat multiple enrollment segments with* ***no gap*** *in enrollment as one segment).*

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 women whose last enrollment segment started before, on or between 280 and 219 days before delivery (or EDD).

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

Step 2 Identify women whose last enrollment segment started less than 219 days before delivery (or EDD).

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

Do not count visits that occur on or after the date of delivery.

Visits that occur prior to the woman's enrollment start date during the pregnancy meet criteria.

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

- A bundled service (Prenatal Bundled Services Value Set) where the organization can identify the date when prenatal care was initiated (because bundled service codes are used on the date of delivery, these codes may be used only if the claim form indicates when prenatal care was initiated).
- A visit for prenatal care (Stand Alone Prenatal Visits Value Set).
- A prenatal visit (Prenatal Visits Value Set; Telephone Visits Value Set; Online Assessments Value Set) ***with*** a pregnancy-related diagnosis code (Pregnancy Diagnosis Value Set).

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

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

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

Note: *The organization is not required to identify practitioner type in administrative data.*

Note

- *Criteria for identifying prenatal care for women who were not continuously enrolled during the first trimester allow more flexibility than criteria for women who were continuously enrolled.*
  - *For women whose last enrollment segment started before, on or between 280 and 219 days before delivery, the organization has sufficient opportunity to provide prenatal care by the end of the first trimester.*

  - *For women whose last enrollment segment started less than 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 excluded 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 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 2 for the definition of* PCP *and* OB/GYN and other prenatal care practitioner.
- *For both rates, services provided during a telephone visit, e-visit, or virtual check-in are eligible for use in reporting.*

Asthma Medication Ratio (AMR)

MEASURE UPDATES JUNE 2021 FOR AMP MY 2021

- None.

MEASURE UPDATES SEPTEMBER 2020 FOR AMP MY 2021

- Removed the restriction that only three of four visits with an asthma diagnosis may be an outpatient telehealth, telephone visit, e-visit, or virtual check-in when identifying the event/diagnosis.
- Clarified in step 1 when the diagnosis must be on the discharge claim.
- Added Dupilumab to the "Anti-interleukin-4" description in the Dupilumab Medications List.
- Clarified NDC code mapping requirements in the *Notes.*

MODIFICATIONS FROM HEDIS

- None.

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

An oral medication dispensing event is 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). The organization should allocate the dispensing events to the appropriate year based on the date when the prescription is filled.

Multiple prescriptions for different medications dispensed on the same day should be assessed separately. 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 filled.

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 filled.

Units of medication

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

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

Eligible Population for Persistent Asthmatics

Note: *Members in hospice are excluded from the eligible population. Refer to General Guideline 15: Members in Hospice.*

Product lines

Commercial HMO/POS, Commercial ACO, Medi-Cal Managed Care (report each product line separately).

Ages

5–64 years by December 31 of the measurement year. Report the following age stratifications and one total rate.

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

The total is the sum of the age stratifications for each product line.

Continuous enrollment

…for self-reporting POs

The measurement year and the year prior to the measurement year in the PO (parent level).

…for health plans

The measurement year and the year prior to the measurement year in the health plan and in the PO (parent level).

Allowable gap No more than one gap in enrollment of up to 45 days during each year of continuous enrollment. To determine continuous enrollment for a Medi-Cal Managed Care beneficiary for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage during each year of continuous enrollment.

Anchor date

…for self-reporting POs Enrolled in the PO (parent level, or, for eligible POs, subgroup level) and in a AMP plan on December 31 of the measurement year.

…for health plans Enrolled in the health plan and the PO (parent level, or, for eligible POs, subgroup level) on December 31 of the measurement year.

Benefits Medical. Pharmacy during the measurement year.

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

Step 1 Identify members as having persistent asthma who met at least one of the following criteria during both the measurement year and the year prior to the measurement year. Criteria need not be the same across both years.

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

Step 3: Required exclusions Exclude members who met any of the following criteria:

- Members who had any diagnosis from any of the following value sets, any time during the member's history through December 31 of the measurement year:
  - Emphysema Value Set.
  - Other Emphysema Value Set.
  - COPD Value Set.
  - Obstructive Chronic Bronchitis Value Set.
  - Chronic Respiratory Conditions Due to Fumes or Vapors Value Set.
  - Cystic Fibrosis Value Set.
  - Acute Respiratory Failure Value Set.
- Members who had no asthma controller or reliever medications dispensed during the measurement year. Use all the medication lists in the tables below to identify asthma controller and reliever medications.

Administrative Specification

Denominator The eligible population.

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

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

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

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

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

Step 4 For each member, calculate the ratio of controller medications to total asthma medications using the following formula. Round (using the .5 rule) to the nearest whole number.

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

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

Asthma Controller Medications

Description	Prescriptions	Medication Lists	Route
Antiasthmatic combinations	• Dyphylline-guaifenesin	Dyphylline Guaifenesin Medications List	Oral
Antibody inhibitors	• Omalizumab	Omalizumab Medications List	Injection
Anti-interleukin-4	• Dupilumab	Dupilumab Medications List	Injection
Anti-interleukin-5	• Benralizumab	Benralizumab Medications List	Injection
Anti-interleukin-5	• Mepolizumab	Mepolizumab Medications List	Injection
Anti-interleukin-5	• Reslizumab	Reslizumab Medications List	Injection
Inhaled steroid combinations	• Budesonide-formoterol	Budesonide Formoterol Medications List	Inhalation
Inhaled steroid combinations	• Fluticasone-salmeterol	Fluticasone Salmeterol Medications List	Inhalation
Inhaled steroid combinations	• Fluticasone-vilanterol	Fluticasone Vilanterol Medications List	Inhalation
Inhaled steroid combinations	• Formoterol-mometasone	Formoterol Mometasone Medications List	Inhalation
Inhaled corticosteroids	• Beclomethasone	Beclomethasone Medications List	Inhalation
Inhaled corticosteroids	• Budesonide	Budesonide Medications List	Inhalation
Inhaled corticosteroids	• Ciclesonide	Ciclesonide Medications List	Inhalation
Inhaled corticosteroids	• Flunisolide	Flunisolide Medications List	Inhalation
Inhaled corticosteroids	• Fluticasone	Fluticasone Medications List	Inhalation
Inhaled corticosteroids	• Mometasone	Mometasone Medications List	Inhalation
Leukotriene modifiers	• Montelukast	Montelukast Medications List	Oral
Leukotriene modifiers	• Zafirlukast	Zafirlukast Medications List	Oral
Leukotriene modifiers	• Zileuton	Zileuton Medications List	Oral
Methylxanthines	• Theophylline	Theophylline Medications List	Oral

Asthma Reliever Medications

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

Note

- *Do not use RxNorm codes when assessing the numerator.*
- *When mapping NDC codes, medications described as "injection," "prefilled syringe," "subcutaneous," "intramuscular," or "auto-injector" are considered "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.*

Appropriate Testing for Pharyngitis (CWP)

MEASURE UPDATES JUNE 2021 FOR AMP MY 2021

- Added a denominator note to the Event/diagnosis.

MEASURE UPDATES SEPTEMBER 2020 FOR AMP MY 2021

- Updated the instructions for excluding visits that result in an inpatient stay.
- Removed Sulfisoxazole from the "Sulfonamides" description in the CWP Antibiotic Medications List.
- Deleted step 8; this step is unnecessary because these members are removed in step 5.

MODIFICATIONS FROM HEDIS

- None.

Description

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

Definitions

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

Eligible Population

Note: *Members in hospice are excluded from the eligible population. Refer to General Guideline 15: Members in Hospice.*

Product lines Commercial HMO/POS, Commercial ACO, Medi-Cal Managed Care (report each product line separately).

Ages Members who were 3 years or older as of the Episode Date.

Report three age stratifications and total rate:

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

The total is the sum of the age stratifications.

Continuous enrollment

…. for self-reporting POs 30 days prior to the Episode Date through 3 days after the Episode Date (34 total days) in the PO (parent level).

…. for health plans 30 days prior to the Episode Date through 3 days after the Episode Date (34 total days) in the health plan and in the PO (parent level).

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

Anchor date

…. for self-reporting POs None.

…. for health plans None.

Benefits Medical and pharmacy.

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

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

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

Do not include visits that result in an inpatient stay (Inpatient Stay Value Set).

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

Exclude Episode Dates if the member did not receive antibiotics on or up to three days after the Episode Date.

CWP Antibiotic Medications

Description	Prescription	
Aminopenicillins	• Amoxicillin	• Ampicillin
Beta-lactamase inhibitors	• Amoxicillin-clavulanate	
First generation cephalosporins	• Cefadroxil • Cefazolin	• Cephalexin
Folate antagonist	• Trimethoprim	
Lincomycin derivatives	• Clindamycin	
Macrolides	• Azithromycin • Clarithromycin • Erythromycin	• Erythromycin ethylsuccinate • Erythromycin lactobionate • Erythromycin stearate
Natural penicillins	• Penicillin G benzathine • Penicillin G potassium	• Penicillin G sodium • Penicillin V potassium
Penicillinase-resistant penicillins	• Dicloxacillin	
Quinolones	• Ciprofloxacin • Levofloxacin	• Moxifloxacin • Ofloxacin
Second generation cephalosporins	• Cefaclor • Cefprozil	• Cefuroxime
Sulfonamides	• Sulfamethoxazole-trimethoprim	
Tetracyclines	• Doxycycline • Minocycline	• Tetracycline
Third generation cephalosporins	• Cefdinir • Cefixime • Cefpodoxime	• Ceftibuten • Cefditoren • Ceftriaxone

Step 4 Test for Negative Comorbid Condition History. Exclude Episode Dates when the member had a claim/encounter with any diagnosis for a comorbid condition during the 12 months prior to or on the Episode Date. A code from any of the following meets criteria for a comorbid condition:

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

Step 5 Test for Negative Medication History. Exclude Episode Dates where a new or refill prescription for an antibiotic medication (CWP Antibiotic Medications List) was filled 30 days prior to the Episode Date or was active on the Episode Date.

Step 6 Test for Negative Competing Diagnosis. Exclude Episode Dates where the member had a claim/encounter with a competing diagnosis (Competing Diagnosis Value Set) on or 3 days after the Episode Date.

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

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

Administrative Specification

Denominator The eligible population.

Numerator A group A streptococcus test (Group A Strep Tests Value Set) in the seven-day period from three days prior to the Episode Date through three days after the Episode Date.

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

MEASURE UPDATES JUNE 2021 FOR AMP MY 2021

- Added Anchor Date criteria for clarification and to align with native specification.

MEASURE UPDATES SEPTEMBER 2020 FOR AMP MY 2021

- Updated the instructions for excluding visits that result in an inpatient stay.
- Removed Ticarcillin-clavulanate from the "Beta-lactamase inhibitors" description, Erythromycin-sulfisoxazole from the "Miscellaneous antibiotics" description and Norfloxacin from the "Quinolones" description in the AAB Antibiotic Medications List.

MODIFICATIONS FROM HEDIS

- None.

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.

Note: *Submit the data for the measure as the direct rates (lower is better), not as the inverted calculation of the numerator and denominator.*

Calculation

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

Definitions

Intake Period

A 12-month window that begins on July 1 of the year prior to the measurement year and ends on June 30 of the measurement year. The Intake Period captures eligible episodes of treatment.

Episode Date

The date of service for any outpatient, telephone, observation or ED visit, e-visit or virtual check-in during the Intake Period with a diagnosis of 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 filled 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 filled the prescription is the number of days or more between

	that date and the relevant service date. The 30-day look-back period for pharmacy data includes the 30 days prior to the Intake Period.
Negative Comorbid Condition History	A period of 12 months prior to and including the Episode Date, when the member had no claims/encounters with any diagnosis for a comorbid condition.
Negative Competing Diagnosis	The Episode Date and 3 days following the Episode Date when the member had no claims/encounters with any competing diagnosis.

Eligible Population

Note: *Members in hospice are excluded from the eligible population. Refer to General Guideline 15: Members in Hospice.*

Product lines	Commercial HMO/POS, Commercial ACO, Medi-Cal Managed Care (report each product line separately).
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	
…. for self-reporting POs	30 days prior to the Episode Date through three days after the Episode Date (34 total days) in the PO (parent level).
…. for health plans	30 days prior to the Episode Date through three days after the Episode Date (34 total days) in the health plan and the PO (parent level).
Allowable gap	No gaps in enrollment during the continuous enrollment period.
Anchor date	
…. for self-reporting POs	None.
…. for health plans	None.
Benefits	Medical and pharmacy.
Event/diagnosis	Follow the steps below to identify the eligible population:
Step 1	Identify all members who had an outpatient visit (Outpatient Value Set), a telephone visit (Telephone Visits Value Set), e-visit or virtual check-in (Online Assessments Value Set), an observation visit (Observation Value Set), or an ED visit (ED Value Set) during the Intake Period, with a diagnosis of acute bronchitis/bronchiolitis (Acute Bronchitis Value Set).

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

Do not include visits that result in an inpatient stay (Inpatient Stay Value Set).

Step 3 Test for Negative Comorbid Condition History. Exclude Episode Dates when the member had a claim/encounter with a diagnosis for a comorbid condition during the 12 months prior to or on the Episode Date. A code from any of the following meets criteria for a comorbid condition:

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

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

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

- Pharyngitis Value Set.
- Competing Diagnosis Value Set.

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

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

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

Administrative Specification

Denominator The eligible population.

Numerator Dispensed prescription for an antibiotic medication (AAB Antibiotic Medications List) on or three 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		
Ketolides	• Telithromycin		
Lincomycin derivatives	• Clindamycin	• Lincomycin	
Macrolides	• Azithromycin • Clarithromycin • Erythromycin	• Erythromycin ethylsuccinate • Erythromycin lactobionate • Erythromycin stearate	
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 • Cefditoren • Cefixime	• Cefotaxime • Cefpodoxime • Ceftazidime	• Ceftibuten • Ceftriaxone
Urinary anti-infectives	• Fosfomycin • Nitrofurantoin • Nitrofurantoin macrocrystals	• 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.*

*Use of Opioids at High Dosage (HDO)**

***Adapted with financial support from CMS and with permission from the measure developer, Pharmacy Quality Alliance (PQA).**

MEASURE UPDATES JUNE 2021 FOR AMP MY 2021

- Added the following medications to Table HDO-A: Opioid Medications:
    - Meperidine 75 mg Medications List
    - Meperidine 150 mg Medications List
    - Acetaminophen Oxycodone 1 MGPML Medications List
    - Acetaminophen Oxycodone 2 MGPML Medications List
    - Tramadol 5 MGPML Medications List
- Deleted the following medications from Table HDO-A: Opioid Medications:
    - Levorphanol 1 mg Medications List
    - Morphine 70 mg Medications List
    - Morphine 130 mg Medications List

MEASURE UPDATES SEPTEMBER 2020 FOR AMP MY 2021

- Clarified the instructions for calculating covered days for the denominator.
- Clarified the instructions for treatment period.
- Added palliative care as a required exclusion.
- Added medication lists for acetaminophen benzhydrocodone, aspirin codeine, and codeine phosphate.
- Removed Acetaminophen Hydrocodone 7.5 mg Medications List from the Hydrocodone description in Table HDO-A: Opioid Medications.

MODIFICATIONS FROM HEDIS

- None.

Description

The proportion of members 18 years and older who received prescription opioids at a high dosage (average morphine milligram equivalent dose [MME] ≥90) for ≥15 days during the measurement year.

Note: *A lower rate indicates better performance. Onpoint will run this measure using Health Plans claims submission for MY 2021. Health plans and POs are not expected to report it.*

Definitions

Calculating number of days covered for the denominator	Use the following steps to identify and calculate covered days for the denominator.

Step 1 Identify dispensing events where multiple prescriptions for the same medication are dispensed with overlapping days supply (i.e., dispensed on the same day *or* dispensed on different days with overlapping days supply). Sum the days supply for these dispensing events.

Identify the start and end dates: The start date is the date of service of the earliest dispensing event and the end date is the start date plus the summed days supply minus 1. The start date through the end date are considered covered days. For example:

- If there are three 7-days supply dispensing events for the same medication on January 1, the start date is January 1 and the end date is January 21. Covered days include January 1–21.
- If there are two 7-days supply dispensing events for the same medication on January 1 and January 5, the start date is January 1 and the end date is January 14. Covered days include January 1–14.
- If there are three 7-days supply dispensing events for the same medication on January 1, a 7-days supply dispensing event on January 20, and a 7-days supply dispensing event on January 28, the start date is January 1 and the end date is February 4. Covered days include January 1–February 4.

Step 2 For all other dispensing events (i.e., multiple prescriptions for the same medication on different days, without overlap, and multiple prescriptions for different medications on the same or different days, with or without overlap), identify the start and end dates for each dispensing event individually. The start date through the end date are considered covered days.

Step 3 Count the covered days. Consider each calendar day covered by one or more medications to be one covered day.

Identifying same or different drugs To identify "same" or "different" drugs, use Table HDO-A, which identifies the medications lists for the measure. Dispensing events from any of the Fentanyl Medications Lists, even if they are on different rows, are all considered the "same" drug.

For all other types of opioids, the table includes a "Medication Lists" column that identifies the "same" high-risk medications by grouping them on the same row.

For example, a dispensing event from the Codeine Sulfate 15 mg Medications List is considered the same drug as a dispensing event from the Codeine Sulfate 30 mg Medications List. Conversely, a dispensing event from the Codeine Sulfate 15 mg Medications List is considered a different drug than a dispensing event from the Acetaminophen Codeine 15 mg Medications List because they are in different table rows.

Treatment period To identify the treatment period: For all dispensing events, identify the start and end dates for each dispensing event individually. The treatment period start date is the start date of the earliest dispensing event during the measurement year. The treatment period end date is the last end date during the measurement year.

MME Morphine milligram equivalent. The dose of oral morphine that is the analgesic equivalent of a given dose of another opioid analgesic (Table HDO-A).

Opioid Dosage Unit	For each dispensing event, use the following calculation to the determine the Opioid Dosage Unit. # of Opioid Dosage Units per day = (opioid quantity dispensed) / (opioid days supply)
MME Daily Dose	For each dispensing event, use the following calculation to determine the MME Daily Dose. Convert each medication into the MME using the appropriate MME conversion factor and strength associated with the opioid product of the dispensing event (refer to Table HDO-A for MME conversion factor and strength). MME Daily Dose = (# of opioid dosage units per day) X (strength (e.g., mg, mcg)) X (MME conversion factor [Table HDO-A]). *Example 1:* 10 mg oxycodone tablets X (120 tablets / 30 days) X 1.5 = 60 MME/ day. *Example 2:* 25 mcg/hr fentanyl patch X (10 patches / 30 days) X 7.2 = 60 MME/ day.
Total Daily MME	The total sum of the MME Daily Doses for all opioid dispensing events on one day.
Average MME	The average MME for all opioids dispensed during the treatment period.

Eligible Population

Note: *Members in hospice are excluded from the eligible population. Refer to General Guideline 15: Members in Hospice.*

Product lines	Commercial HMO/POS, Commercial ACO, Medicare Advantage, Medi-Cal Managed Care (report each product line separately).
Age	18 years and older as of January 1 of the measurement year.
Continuous enrollment	
…for self-reporting POs	The measurement year in the PO (parent level).
…for health plans	The measurement year in the health plan and the PO (parent level).
Allowable gap	No gaps in enrollment.
Anchor date	
…for self-reporting POs	None.
…for health plans	None.
Benefit	Medical and pharmacy.

Event/diagnosis Use the steps below to determine the eligible population.

Step 1 Identify members who met both of the following criteria during the measurement year:

- Two or more opioid dispensing events on different dates of service. Use all the medication lists in Table HDO-A to identify opioid medication dispensing events.
- ≥15 total days covered by opioids.

Step 2: Required exclusions Exclude members who met at least one of the following during the measurement year:

- Cancer (Malignant Neoplasms Value Set).
- Sickle cell disease (Sickle Cell Anemia and HB-S Disease Value Set).
- Members receiving palliative care (Palliative Care Assessment Value Set; Palliative Care Encounter Value Set; Palliative Care Intervention Value Set).

Administrative Specification

Denominator The eligible population.

Numerator The number of members whose average MME was ≥90 MME during the treatment period. Follow the steps below to identify numerator compliance.

Step 1 Use all the medication lists in Table HDO-A to identify all opioid medication dispensing events during the measurement year.

Step 2 For each member, calculate the MME Daily Dose for each medication dispensing event.

Step 3 For a single dispensing event, multiply the MME Daily Dose by the dispensing event's days supply. For example, a dispensing event with a MME Daily Dose of 90 mg and a days supply of 5 would have a total MME of 450 mg for that dispensing event. As multiple dispensing events can overlap on one calendar day, for each day, sum the MME Daily Doses for all dispensing events to determine the Total Daily MME for that day.

Step 4 Determine the treatment period.

Step 5 Determine the Average MME. Sum the Total Daily MME for the treatment period and divide by the number of days in the treatment period. Members whose Average MME was ≥90 meet the numerator criteria.

Table HDO-A: Opioid Medications[1]

Type of Opioid	Medications List	Strength	MME Conversion Factor
Benzhydrocodone	Acetaminophen Benzhydrocodone 4.08 mg Medications List	4.08 mg	1.2
	Acetaminophen Benzhydrocodone 6.12 mg Medications List	6.12 mg	
	Acetaminophen Benzhydrocodone 8.16 mg Medications List	8.16 mg	

Type of Opioid	Medications List	Strength	MME Conversion Factor
Butorphanol	Butorphanol 10 MGPML Medications List	10 mg per mL	7
Codeine	Codeine Sulfate 15 mg Medications List Codeine Sulfate 30 mg Medications List Codeine Sulfate 60 mg Medications List	15 mg 30 mg 60 mg	0.15
Codeine	Codeine Phosphate 15 mg Medications List Codeine Phosphate 2 MGPML Medications List	15 mg 2 mg per mL	0.15
Codeine	Acetaminophen Codeine 2.4 MGPML Medications List Acetaminophen Codeine 15 mg Medications List Acetaminophen Codeine 30 mg Medications List Acetaminophen Codeine 60 mg Medications List	2.4 mg per mL 15 mg 30 mg 60 mg	0.15
Codeine	Acetaminophen Butalbital Caffeine Codeine 30 mg Medications List	30 mg	0.15
Codeine	Aspirin Butalbital Caffeine Codeine 30 mg Medications List	30 mg	0.15
Codeine	Aspirin Carisoprodol Codeine 16 mg Medications List	16 mg	0.15
Codeine	Aspirin Codeine 8 mg Medications List	8 mg	0.15
Dihydrocodeine	Acetaminophen Caffeine Dihydrocodeine 16 mg Medications List	16 mg	0.25
Dihydrocodeine	Aspirin Caffeine Dihydrocodeine 16 mg Medications List	16 mg	0.25
Fentanyl buccal or sublingual tablet, transmucosal lozenge (mcg)[2]	Fentanyl 100 mcg Medications List Fentanyl 200 mcg Medications List Fentanyl 300 mcg Medications List Fentanyl 400 mcg Medications List Fentanyl 600 mcg Medications List Fentanyl 800 mcg Medications List Fentanyl 1200 mcg Medications List Fentanyl 1600 mcg Medications List	100 mcg 200 mcg 300 mcg 400 mcg 600 mcg 800 mcg 1200 mcg 1600 mcg	0.13
Fentanyl oral spray (mcg)[3]	Fentanyl 100 MCGPS Oral Medications List Fentanyl 200 MCGPS Oral Medications List Fentanyl 400 MCGPS Oral Medications List Fentanyl 600 MCGPS Oral Medications List Fentanyl 800 MCGPS Oral Medications List	100 mcg per spray 200 mcg per spray 400 mcg per spray 600 mcg per spray 800 mcg per spray	0.18
Fentanyl nasal spray (mcg)[4]	Fentanyl 100 MCGPS Nasal Medications List Fentanyl 300 MCGPS Nasal Medications List Fentanyl 400 MCGPS Nasal Medications List	100 mcg per spray 300 mcg per spray 400 mcg per spray	0.16
Fentanyl transdermal film/ patch (mcg/hr)[5]	Fentanyl 12 MCGPH Medications List Fentanyl 25 MCGPH Medications List Fentanyl 37.5 MCGPH Medications List Fentanyl 50 MCGPH Medications List Fentanyl 62.5 MCGPH Medications List Fentanyl 75 MCGPH Medications List Fentanyl 87.5 MCGPH Medications List Fentanyl 100 MCGPH Medications List	12 mcg per hour 25 mcg per hour 37.5 mcg per hour 50 mcg per hour 62.5 mcg per hour 75 mcg per hour 87.5 mcg per hour 100 mcg per hour	7.2

Type of Opioid	Medications List	Strength	MME Conversion Factor
Hydrocodone	Hydrocodone 10 mg Medications List Hydrocodone 15 mg Medications List Hydrocodone 20 mg Medications List Hydrocodone 30 mg Medications List Hydrocodone 40 mg Medications List Hydrocodone 50 mg Medications List Hydrocodone 60 mg Medications List Hydrocodone 80 mg Medications List Hydrocodone 100 mg Medications List Hydrocodone 120 mg Medications List	10 mg 15 mg 20 mg 30 mg 40 mg 50 mg 60 mg 80 mg 100 mg 120 mg	1
Hydrocodone	Acetaminophen Hydrocodone .5 MGPML Medications List Acetaminophen Hydrocodone .67 MGPML Medications List Acetaminophen Hydrocodone 2.5 mg Medications List Acetaminophen Hydrocodone 5 mg Medications List Acetaminophen Hypdrocodone 7.5 mg Medications List Acetaminophen Hydrocodone 10 mg Medications List	.5 mg per mL .67 mg per mL 2.5 mg 5 mg 7.5 mg 10 mg	1
Hydrocodone	Hydrocodone Ibuprofen 2.5 mg Medications List Hydrocodone Ibuprofen 5 mg Medications List Hydrocodone Ibuprofen 7.5 mg Medications List Hydrocodone Ibuprofen 10 mg Medications List	2.5 mg 5 mg 7.5 mg 10 mg	1
Hydromorphone	Hydromorphone 1 MGPML Medications List Hydromorphone 2 mg Medications List Hydromorphone 3 mg Medications List Hydromorphone 4 mg Medications List Hydromorphone 8 mg Medications List Hydromorphone 12 mg Medications List Hydromorphone 16 mg Medications List Hydromorphone 32 mg Medications List	1 mg per mL 2 mg 3 mg 4 mg 8 mg 12 mg 16 mg 32 mg	4
Levorphanol	Levorphanol 2 mg Medications List Levorphanol 3 mg Medications List	2 mg 3 mg	11
Meperidine	Meperidine 10 MGPML Medications List Meperidine 50 mg Medications List Meperidine 75 mg Medications List Meperidine 100 mg Medications List Meperidine 150 mg Medications List	10 mg per mL 50 mg 75 mg 100 mg 150 mg	0.1
Meperidine	Meperidine Promethazine 50 mg Medications List	50 mg	0.1
Methadone[6]	Methadone 1 MGPML Medications List Methadone 2 MGPML Medications List Methadone 5 mg Medications List Methadone 10 mg Medications List Methadone 10 MGPML Medications List Methadone 40 mg Medications List	1 mg per mL 2 mg per mL 5 mg 10 mg 10 mg per mL 40 mg	3

Type of Opioid	Medications List	Strength	MME Conversion Factor
Morphine	Morphine 2 MGPML Medications List Morphine 4 MGPML Medications List Morphine 5 mg Medications List Morphine 10 mg Medications List Morphine 15 mg Medications List Morphine 20 MGPML Medications List Morphine 20 mg Medications List Morphine 30 mg Medications List Morphine 40 mg Medications List Morphine 45 mg Medications List Morphine 50 mg Medications List Morphine 60 mg Medications List Morphine 75 mg Medications List Morphine 80 mg Medications List Morphine 90 mg Medications List Morphine 100 mg Medications List Morphine 120 mg Medications List Morphine 200 mg Medications List	2 mg per mL 4 mg per mL 5 mg 10 mg 15 mg 20 mg per mL 20 mg 30 mg 40 mg 45 mg 50 mg 60 mg 75 mg 80 mg 90 mg 100 mg 120 mg 200 mg	1
Morphine	Morphine Naltrexone 20 mg Medications List Morphine Naltrexone 30 mg Medications List Morphine Naltrexone 50 mg Medications List Morphine Naltrexone 60 mg Medications List Morphine Naltrexone 80 mg Medications List Morphine Naltrexone 100 mg Medications List	20 mg 30 mg 50 mg 60 mg 80 mg 100 mg	1
Opium	Belladonna Opium 30 mg Medications List Belladonna Opium 60 mg Medications List	30 mg 60 mg	1
Oxycodone	Oxycodone 1 MGPML Medications List Oxycodone 5 mg Medications List Oxycodone 7.5 mg Medications List Oxycodone 9 mg Medications List Oxycodone 10 mg Medications List Oxycodone 13.5 mg Medications List Oxycodone 15 mg Medications List Oxycodone 18 mg Medications List Oxycodone 20 mg Medications List Oxycodone 20 MGPML Medications List Oxycodone 27 mg Medications List Oxycodone 30 mg Medications List Oxycodone 36 mg Medications List Oxycodone 40 mg Medications List Oxycodone 60 mg Medications List Oxycodone 80 mg Medications List	1 mg per mL 5 mg 7.5 mg 9 mg 10 mg 13.5 mg 15 mg 18 mg 20 mg 20 mg per mL 27 mg 30 mg 36 mg 40 mg 60 mg 80 mg	1.5
Oxycodone	Acetaminophen Oxycodone 1 MGPML Medications List	1 mg	1.5

Type of Opioid	Medications List	Strength	MME Conversion Factor
	Acetaminophen Oxycodone 2 MGPML Medications List Acetaminophen Oxycodone 2.5 mg Medications List Acetaminophen Oxycodone 5 mg Medications List Acetaminophen Oxycodone 7.5 mg Medications List Acetaminophen Oxycodone 10 mg Medications List	2 mg 2.5 mg 5 mg 7.5 mg 10 mg	
Oxycodone	Aspirin Oxycodone 4.8355 mg Medications List	4.8355 mg	1.5
Oxycodone	Ibuprofen Oxycodone 5 mg Medications List	5 mg	1.5
Oxymorphone	Oxymorphone 5 mg Medications List Oxymorphone 7.5 mg Medications List Oxymorphone 10 mg Medications List Oxymorphone 15 mg Medications List Oxymorphone 20 mg Medications List Oxymorphone 30 mg Medications List Oxymorphone 40 mg Medications List	5 mg 7.5 mg 10 mg 15 mg 20 mg 30 mg 40 mg	3
Pentazocine	Naloxone Pentazocine 50 mg Medications List	50 mg	0.37
Tapentadol	Tapentadol 50 mg Medications List Tapentadol 75 mg Medications List Tapentadol 100 mg Medications List Tapentadol 150 mg Medications List Tapentadol 200 mg Medications List Tapentadol 250 mg Medications List	50 mg 75 mg 100 mg 150 mg 200 mg 250 mg	0.4
Tramadol	Tramadol 5 MGPML Medications List Tramadol 50 mg Medications List Tramadol 100 mg Medications List Tramadol 150 mg Medications List Tramadol 200 mg Medications List Tramadol 300 mg Medications List	5 mg 50 mg 100 mg 150 mg 200 mg 300 mg	0.1
Tramadol	Acetaminophen Tramadol 37.5 mg Medications List	37.5 mg	0.1

[1]National Center for Injury Prevention and Control. CDC compilation of benzodiazepines, muscle relaxants, stimulants, zolpidem, and opioid analgesics with oral morphine milligram equivalent conversion factors, 2017 version. Atlanta, GA: Centers for Disease Control and Prevention; 2017. Available at https://www.cdc.gov/drugoverdose/resources/data.html

[2] MME conversion factor for fentanyl buccal tablets, sublingual tablets, and lozenges/troche is 0.13. This conversion factor should be multiplied by the number of micrograms in a given tablet or lozenge/troche.

[3] MME conversion factor for fentanyl films and oral sprays is 0.18. This reflects a 40% greater bioavailability for films compared to lozenges/tablets and 38% greater bioavailability for oral sprays compared to lozenges/tablets.

[4] MME conversion factor for fentanyl nasal spray is 0.16, which reflects a 20% greater bioavailability for sprays compared to lozenges/tablets.

[5] MME conversion factor for fentanyl patches is 7.2 based on the assumption that one milligram of parenteral fentanyl is equivalent to 100 milligrams of oral morphine and that one patch delivers the dispensed micrograms per hour over a 24-hour day and remains in place for 3 days. Using the formula, Strength per Unit * (Number of Units/ Days Supply) * MME conversion factor = MME/Day: 25 µg/hr. fentanyl patch * (10 patches/30 days) * 7.2 = 60 MME/day.

[6] Adapted from Von Korff M, Saunders K, Ray GT, et al. Clin J Pain 2008;24:521–7 and Washington State Interagency Guideline on Prescribing Opioids for Pain (http://www.agencymeddirectors.wa.gov/Files/2015AMDGOpioidGuideline.pdf).

Note

- *Do not include denied claims when identifying the eligible population (except for required exclusions) or assessing the numerator.*
- 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.
- *This measure does not include the following opioid medications:*
  - *Injectables.*
  - *Opioid cough and cold products.*
  - *Ionsys® (fentanyl transdermal patch), because:*
    - *This is for inpatient use only and is available only through a restricted program under a Risk Evaluation and Mitigation Strategy (REMS)*
  - *Methadone for the treatment of opioid use disorder.*

Concurrent Use of Opioids and Benzodiazepines (COB)

MEASURE UPDATES JUNE 2021 FOR AMP MY 2021

- Updated language for the measure description.
- Added clarifying language to "Event/Diagnosis."
- Added clarifying language to Numerator.

MEASURE UPDATES SEPTEMBER 2020 FOR AMP MY 2021

- None.

MODIFICATIONS FROM PQA

- None.

Measure Description

The percentage of members 18 years of age and older with concurrent use of prescription opioids and benzodiazepines.

A lower rate indicates better performance for this measure.

Note: *Refer to the AMP Value Set Directory download for a comprehensive list of PQA medications and associated codes (PQA NDC Code List and PQA ICD Code List). Do not distribute NDC lists outside your organization. Onpoint will run this measure for MY 2021. Health plans and POs are not expected to report it.*

Definitions

Opioids	Refer to Medication Table COB-A: Opioids.
Benzodiazepines	Refer to Medication Table COB-B: Benzodiazepines.
Measurement year	The calendar year (January 1–December 31) when the measure is assessed.
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 an opioid during the measurement year.
Concurrent use	Overlapping supply for an opioid and a benzodiazepine for 30 or more cumulative days. Concurrent use is identified using the dates of service and days supply of an individual's prescription claims. The days of concurrent use is the count of the number of days with overlapping days supply for an opioid and a benzodiazepine.

Hospice exclusion	For Commercial HMO, Commercial ACO and Medi-Cal Managed Care reporting, refer *to General Guideline 15: Members in Hospice*. Health plans reporting for Medicare Advantage, identify any member with a hospice indicator from the Monthly Membership Detail File. POs reporting for Medicare Advantage have the option of using the Monthly Membership Detail File or the HEDIS Hospice Encounter Value Set and Hospice Intervention Value Set to identify members in Hospice, refer *to General Guideline 15: Members in Hospice*.
Cancer diagnosis exclusion	Any member with a cancer diagnosis during the measurement year. Refer to the PQA Value Set Cancer. A cancer diagnosis is defined as having at least one claim with any of the listed cancer diagnoses, including primary diagnosis or any other diagnosis fields during the measurement year. Medicare Data (if ICD codes not available): RxHCCs 15, 16, 17, 18, 19 for Payment Year 2020. Available at: https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Risk-Adjustors.html).
Sickle cell disease diagnosis exclusion	Any member with a sickle cell disease diagnosis during the measurement year. Refer to the PQA Value Set Sickle Cell Disease. A sickle cell disease diagnosis is defined as having at least one claim with any of the list sickle cell disease diagnoses, including primary diagnosis or any other diagnosis fields during the measurement year.

Eligible Population

Product Lines	Commercial HMO/POS, Commercial ACO, Medicare Advantage, Medi-Cal Managed Care (report each product line separately).
Ages	18 years and older as of the first day of the measurement year.
Continuous Enrollment	
…for health plans	The measurement year, with one allowable gap.
…for POs	The measurement year, with one allowable gap.
Allowable gap	No more than one gap in 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).
Anchor date	
…for self-reporting POs	December 31 of the measurement year.
...for health plans	December 31 of the measurement year.
Benefit	Medical, Pharmacy.

Event/diagnosis Members with ≥2 prescriptions for any opioid medications (Table COB-A: Opioids) on different dates of service and with ≥15 cumulative days' supply during the measurement year.

Step 1 Identify individuals ≥18 years of age as of the first day of the measurement year.

Step 2 Identify individuals meeting the continuous enrollment criteria.

Step 3 Identify individuals with an IPSD that is ≥30 days from the last day of the measurement year (January 1 through December 2).

Step 4 Identify individuals with ≥2 prescription claims for opioids on different dates of service and with ≥15 cumulative days supply during the measurement year. Exclude days supply that occur after the end of the measurement year.

Note:

- *The prescription claims can be for the same or different opioids.*
- *If multiple prescriptions for opioids are dispensed on the same day, calculate the number of days covered by an opioid using the prescriptions with the longest days supply.*
- *If multiple prescriptions for opioids are dispensed on different days, sum the days supply for all the prescription claims, regardless of overlapping days supply.*

Step 5 Exclude individuals who met at least one of the following:

- *Hospice:* A hospice indicator at any time during the measurement year.
- *Cancer:* A cancer diagnosis at any time during the measurement year.
- *Sickle cell disease:* A sickle cell disease diagnosis at any time during the measurement year.

Note

- *If a PO receives pharmacy claim information for a member, the PO can assume the member has a pharmacy benefit and that the pharmacy benefit dates align with the medical benefit dates.*

Administrative Specification

Denominator The eligible population.

Numerator Members with:

- ≥2 prescription claims for any benzodiazepines on different dates of service, ***and***
- Concurrent use of opioids and benzodiazepines for ≥30 cumulative days.

Step 1 From the denominator population, identify members with ≥2 prescription claims with different dates of service for any benzodiazepine (Table COB-B) during the measurement year.

Step 2 Determine the total days of overlap (concurrent use) between opioids and benzodiazepine prescription claims during the measurement year.

Concurrent use is identified using the dates of service and days supply of an individual's opioid and benzodiazepine prescription drug claims. The days of concurrent use is the count of days during the measurement year with overlapping days supply for an opioid and a benzodiazepine. Exclude days supply and overlap that occur after the end of the measurement year.

Note:

- *If multiple prescriptions for opioids (or benzodiazepines) are dispensed on the same day, calculate the number of days covered by an opioid (or benzodiazepine) using the prescriptions with the longest days supply.*
- *If multiple prescription claims of opioids (or benzodiazepines) are dispensed on different days with overlapping days supply, count each day in the measurement year only once toward the numerator. There is no adjustment for early fills or overlapping days supply for opioids (or benzodiazepines).*

Step 3 Count the number of individuals with concurrent use for 30 or more cumulative days.

Table COB-A: Opioids[a,b]

Opioid Medications		
• Benzhydrocodone	• Hydromorphone	• Oxymorphone
• Buprenorphine[b]	• Levorphanol	• Pentazocine
• Butorphanol	• Meperidine	• Tapentadol
• Codeine	• Methadone	• Tramadol
• Dihydrocodeine	• Morphine	
• Fentanyl	• Opium	
• Hydrocodone	• Oxycodone	

[a] Includes combination products and prescription opioid cough medications.
[b] Excludes the following: injectable formulations; sufentanil (used in a supervised setting); and single-agent and combination buprenorphine products used to treat opioid use disorder (i.e., buprenorphine sublingual tablets, Probuphine® Implant kit subcutaneous implant, and all buprenorphine/naloxone combination products).

Table COB-B: Benzodiazepines[a,b]

Benzodiazepines		
• Alprazolam	• Diazepam	• Oxazepam
• Chlordiazepoxide	• Estazolam	• Quazepam
• Clobazam	• Flurazepam	• Temazepam
• Clonazepam	• Lorazepam	• Triazolam
• Clorazepate	• Midazolam	

[a] Includes combination products.
[b] Excludes injectable formulations.

Note

This measure is not intended for clinical decision making. *This measure is intended for retrospective evaluation of populations of patients and should not be used to guide clinical decisions for individual patients. For clinical guidance on opioid prescribing,* see the *Centers for Disease Control and Prevention (CDC) Guideline for Prescribing Opioids for Chronic Pain* and *Guideline Resources*.

Data Quality Domain Technical Specifications

For AMP MY 2021

Encounter Rate by Service Type (ENRST)

MEASURE UPDATES JUNE 2021 FOR AMP MY 2021

- Added clarifying language for health plans to report the denominator as total member months.

MEASURE UPDATES SEPTEMBER 2020 FOR AMP MY 2021

- Clarified that health plans should submit the denominator as total member months.
- Added a calculation for overall rate.

Description

The encounter rate is the number of encounters and claims by service type for each PO. Each health plan calculates the rate for each PO with which it contracts and uses it to measure data completeness. The method for identifying encounters by service type is based on the HEDIS Use of Service measures and the General Guidelines. Each service type is calculated as a separate rate.

Note: *Health plans submit the denominator data for the measure as the total member months.*

Calculation

Health plans submit the denominator for each rate as total member months. After submission, the denominator data is recalculated and reported as member years for each rate. The reported encounter rate is total encounters and claims/total member years. Plans should report the total number of unduplicated encounters or claims for each service type and the member months only (refer to steps in "Member months" under *Definitions*).

POs are not expected to report this measure.

Definitions

Note: *Members in hospice are excluded from the eligible population. Refer to General Guideline 15: Members in Hospice.*

Member months Calculate the member months of enrollment for the measurement year for all members. Include all members (adults and children) in the Commercial HMO and POS lines of business, regardless of the type of reimbursement contract. Member months will be the denominator submitted for all rates.

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

Step 2 Use the member's product line and PO affiliation on the specified day of each month to determine the product line and PO to which the member months will be contributed.

Member years

After member months are submitted, member years are calculated for each PO by dividing total member months by 12.

X member months/12 months = Y member years

Note: *Health plans are only expected to calculate and submit member months and are not expected to calculate member years.*

Encounter

An **encounter** differs from a **claim** in that it represents a service for which there is no claim for payment sent to the health plan (i.e., all member encounters are covered in the health plan's capitation payment) or a service where the PO may pay the provider a fee for service for the encounter but does not bill the health plan for the service. Follow these guidelines for determining encounters. Include all encounters and claims for services rendered, whether or not they were approved or paid by the PO.

Determining encounters/ claims

Count any code that represents a unique date of service, a unique provider identifier, and a unique patient.

Count multiple lab tests in one day by the same lab provider as one unique encounter. An encounter for the same date of service, provider, and patient that contains multiple types of services should be counted in each category, as appropriate (e.g., an office visit with lab procedures should be included in both categories).

Allow at least a two-month lag in submission and count all Commercial HMO and POS member encounters or transactions (including out-of-network POS claims) with a date of service in 2021.

Report services without regard to practitioner type, training, or licensing. Include after-hours, nonemergency urgent care, nursing home visits, and outpatient surgical procedures.

IHA encourages detailed service reporting to facilitate comparability and complete reporting, even when the financial reimbursement arrangement does not require it.

Overall professional encounter rate

Sum of the numerators for rates 1, 2, 3, 4a, and 5a, divided by member months for the PO. Member years will be calculated after submission.

Overall facility encounter rate

Sum of the numerators for rates 6, 7, and 8, divided by member months for the PO. Member years will be calculated after submission.

Overall rate

Sum of the numerators for rates 1, 2, 3, 4a, 5a, and 6, divided by member months for the PO. Member years will be calculated after submission.

Eligible Population

Product lines

Commercial HMO/POS, Commercial ACO, Medicare Advantage, Medi-Cal Managed Care (report each product line separately).

Encounter Rate 1: Office and Other Outpatient Services

Denominator Member years (submitted by health plans as member months, and then calculated and reported as member years).

Numerator Count the total number of unduplicated office and other outpatient services encounters/claims using the (Outpatient Services Value Set) and the (Observation Value Set).

Note

- *Count office-based surgeries/procedures in this category.*

Encounter Rate 2: Preventive Medicine

Denominator Member years (submitted by health plans as member months, and then calculated and reported as member years).

Numerator Count the total number of preventive medicine encounters/claims using the (Preventive Medicine Services Value Set).

Encounter Rate 3: Ophthalmology and Optometry

Denominator Member years (submitted by health plans as member months, and then calculated and reported as member years).

Numerator Count the total number of ophthalmology or optometry encounters/claims (Ophthalmological Services Value Set). Report services without regard to practitioner type, training, or licensing.

Encounter Rate 4: Laboratory/Pathology Services

Denominator Member years (submitted by health plans as member months, and then calculated and reported as member years).

Numerator

Rate 4a Count the total number of encounters/claims (Laboratory and Pathology Services Value Set).

Note: *Identify one encounter/claim as the same person receiving at least one test on the same day from the same (lab) provider. Do not count multiple tests (i.e., codes) separately that occurred on the same day with the same provider (either within the same encounter/claim record or on a different encounter/claim record).*

Rate 4b Calculate the total number of tests (Laboratory and Pathology Services Value Set).

Count all laboratory/pathology procedure codes separately. For example, if an encounter record contains three different codes (i.e., for three different lab tests), record three "tests." Sum all the tests to calculate the total numerator.

Encounter Rate 5: Radiology and Imaging

Denominator Member years (submitted by health plans as member months, and then calculated and reported as member years).

Numerator

Rate 5a Count the total number of radiology and imaging encounters/claims using the (Radiology and Imaging Services Value Set).

Note: *Identify one encounter/claim as the same person receiving at least one test on the same day from the same provider. Do not count multiple tests (e.g., CPT codes) separately that occurred on the same day with the same provider (either within the same encounter/claim record or on a different encounter record).*

Rate 5b Calculate the total number of tests using the (Radiology and Imaging Services Value Set). Count all radiology procedure codes separately for this metric. For example, if an encounter record contains three different CPT codes (i.e., for three different imaging tests), record three "tests." Sum all the tests to calculate the total numerator.

Encounter Rate 6: Ambulatory Surgery/Procedures

Denominator Member years (submitted by health plans as member months, and then calculated and reported as member years).

Numerator Count the total number of ambulatory surgery/procedure encounters/claims. A claim with a code from any of the following value set combinations meets the criteria:

- Ambulatory Surgery Option A Value Set ***with*** Ambulatory Surgery POS Value Set.
- Ambulatory Surgery Option A Value Set ***with*** Ambulatory Surgery UBTOB Value Set.

Report services without regard to practitioner type, training, or licensing.

The health plan/PO must avoid double counting and report only ambulatory surgery/procedures performed at a hospital outpatient facility or at a free-standing surgery center. Count every ambulatory surgery/procedure encounter/claim, which is one discrete service date for a specific member at a specific site (regardless of the number of services provided at that site on that day for that member).

Note

- *Do not report office-based surgeries/procedures in this category; report them under Office and Other Outpatient Services.*

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Encounter Rate 7: ED Visits

Denominator Member years (submitted by health plans as member months, and then calculated and reported as member years).

Numerator Count each visit to an ED once, regardless of the intensity or duration of the visit. Count multiple ED visits on the same date of service as one visit. Identify ED visits using either of the following:

- An ED visit (ED Value Set).
- A procedure code (ED Procedure Code Value Set) with an ED place of service code (ED POS Value Set).

Do not include ED visits that result in an inpatient stay (Inpatient Stay Value Set).

Encounter Rate 8: Inpatient Stays

Denominator Member years (submitted by health plans as member months, and then calculated and reported as member years).

Numerator Identify all acute inpatient discharges on or between January 1 and December 31 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.

Exclusions *(required)*

- Duplicate encounters/claims within a service type.
  - Do not count multiple encounters/claims within this service type where the member, provider and date of service are the same, regardless of whether the procedure (CPT) codes are the same or different; if this occurs, only record one encounter/claim.
- Rates 4b and 5b should count the actual number of tests performed and are not subject to de-duplication by:
  - Member.
  - Provider.
  - Date of service.

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Encounter Format (ENFMT)

MEASURE UPDATES JUNE 2021 FOR AMP MY 2021

- Added clarifying note in Step 2 of Encounter Format Calculation: Standard Provider Identifiers.

MEASURE UPDATES SEPTEMBER 2020 FOR AMP MY 2021

- Defined “service line,” “claims,” “institutional claims,” “institutional encounters,” “professional claims,” “professional encounter,” “pharmacy claims/encounters.”
- Clarified the definition of “visits.”
- Clarified step 3 of Encounter Format Calculation: Procedure Modifier and Rendering Provider Identifier Per Service Line.

Description

Correct coding and formatting of the content in an encounter submission affects both its acceptance by a health plan and its usability for everything from care gap reporting and performance measurement to risk adjustment and rate setting.

The following measures assess whether key encounter data elements meet expectations on use of standard codes, consistency, and completeness.

- Review of Codes:
  - Procedure Codes, including use of procedure modifiers.
  - Revenue Codes.
  - Diagnosis Codes.
- Review of Identifiers:
  - Billing Provider Identifier.
  - Rendering Provider Identifier.
  - Prescribing Provider Identifier.

Rates for each measure are reported by service type (i.e., institutional and professional) and transaction type (i.e., claims and encounters).

For additional information on timeliness measures, refer to the California Department of Health Care Services Quality Measures for Encounter Data.

Note: *Health plans and POs are not expected to report this measure. Onpoint will run this measure using health plans claim and encounter submissions for MY 2021.*

Definitions

Note: *Members in hospice are excluded from the eligible population. Refer to General Guideline 15: Members in Hospice.*

Service Line	All individual service records in a claim or encounter submitted to the health plan. Identified by each record that health plans submit to Onpoint.
Claims	A set of service lines reflected in a unique claim for health plan payment.

Encounter	An **encounter** differs from a **claim** in that it represents a service for which there is no claim for payment sent to the health plan (i.e., all member encounters are covered in the health plan's capitation payment), or a service where the PO may pay the provider a fee for service for the encounter but does not bill the health plan for the service. Include all encounters and claims for services rendered, whether or not they were approved or paid by the PO.
Visits	Records with a unique combination of date of service, a unique billing provider identifier, and a unique patient identifier. If one record is capitated in a claim/encounter, the event should be treated as an encounter; for example, a regular office visit (capitated) that had lab tests (fee-for-service). Allow at least a three-month lag in submission (e.g., January 1–March 31 of the year following the measurement year) and count all Commercial HMO and POS member encounters or transactions (including out of network POS claims) with a date of service in the measurement year. Report services without regard to practitioner type, training, or licensing. Include after-hours, nonemergency urgent care, nursing home visits, and outpatient surgical procedures. IHA encourages detailed service reporting to facilitate comparability and complete reporting, even when the financial reimbursement arrangement does not require it.
Institutional Claims	Services submitted with a unique claim ID using an 837I format for health plan payment.
Institutional Encounters	Services submitted with a unique claim ID using an 837I format for reasons other than reimbursement.
Professional Claims	Services submitted with a unique claim ID using an 837P format for health plan payment.
Professional Encounters	Services submitted with a unique claim ID using an 837P format for reasons other than reimbursement.
Pharmacy Claims/ Encounters	Prescription records submitted to health plans using an NCDPDP format. There is currently no way to distinguish between pharmacy claims from encounters. Prescription records will be considered pharmacy claims.

Eligible Population

Product lines Commercial HMO/POS, Commercial ACO, Medicare Advantage, Medi-Cal Managed Care (report each product line separately).

Encounter Format Calculation: Valid Standard Codes

Step 1 Identify all Institutional (837I) and Professional (837P) claims and/or encounters.

Step 2 *Calculate the percentage of all claims/encounters with a valid national standard field.* Divide the number of claims/encounters populated with a valid national standard field by the total count of claims/encounters submitted. Refer to the list of valid national standard fields below.

Step 3 *Calculate the average number of valid national standard fields per claim and/or encounter.* Divide the total number of valid national standard fields by the number of all claims/ encounters submitted. Refer to the list of valid national standard fields below.

List of Valid National Standard Fields

Procedure Code	Include claims and/or encounters populated with a valid national standard procedure code (CPT, HCPCS) for professional and outpatient service.
Revenue Code	Include encounters and claims populated with a valid national standard revenue code (From (National Uniform Billing Committee) for institutional records. Institutional records are those that would be reported with a populated type of bill code on a UB04 under a fee-for-service arrangement.
Diagnosis Code	Include claims and/or encounters populated with a valid national standard diagnosis code (ICD-10-CM). To make information comparable across POs and consistent across AMP programs, diagnosis codes will be limited to 13 professional/13 facility.

Encounter Format Calculation: Standard Provider Identifiers

Step 1 *Identify all Institutional (837I) and Professional (837P) claims and/or encounters.*

Step 2 *Calculate the percentage of all claims/encounters with a valid NPI.* An NPI is considered valid if the NPI passes OnPoint current formatting checks and validation checks against first and last name. Divide the total count of claims/encounters by the number of claims/encounters populated with a valid NPI for each of the following provider categories:

- Billing Provider.
- Referring Provider.
- Prescribing Provider.

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Encounter Format Calculation: Procedure Codes Per Visit

Step 1 *Identify all visits based on Institutional (837I) and Professional (837P) claims and/or encounters.* "Visits" are defined as the unique combination of billing provider, beneficiary, and DOS.

Step 2 *Calculate the percentage of visits with more than one procedure code.* Divide the number of visits with more than one procedure code by the total number of visits.

Step 3 *Calculate the average number of procedure codes per visit.* Count the number of procedure codes and divide by the number of visits with a procedure code.

Encounter Format Calculation: Procedure Modifier and Rendering Provider Identifier Per Service Line

Step 1 Identify all service lines from Institutional (837I) and Professional (837P) claims and/or encounters that include a procedure code.

Step 2 *Calculate the percentage of service lines with a valid Rendering Provider Identifier NPI.* Count the number of service lines with Rendering Provider Identifier populated with a valid NPI and divide by the count of all service lines.

Step 3 *Calculate the average number of modifiers per service line with a procedure code.* Count the number of procedure modifiers and divide by the total count of service lines with a procedure code for professional and facility outpatient service lines.

Encounter Timeliness (ENLAG)

MEASURE UPDATES JUNE 2021 FOR AMP MY 2021

- None.

MEASURE UPDATES SEPTEMBER 2020 FOR AMP MY 2021

- Added reported Categories of Lagtime for "Zero to 180 days" and "Zero to 364 days."
- Clarified Average Lagtime by Service Date and Average Lagtime by Paid/Remittance Date.
- Defined "service line," "claims," "institutional claims," "institutional encounters," "professional claims," "professional encounter," "pharmacy claims/encounters."
- Clarified the time frame for included service dates in step 4 of Encounter Timeliness Lagtime Categories Calculation.
- Clarified the time frame for included service dates in steps 1 and 2 of Encounter Timeliness Average Lagtime Calculation.

Description

Encounter data timeliness assesses the elapsed time in days between the date when a patient receives care (date of service [DOS]) and the date when the claim or encounter is accepted by the health plan (submission date). The number of calendar days between those dates is the "lag time." Shortening the lag time between the DOS and the submission date ensures that the information provided on the encounter is available for health plan quality improvement initiatives, performance measurement reporting and risk-score calculations.

The following three measures are reported by service type (Facility, Professional, Pharmacy) and by transaction type (claim and encounter).

- **Categories of Lagtime:** The percentage of claims/encounters where the lag time falls within the category duration. Reported categories are:
  - Zero to 30 days (higher is better).
  - Zero to 60 days (higher is better).
  - Zero to 90 days (higher is better).
  - Zero to 180 days (higher is better).
  - Zero to 364 days (higher is better).
  - Greater than or equal to 365 days (lower is better).
- **Average Lagtime by Service Date:** The average lagtime for claims/encounters with dates of service during the measurement period and including the date of payment during the measurement year plus a 3-month runout (i.e. January 1–March 31 of the year following the measurement year).
- **Average Lagtime by Paid/Remittance Date:** The average lagtime for claims/encounters with paid/remittance dates during the measurement period where the service date is during the year prior to the measurement year and during the measurement year.

For additional information on timeliness measures under consideration, refer to the California Department of Health Care Services Quality Measures for Encounter Data.

Note: *Health plans and POs are not expected to report this measure. Onpoint will run this measure using health plans claim and encounter submissions for MY 2021.*

Definitions

Note: *Members in hospice are excluded from the eligible population. Refer to General Guideline 15: Members in Hospice.*

Service Line	All individual service records within a claim or encounter submitted to the health plan. Identified by each record that health plans submit to Onpoint.
Claims	A set of service lines reflected in a unique claim for health plan payment.
Encounter	An **encounter** differs from a **claim** in that it represents a service for which there is no claim for payment sent to the health plan (i.e., all member encounters are covered in the health plan's capitation payment), or a service where the PO may pay the provider a fee for service for the encounter but does not bill the health plan for the service. Include all claims and/or encounters for services rendered, whether or not they were approved or paid by the health plan.
Lagtime	The elapsed time in days between the date when a patient receives care (DOS) and the date when claim/encounter is accepted by the health plan (submission date).
Institutional Claims	Services submitted with a unique claim ID using an 837I format for health plan payment.
Institutional Encounters	Services submitted with a unique claim ID using an 837I format for reasons other than reimbursement.
Professional Claims	Services submitted with a unique claim ID using an 837P format for health plan payment.
Professional Encounters	Services submitted with a unique claim ID using an 837P format for reasons other than reimbursement.
Pharmacy Claims/ Encounters	Prescription records submitted to health plans using an NCDPDP format. There is currently no way to distinguish between pharmacy claims from encounters. Prescription records will be considered as pharmacy claims.

Eligible Population

Product lines	Commercial HMO/POS, Commercial ACO, Medicare Advantage, Medi-Cal Managed Care (report each product line separately).

Encounter Timeliness Lagtime Categories Calculation

Step 1 Distinguish encounters from claims.

Step 2 *Determine the lagtime for each claim/encounter.* Health plans submit all claims/encounters through their medical claims file submission to Onpoint. Onpoint will identify the lagtime for each member claim/encounter by identifying the elapsed time in days between the DOS and the submission date.

Step 3 Categorize all claims/encounters by service type (Professional, Facility, Pharmacy) using the following determination:

- *Institutional:* Records for services that would be submitted using the UB04 format with a Type of Bill code populated under a fee-for-service arrangement.
- *Professional:* Records for services that would be submitted via CMS 1500 with a Place of Service Code populated under a fee-for-service arrangement.
- *Pharmacy:* Records for services for prescription drug coverage normally provided at a pharmacy that have a National Drug Code populated.
  - Pharmaceuticals provided as part of medical procedures or hospital stays would not be included here but would be grouped with the corresponding professional and institutional service.

Step 4 *Assign claims/encounters into the appropriate category based on lagtime.* For the total number of Professional, Facility, and Pharmacy claims/encounters with a service date during the measurement year and a submission date on or before March 31 of the year following the measurement year, calculate the percentage of claims/encounters whose lagtime meets the following categories:

- Zero to 30 days.
- Zero to 60 days.
- Zero to 90 days.
- Zero to 180 days.
- Zero to 364 days.
- Greater than or equal to 365 days.

Step 5 *Calculate the percentage of claims/encounters that fall into each category.* For each claim/encounter type, count claims/encounters within a lagtime category and divide by the count of all claims/encounters of that type.

Encounter Timeliness Average Lagtime Calculation

Step 1 *Calculate the average lagtime by service date.* For all claims/encounters with a DOS occurring January 1–December 31 of the measurement year (and with a submission date on or before March 31 of the year following the measurement year), identify the average lagtime of all claims/encounters in days. For each claim/encounter type, sum the lagtimes across all claims/encounters and divide by the count of all claims/encounters.

Step 2 *Calculate the average lagtime by submission date.* For all encounters/claims with a submission date occurring January 1–December 31 of the measurement year, identify the average lagtime of all claims/encounters in days for claims/encounters with a service date prior to the measurement year and during the measurement year. For each claim/encounter type, sum the lagtimes across all claims/encounters and divide by the count of all claims/encounters.

Advancing Care Information Domain Technical Specifications

For AMP MY 2021

Overview

Description

To support the continued implementation of technology and eliminate redundancy, the IHA committees recommended aligning with the CMS EHR Incentive Program starting in MY 2011. Promoting health IT adoption and use also allow addition of measures that require clinically enriched data from EHRs.

Starting in MY 2014, IHA began collecting two e-measures as part of the Advancing Care Information domain.

- Controlling High Blood Pressure.
- Screening for Depression and Follow-Up Plan.

Both measures are included for reporting under the Merit-Based Incentive Payment System (MIPS) Quality Measure reporting program; eCQMs are included as one of the one of the five collection types for Quality measures.

For AMP, credit is based on the PO's ability to report these two measures. While the data for these measures will be collected through the Physician Organization Clinical Measure File Layout, points will be assigned to the Advancing Care Information Domain.

A list of all the CMS eCQMs and measure specifications can be found on the CMS website here.

IHA staff will hold training webinars for e-measure reporting in 2022.

Who We Measure

For the Advancing Care Information domain, IHA will score POs based on all PCPs (MDs and DOs), including internists, family practitioners, GPs, and pediatricians who can report both e-measure rates to the PO.

Data Collection

Electronic Clinical Quality Measures (eCQM) have specifications for calculation from EHR data. Measures are already programmed into the ONC-ATCB-certified EHR systems of providers who can report the measures.

For each measure, report two metrics:

- ***Rate 1:*** **Percentage reportable.** The percentage of providers who can report the e-measure (i.e., report a numerator and denominator to the PO).
  - Providers in the denominator should include all employed and contracted PCPs (MD or DO) in the following specialties: family/general practice, internal medicine, and pediatric/adolescent medicine.
- ***Rate 2:*** **PO-level aggregated performance.** The aggregated patient numerator and denominator, for those providers who can report the e-measure.
  - To calculate, pull the numerators and denominators from the EHR systems of all providers who can report the measures. Certified EHR systems should be able to create a report with the patient numerator and denominators for the e-measures.

IHA staff are not prescriptive about how POs collect e-measure data and assume that POs use different methods to collect data. POs using one integrated EHR system may be able to create a global report to generate numerators and denominators for providers across the PO. Organizations not using one centralized EHR system may need to collect numerators and denominators from individual providers and aggregate across the PO. Methods for collecting these data may include, but are not limited to, surveys or direct correspondence with the practice or provider.

Submitting Results

These e-measures are included in the Advancing Care Information domain, but the numerators and denominators will be collected as part of the Physician Organization Clinical Measure File Layout and submitted to TransUnion. All participating POs, whether or not they self-report, may participate in e-measure reporting. Non-self-reporting POs complete a separate file layout provided for non-self-reporting PO submission of e-measures.

Note

- *To receive credit, POs must submit valid rates (i.e., greater than zero) for each e-measure. If the PO cannot report a valid numerator and denominator for Rate 2, this is considered not reportable.*
- *The PO-level aggregated patient numerator and denominator for Rate 2 are only for those PCPs that can report the e-measure in Rate 1; the patient denominator in Rate 2 are the patients of PCPs counted in the numerator for Rate 1.*
- *POs may include all patients for the provider, even if they are not PO members. If the provider has the ability to include only PO members, that is also accepted.*
- *The AMP program intends to measure all Commercial HMO/POS members, but we understand that not all POs can limit their numerators and denominators to specific product lines. For this reason, and because IHA is not currently scoring the PO-level aggregated performance, POs may include all payer types. If the PO has the ability to limit the patient population to only Commercial HMO/POS, that is also accepted.*

Example

The PO has 50 PCPs that meet the measure criteria.

- 40 PCPs have an EHR with the Controlling High Blood Pressure e-measure activated; the PO can collect the e-measure (including numerator, denominator, and rate) from those PCPs.
  - These PCPs can report an individual performance rate to the PO, with patient numerators and denominators, for this measure. This is Rate 1: Percent Reportable (40 of 50 PCPs, or 80%).
- There are 1,000 patients in the rates reported by these PCPs (aggregated, across-PO denominator). Of those, 450 have a controlled BP. This is Rate 2: PO-Level Aggregated Performance (450 of 1,000 patients, or 45%).

e-Measure Name	Measure ID	Measure Rate	Denominator	Numerator	Rate
Controlling High Blood Pressure	MU_CBPH_RPT	Rate 1: Percent Reportable	50	40	80%
	MU_CBPH	Rate 2: PO-Level Aggregated Performance	1,000	450	45%

Optional Exclusions for Rate 1 of Each e-Measure

- Pediatricians may be excluded from the Controlling High Blood Pressure e-measure denominator.
- Providers who were employed or contracted with a PO for less than six months of the measurement year.
- Providers who meet the criterion but are employed in an administrative-only role (e.g., medical director).

Controlling High Blood Pressure (e-Measure)

MEASURE UPDATES JUNE 2021 FOR AMP MY 2021

- Updated the Description and Initial population to capture "or the year prior to the measurement period."
- Captured minor updates to the Initial population and Numerator to align with the native specification.

MEASURE UPDATES SEPTEMBER 2020 FOR AMP MY 2021

- Updated eCQM Version Number.
- Updated copyright.
- Updated the clinical recommendations statement to remove outdated references and update with the most recent clinical recommendations.
- Updated references.
- Added text to identify the Quality Data Model (QDM) version used in the measure specification.
- Added text to indicate whether the measure is patient-based or episode-based.
- Updated denominator exclusions to add the word "consecutive" to clarify that the Long-Term Illness (LTI) exclusion should be for 90 consecutive days.

Note: *This Advancing Care Information measure is collected with the clinical measures. The measure specification is provided for reference.* ***POs are not expected to program this measure****. If a provider's EHR system already has this measure programmed, the provider should be able to report this measure. The PO should report the percentage of its providers who can report the measure, and the aggregated numerator and denominator for those providers across the PO.*

Specifications

e-Measure identifier	165	**e-Measure version number**[1]	9.2.000
NQF number	Not Applicable	**GUID**	abdc37cc-bac6-4156-9b91-d1be2c8b7268
Measurement period	January 1–December 31, 2021.		
Measure steward	National Committee for Quality Assurance.		
Measure developer	National Committee for Quality Assurance.		
Endorsed by	None.		
Description	Percentage of patients 18–85 years of age who had a diagnosis of hypertension overlapping the measurement period or the year prior to the		

[1]This measure specification is based on the most recent version of the *eCQM Specifications for Eligible Professionals Update*, published by CMS in May 2020. These specifications are available on the *eCQM Library* page of the CMS website (https://ecqi.healthit.gov/ep-ec-ecqms). AMP does not specify with which version of the measure specification POs comply.

The full measure specifications are located at https://ecqi.healthit.gov/sites/default/files/ecqm/measures/CMS165v9.html

measurement period, and whose most recent blood pressure was adequately controlled (<140/90mmHg) during the measurement period.

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Measure scoring Proportion.

Measure type Intermediate Clinical Outcome.

Stratification None.

Risk adjustment None.

Rate aggregation

None.

Rationale

High blood pressure (HBP), also known as hypertension, is when the pressure in blood vessels is higher than normal (Centers for Disease Control and Prevention [CDC], 2016). The causes of hypertension are multiple and multifaceted and can be based on genetic predisposition, environmental risk factors, being overweight and obese, sodium intake, potassium intake, physical activity, and alcohol use. High blood pressure is common; according to the National Health and Nutrition Examination Survey (NHANES), approximately 85.7 million adults 20 years of age and older had HBP (140/90 mm Hg) between 2011 and 2014 (Crim, 2012). From 2011–2014 the prevalence of hypertension (≥140/90 mm Hg) among US adults 60 and older was approximately 67.2% (Benjamin et al., 2017).

HBP, known as the "silent killer," increases risks of heart disease and stroke, two of the leading causes of death in the U.S. (Yoon, Fryar, & Carroll, 2015). A person who has HBP is four times more likely to die from a stroke and three times more likely to die from heart disease (CDC, 2012). The National Vital Statistics Systems Center for Disease Control and Prevention reported that in 2014 there were approximately 73,300 deaths directly due to HBP and 410,624 deaths with any mention of HBP (CDC, 2015). Between 2004 and 2014, the number of deaths due to HBP rose by 34.1% (Benjamin et al., 2017). Managing and treating HBP would reduce cardiovascular disease mortality for males and females by 30.4% and 38.0%, respectively (Patel et al., 2015).

The estimated annual average direct and indirect cost of HBP from 2012–2013 was $51.2 billion (Benjamin et al., 2017). Total direct costs of HBP are projected to increase to $200 billion by 2030 (Benjamin et al., 2017). A study on cost-effectiveness on treating hypertension found that controlling HBP in patients with cardiovascular disease and systolic blood pressures of ≥160 mm Hg could be effective and cost-saving (Moran et al., 2015).

Many studies have shown that controlling high blood pressure reduces cardiovascular events and mortality. The Systolic Blood Pressure Intervention Trial (SPRINT) investigated the impact of obtaining an SBP goal of <120 mm Hg compared to an SBP goal of <140 mm Hg among patients 50 and older with established cardiovascular disease, and found that the patients with the former goal had reduced cardiovascular events and mortality (SPRINT Research Group et al., 2015).

Controlling HBP will significantly reduce the risks of cardiovascular disease mortality and lead to better health outcomes such as reduction of heart attacks, stroke, and kidney disease (James et al., 2014). Thus, the relationship between the measure (control of hypertension) and the long-term clinical outcomes listed is well established.

Clinical recommendation statement

The U.S. Preventive Services Task Force (2015) recommends screening for high blood pressure in adults age 18 years and older. This is a grade A recommendation.

American College of Cardiology/American Heart Association (2017)

- For adults with confirmed hypertension and known CVD or 10-year ASCVD event risk of 10% or higher, a blood pressure target of less than

130/80 mmHg is recommended (Level of evidence: B-R [for systolic blood pressure]; Level of evidence: C-EO [for diastolic blood pressure]).
- For adults with confirmed hypertension without additional markers of increased CVD risk, a blood pressure target of <130/80 mmHg may be reasonable. (Level of evidence: B-NR [for systolic blood pressure]; Level of evidence: C-EO [for diastolic blood pressure]).
  Note: *Clinical trial evidence is strongest for a target blood pressure of 140/90 mmHg in this population; however, observational studies suggest that these individuals often have a high lifetime risk and would benefit from blood pressure control earlier in life.*

American College of Physicians and the American Academy of Family Physicians (2017):

- Initiate intensifying pharmacologic treatment in adults aged 60 and older at high cardiovascular risk, based on individualized assessment, to achieve a target systolic blood pressure of less than 140 mmHg. (Grade: weak recommendation, quality of evidence: low)
- Initiate intensifying pharmacologic treatment in adults aged 60 and older with a history of stroke or transient ischemic attack to achieve a target systolic blood pressure of less than 140 mmHg to reduce the risk of recurrent stroke. (Grade: weak recommendation, quality of evidence: moderate)

American Diabetes Association (2019):

- For individuals with diabetes and hypertension at higher cardiovascular risk (existing atherosclerotic cardiovascular disease or 10-year atherosclerotic cardiovascular disease risk >15%), a blood pressure target of <130/80 mmHg may be appropriate if it can be safely attained. (Level of evidence: C)
- For individuals with diabetes and hypertension at lower risk for cardiovascular disease (10-year atherosclerotic cardiovascular disease risk <15%), treat to a blood pressure target of <140/90 mmHg. (Level of evidence: A)

Improvement notation Higher score indicates better quality.

Reference American Diabetes Association. (2019). 10. Cardiovascular disease and risk management: Standards of medical care in diabetes—2019. Diabetes Care, 42(Suppl. 1), S103-S123. https://doi.org/10.2337/dc19S010

Reference Benjamin, E. J., Blaha, M. J., Chiuve, S. E., et al. (2017). Heart disease and stroke statistics-2017 update: A report from the American Heart Association. Circulation, 135(10), e146-e603.doi: 10.1161/CIR.0000000000000485

Reference Centers for Disease Control and Prevention. (2012). Vital signs: Getting blood pressure under control. Retrieved from https://www.cdc.gov/vitalsigns/hypertension/index.html

Reference Centers for Disease Control and Prevention. Division for Heart Disease and Stroke Prevention. (2016). High blood pressure fact sheet. Retrieved from https://www.cdc.gov/dhdsp/data_statistics/fact_sheets/fs_bloodpressure.htmhttps://www.cdc.gov/dhdsp/data_statistics/fact_sheets/fs_bloodpressure.htm.

Reference Centers for Disease Control and Prevention, National Center for Health Statistics. (2015). Underlying Cause of Death 1999-2013 on CDC WONDER Online Database. Data are from the Multiple Cause of Death Files, 1999-2013, as compiled from data provided by the 57 vital statistics jurisdictions through the Vital Statistics Cooperative Program. Retrieved from http://wonder.cdc.gov/ucd-icd10.html

Reference Crim, M. T., Yoon, S. S., Ortiz, E., et al. (2012). National Surveillance Definitions for Hypertension Prevalence and Control Among Adults. Circulation: Cardiovascular Quality and Outcomes. 2012, ;5(3), :343–‑351. doi: 10.1161/CIRCOUTCOMES.111.963439.

Reference Moran, A. E., Odden, M. C., Thanataveerat, A., et al.Tzong KY, Rasmussen PW, Guzman D, Williams L, Bibbins-Domingo K, Coxson PG, Goldman L. (2015). Cost-Effectiveness of Hypertension Therapy According to 2014 Guidelines. [published correction appears in N Engl J. Med. 2015;372:1677]. New England Journal of Medicine,. 2015 ;372, :447-–455. doi: 10.1056/NEJMsa1406751. [published correction appears on page 1677]

Reference Patel, S. A., Winkel, M., Ali, M. K., et al. (2015). Cardiovascular Mortality Associated with 5 Leading Risk Factors: National and State Preventable Fractions Estimated from Survey Data. Annals of Internal Medicine, 163(4), :245–253. doi: 10.7326/M14-1753

Reference Qaseem, A., Wilt, T. J., Rich, R., et al. (2017). Pharmacologic treatment Of Hypertension in Adults Aged 60 Years or Older to Higher Versus Lower Blood Pressure Targets: A Clinical Practice Guideline from the American College of Physicians and the American Academy of Family Physicians. Annals of Internal Medicine, 166(6), 430-437.

Reference SPRINT Research Group,; Wright, J. T., Jr., Williamson, J. D., et al. (2015). A Randomized Trial of intensive Versus Standard Blood-Pressure Control. New England Journal of Medicine, 373(22), 2103–2116.

Reference U.S. Preventive Services Task Force. (2015). Screening for High Blood Pressure in Adults: U.S. Preventive Services Task Force Recommendation Statement. Annals of Internal Medicine, 163(10), 778-787.

Reference Whelton, P. K., Carey, R. M., Aronow, W. S., et al. (2017). 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. Journal of the American College of Cardiology. https://doi.org/10.1161/HYP.0000000000000065

Reference Yoon, S. S., Fryar, C. D., & Carroll, M. D. (2015). Hypertension Prevalence and Control Among Adults: United States, 2011-2014. NCHS Data Brief No. 220. Hyattsville, MD: National Center for Health Statistics.

Reference Farley TA, Dalal MA, Mostashari F, Frieden TR. Deaths Preventable in the US by Improvements in the Use of Clinical Preventive Services. Am J Prev Med. 2010;38:600-9. Retrieved from https://www.ajpmonline.org/article/S0749-3797(10)00207-2/fulltext

Definition None.

Guidance	In reference to the numerator element, only BP readings performed by a clinician in the provider office are acceptable for numerator compliance with this measure. 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. • Reported by or taken by the member. If no blood pressure is recorded during the measurement period, the patient's blood pressure is assumed "not controlled." If there are multiple blood pressure readings on the same day, use the lowest systolic and the lowest diastolic reading as the most recent blood pressure reading. This eCQM is a patient-based measure. This version of the eCQM uses QDM version 5.5. Refer to the eCQI resource center (https://ecqi.healthit.gov/qdm) for more information on the QDM.
Transmission format	TBD.
Initial population	Patients 18–85 years of age who had a visit and diagnosis of essential hypertension overlapping the measurement period or the year prior to the measurement period.
Denominator	Equals initial population.
Denominator exclusions	Patients with evidence of end stage renal disease (ESRD), dialysis, or renal transplant before or during the measurement period. Also exclude patients with a diagnosis of pregnancy during the measurement period. Exclude patients whose hospice care overlaps the measurement period. Exclude patients 66 and older who are living long term in an institution for more than 90 consecutive days during the measurement period. Exclude patients 66 and older with advanced illness and frailty because it is unlikely that patients will benefit from the services being measured.
Numerator	Patients whose most recent blood pressure is adequately controlled (systolic blood pressure <140 mmHg; diastolic blood pressure <90 mmHg) during the measurement period.
Numerator exclusions	NA
Denominator exceptions	None.
Supplemental data elements	For every patient evaluated by this measure, also identify payer, race, ethnicity, and sex.

Preventive Care and Screening: Screening for Depression and Follow-Up Plan (PREV-12)

MEASURE UPDATES JUNE 2021 FOR AMP MY 2021

- Removed the following from the Follow-up plan Definitions to align with the native specification, "Additional evaluation or assessment for depression." and "Suicide risk assessment."

MEASURE UPDATES SEPTEMBER 2020 FOR AMP MY 2021

- Updated the eCQM Version Number.
- Updated the measure developer field.
- Revised the description to improve alignment with measure intent and initial population language.
- Updated the copyright and the disclaimer.
- Revised the rationale to align with updated guidelines and evidence.
- Removed the clinical recommendation statement from an outdated guideline and removed the reference to the guideline.
- Updated references to align with American Psychological Association (APA) formatting.
- Removed guidance related to additional evaluation or assessment for depression and suicide risk assessment as appropriate follow-up.
- Added guidance about the importance of escalating patient care or circumstances that are not captured in the measure.
- Added guidance about the intent of the denominator exclusions.
- Added guidance to clarify the measure's use of the most recent depression screening.
- Added text to identify the Quality Data Model (QDM) version used in the measure specification.
- Clarified that the measure is patient-based.
- Removed guidance inconsistent with the measure intent.
- Revised guidance related to examples of appropriate follow-up plans.
- Revised guidance to consolidate and more accurately reflect the intent of using a standardized, age-appropriate depression screening tool.
- Revised denominator exclusions language based upon subject matter experts' feedback to reflect that any patient with a current or historical diagnosis of bipolar disorder or depression should be excluded from the measure.
- Revised denominator exception language to follow a similar format as other eCQMs.

Note: *This Advancing Care Information measure is collected with the Clinical measures. The measure specification is provided for reference.* ***POs are not expected to program this measure.*** *If a provider's EHR system already has this measure programmed, the provider should be able to report this measure. The PO should report the percentage of its providers who can report the measure, and the aggregated numerator and denominator for those providers across the PO.*

Specifications

e-Measure identifier	2	**e-Measure[2] version number**	10.2.000
NQF number	0418e	**GUID**	9a031e24-3d9b-11e1-8634-00237d5bf174
Measurement period	January 1–December 31, 2021.		
Measure steward	Centers for Medicare & Medicaid Services (CMS)		
Measure developer	PCPI(R) Foundation (PCPI[R])		
Endorsed by	National Quality Forum.		
Description	Percentage of patients aged 12 years and older screened for depression on the date of the encounter or up to 14 days prior to the date of the encounter using an age-appropriate standardized depression screening tool, ***and*** if positive, a follow-up plan is documented on the date of the eligible encounter.		
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Disclaimer	These performance measures are not clinical guidelines and do not establish a standard of medical care, and have not been tested for all potential applications. THE MEASURES AND SPECIFICATIONS ARE PROVIDED “AS IS” WITHOUT WARRANTY OF ANY KIND. Due to technical limitations, registered trademarks are indicated by (R) or [R].		
Measure scoring	Proportion.		

[2] This measure specification is based on the most recent version of the *eCQM Specifications for Eligible Professionals Update*, published by CMS in May 2020. These specifications are available on the *eCQM Library* page of the CMS website (https://ecqi.healthit.gov/ep-ec-ecqms). AMP does not specify which version of the measure specification POs comply with.

Full measure specifications are located at https://ecqi.healthit.gov/sites/default/files/ecqm/measures/CMS2v10.html

Measure type Process.

Stratification None.

Risk adjustment None.

Rate aggregation None.

Rationale Depression is a serious medical illness associated with higher rates of chronic disease, increased health care utilization, and impaired functioning (Katon, 2003; Wells et al., 1989). 2016 U.S. survey data indicate that 12.8% of adolescents (3.1 million adolescents) had a major depressive episode (MDE) in the past year, with 9% of adolescents (2.2 million adolescents) having one MDE with severe impairment. The same data indicate that 6.7% of adults aged 18 or older (16.2 million adults) had at least one MDE, with 4.3% of adults (10.3 million adults) having one MDE with severe impairment in the past year (Substance Abuse and Mental Health Services Administration, 2017).

Data indicate that severity of depressive symptoms factor into having difficulty with work, home, or social activities. For example, as the severity of depressive symptoms increase, rates of having difficulty with work, home, or social activities related to depressive symptoms increase. For those 12 and older with mild depressive symptoms, 45.7% reported difficulty with activities; for those with severe depressive symptoms, 88.0% reported difficulty (Pratt & Brody, 2014).

Children and teens with major depressive disorder (MDD) have been found to have difficulty carrying out their daily activities, relating to others, and growing up healthy, and also are at an increased risk of suicide (Siu on behalf of the U.S. Preventive Services Task Force [USPSTF], 2016).

Additionally, perinatal depression (considered here as depression arising in the period from conception to the end of the first postnatal year) affects up to 12% of women (Woody, Ferrari, Siskind, Whiteford, & Harris, 2017). Depression and other mood disorders, such as bipolar disorder and anxiety disorders, especially during the perinatal period, can have devastating effects on women, infants, and families (American College of Obstetricians and Gynecologists, 2018). Maternal suicide rates rise over hemorrhage and hypertensive disorders as a cause of maternal mortality (Palladino, Singh, Campbell, Flynn, & Gold, 2011).

Negative outcomes associated with depression make it crucial to screen in order to identify and treat depression in its early stages. While Primary Care Providers (PCP) serve as the first line of defense in detection of depression, studies show that PCPs fail to recognize up to 50% of depressed patients (Borner, Braunstein, St. Victor, & Pollack, 2010). “In nationally representative U.S. surveys, about 8% of adolescents reported having major depression in the past year. Only 36% to 44% of children and adolescents with depression receive treatment, suggesting that the majority of depressed youth are undiagnosed and untreated” (Siu on behalf of USPSTF, 2016, p. 360 & p. 364).

Evidence supports that screening for depression in pregnant and postpartum women is of moderate net benefit and treatment options for positive depression

screening should be available for patients 12 and older, including pregnant and postpartum women.

If preventing negative patient outcomes is not enough, the substantial economic burden of depression for individuals and society alike makes a case for screening for depression on a regular basis. Depression imposes economic burden through direct and indirect costs: “In the United States, an estimated $22.8 billion was spent on depression treatment in 2009, and lost productivity cost an additional estimated $23 billion in 2011” (Siu & USPSTF, 2016, p. 383-384).

This measure seeks to align with clinical guideline recommendations as well as the Healthy People 2020 recommendation for routine screening for mental health problems as a part of primary care for both children and adults (U.S. Department of Health and Human Services, 2014) and makes an important contribution to the quality domain of community and population health.

Clinical recommendation statement

Adolescent Recommendation (12–18 years): “The USPSTF recommends screening for MDD in adolescents aged 12 to 18 years. Screening should be implemented with adequate systems in place to ensure accurate diagnosis, effective treatment, and appropriate follow-up (B recommendation).” (Siu on behalf of USPSTF, 2016, p. 360).

Adult Recommendation (18 years and older): “The USPSTF recommends screening for depression in the general adult population, including pregnant and postpartum women. Screening should be implemented with adequate systems in place to ensure accurate diagnosis, effective treatment, and appropriate follow-up (B recommendation).” (Siu & USPSTF, 2016, p. 380).

The Institute for Clinical Systems Improvement (ICSI) health care guideline, Adult Depression in Primary Care, provides the following recommendations:

1. “Clinicians should routinely screen all adults for depression using a standardized instrument.”
2. “Clinicians should establish and maintain follow-up with patients.”
3. “Clinicians should screen and monitor depression in pregnant and post-partum women.” (Trangle, 2016 p.p. 8–10)

Improvement notation

Higher score indicates better quality.

Reference

American College of Obstetricians and Gynecologists, Committee on Obstetric Practice. (2018). ACOG Committee Opinion Number 757: Screening for perinatal depression. Obstetrics and Gynecology, 132(5), e208-e212. doi: 10.1097/AOG.0000000000002927

Reference

Borner, I., Braunstein, J. W., St. Victor, R., et al. (2010). Evaluation of a 2-Question Screening Tool for Detecting Depression in Adolescents in Primary Care. Clinical Pediatrics, 49(10), 947-995. doi: 10.1177/0009922810370203

Reference

Katon, W. J. (2003). Clinical and Health Services Relationships Between Major Depression, Depressive Symptoms, and General Medical Illness. Biological Psychiatry, 54(3), 216-226. doi: 10.1016/s0006-3223(03)00273-7

Reference Palladino, C. L., Singh, V., Campbell, J., Flynn, H., & Gold, K. (2011). Homicide and Suicide During the Perinatal Period: Findings from the National Violent Death Reporting System. Obstetrics and Gynecology, 118(5), 1056-1063. doi:10.1097/AOG.0b013e31823294da

Reference Pratt, L. A., & Brody, D. J. (2014). Depression in the U.S. Household Population, 2009-2012. NCHS Data Brief No. 172. Hyattsville, MD: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Health Statistics.

Reference Siu, A. L., on behalf of USPSTF. (2016). Screening for Depression in Children and Adolescents: U.S. Preventive Services Task Force Recommendation Statement. Annals of Internal Medicine, 164(5), 360-366. Retrieved from http://annals.org/article.aspx?articleid=2490528

Reference Siu, A. L., & USPSTF. (2016). Screening for Depression in Adults: U.S. Preventive Services Task Force Recommendation Statement. JAMA, 315(4), 380-387. doi:10.1001/jama.2015.18392. Retrieved from http://jama.jamanetwork.com/article.aspx?articleid=2484345

Reference Substance Abuse and Mental Health Services Administration. (2017). Key Substance Use and Mental Health Indicators in the United States: Results from the 2016 National Survey on Drug Use and Health. Rockville, MD: Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration. Retrieved from https://www.samhsa.gov/data/sites/default/files/NSDUH-FFR1-2016/NSDUH-FFR1-2016.htm

Reference Trangle, M., Gursky, J., Haight, R., et al. (2016, March). Adult Depression in Primary Care. Bloomington, MN: Institute for Clinical Systems Improvement.

Reference U.S. Department of Health and Human Services. (2014). Healthy People 2020: Mental Health and Mental Disorders. Washington, DC: U.S. Department of Health and Human Services. Retrieved from http://www.healthypeople.gov/2020/topicsobjectives2020/objectiveslist.aspx?topicId=28

Reference Wells, K. B., Stewart, A., Hays, R. D., Burnam, M. A., Rogers, W., Daniels, M., … Ware, J. (1989). The Functioning and Well-Being of Depressed Patients. Results from the Medical Outcomes Study. Journal of the American Medical Association, 262(7), 914-919. Abstract retrieved from https://www.ncbi.nlm.nih.gov/pubmed/2754791

Reference Woody, C. A., Ferrari, A. J., Siskind, D. J., Whiteford, H. A., & Harris, M. G. (2017). A Systematic Review and Meta-Regression of the Prevalence and Incidence of Perinatal Depression. Journal of Affective Disorders, 219, 88-92. doi:10.1016/j.jad.2017.05.003

Definitions

Screening Completion of a clinical or diagnostic tool used to identify people at risk of developing or having a certain disease or condition, even in the absence of symptoms.

Standardized depression screening tool

A normalized and validated depression screening tool developed for the patient population in which it is being utilized.

Examples of depression screening tools include, but are not limited to:

- Adolescent screening tools (12–17 years):
  - Patient Health Questionnaire for Adolescents (PHQ-A).
  - Beck Depression Inventory-Primary Care Version (BDI-PC).
  - Mood Feeling Questionnaire (MFQ).
  - Center for Epidemiologic Studies Depression Scale (CES-D).
  - Patient Health Questionnaire (PHQ-9).
  - Pediatric Symptom Checklist (PSC-17).
  - PRIME MD-PHQ2.
- Adult screening tools (18 years and older):
  - Patient Health Questionnaire (PHQ-9).
  - Beck Depression Inventory (BDI or BDI-II).
  - Center for Epidemiologic Studies Depression Scale (CES-D).
  - Depression Scale (DEPS).
  - Duke Anxiety-Depression Scale (DADS).
  - Geriatric Depression Scale (GDS).
  - Cornell Scale Screening for Depression in Dementia (CSDD).
  - PRIME MD-PHQ2.
  - Hamilton Rating Scale for Depression (HAM-D).
  - Quick Inventory of Depressive Symptomatology Self-Report (QID-SR).
  - Computerized Adaptive Testing Depression Inventory (CAT-DI).
  - Computerized Adaptive Diagnostic Screener (CAD-MDD).
- Perinatal Screening Tools
  - Edinburgh Postnatal Depression Scale.
  - Postpartum Depression Screening Scale.
  - Patient Health Questionnaire 9 (PHQ-9).
  - Beck Depression Inventory.
  - Beck Depression Inventory-II.
  - Center for Epidemiologic Studies Depression Scale.
  - Zung Self-rating Depression Scale.

Follow-up plan

Documented follow-up for a positive depression screening must include one or more of the following:

- Referral to a practitioner who is qualified to diagnose and treat depression.
- Pharmacological interventions.
- Other interventions or follow-up for the diagnosis or treatment of depression.

Guidance

A depression screen is completed on the date of the encounter or up to 14 days prior to the date of the encounter using an age appropriate standardized depression screening tool *and* if positive, a follow-up plan is documented on the

date of the encounter, such as referral to a practitioner who is qualified to treat depression, pharmacological interventions, or other interventions for treatment of depression.

This eCQM is a patient-based measure. Depression screening is required once per measurement period, not for all encounters.

The intent of the measure is to screen for depression in patients who have never had a diagnosis of depression or bipolar disorder prior to the eligible encounter used to evaluate the numerator. Patients who have ever been diagnosed with depression or bipolar disorder will be excluded from the measure.

Screening Tools:

- An age-appropriate, standardized, and validated depression screening tool must be used for numerator compliance.
- The name of the age-appropriate, standardized depression screening tool utilized must be documented in the medical record.
- The depression screening must be reviewed and addressed in the office of the provider filing the code on the date of the encounter. Positive pre-screening results indicating a patient is at high risk for self-harm should receive more urgent intervention, as determined by the provider practice.
- The screening should occur during a qualified encounter or up to 14 days prior to the date of the qualifying encounter.
  - The measure assesses the most recent depression screening completed either during the eligible encounter or within the 14 days prior to the encounter. A clinician would not be able to complete another screening at the time of the encounter to count toward a follow-up, because that would serve as the most recent screening. In order to satisfy the follow-up requirement for a patient screening positive, the eligible clinician would need to provide an aforementioned follow-up action, which does not include use of a standardized depression screening tool.

Follow-Up Plan:

The follow-up plan must be related to a positive depression screening; for example: “Patient referred for psychiatric evaluation due to positive depression screening.”

Examples of a follow-up plan include, but are not limited to:

- Referral to a practitioner or program for further evaluation for depression; for example, referral to a psychiatrist, psychologist, social worker, mental health counselor, or other mental health service such as family or group therapy, support group, depression management program, or other service for treatment of depression.
- Other interventions designed to treat depression such as behavioral health evaluation, psychotherapy, pharmacological interventions, or additional treatment options.

If a patient screens positive for depression, the clinician should opt to complete a suicide risk assessment, when appropriate and based on individual patient

	characteristics; however, for the purposes of this measure, a suicide risk assessment or additional screening using a standardized tool does not qualify as a follow-up plan. This version of the eCQM uses QDM version 5.5. Refer to the eCQI resource center (https://ecqi.healthit.gov/qdm) for more information on the QDM.
Transmission format	TBD
Initial population	All patients aged 12 years and older at the beginning of the measurement period with at least one eligible encounter during the measurement period.
Denominator	The initial population.
Denominator exclusions	Patients who have been diagnosed with depression or bipolar disorder.
Numerator	Patients screened for depression on the date of the encounter or up to 14 days prior to the date of the encounter using an age appropriate standardized tool ***and*****,** if positive, a follow-up plan was documented on the date of the eligible encounter.
Numerator exclusions	NA
Denominator exceptions	**Patient reason(s):** • Patient refuses to participate, ***or*** **Medical reason(s):** • Documentation of medical reason for not screening patient for depression (e.g., cognitive, functional, or motivational limitations that may impact accuracy of results; patient is in an urgent or emergent situation where time is of the essence and to delay treatment would jeopardize the patient's health status).
Supplemental data elements	For every patient evaluated by this measure, also identify payer, race, ethnicity, and sex.

Patient Experience Domain

For AMP MY 2020*

Overview

MEASURE UPDATES DECEMBER 2020 FOR AMP MY 2020

- None.

MEASURE UPDATES SEPTEMBER 2020 FOR AMP MY 2020

- None.

Description

***Note:** PAS Updates reflected in this section apply to MY 2020. Due to the timeline transition for releasing the AMP Draft and Final Technical Specifications, PAS updates for each MY will be reflected in the Technical Specifications released for the year following the MY (i.e., MY 2021 PAS updates will be reflected in the MY 2022 Draft and Final AMP Technical Specifications).*

This section includes the AMP guidelines and specifications for POs that participate in the Patient Experience domain for MY 2020. AMP uses the **Patient Assessment Survey (PAS)** to assess PO performance. Health plans do not submit data for the Patient Experience domain; POs voluntarily participate in the survey.

The PAS program is a multi-stakeholder collaborative activity to produce patient care experience ratings of medical groups in California. It is the nation's largest system for evaluating and publishing physician group ratings based on the patient's experience.

Survey instrument	The PAS survey contains a set of patient experience measures on access to care, provider communication, office staff interactions, coordination of care and overall ratings of care. The survey is based on the industry-standard CG-CAHPS©[3] instrument, with some customization for topics of interest locally.

Participation

For MY 2020, PAS offers two group-level survey options for POs serving patients in California: 1.) a commercial survey (HMO and POS patients) and 2.) a Medi-Cal Managed Care survey. POs with over 1,000 enrollees are invited to participate. Registration information was emailed in October 2020.

During the registration process, POs are given information on survey options and the associated fees. POs are required to provide up-to-date contact information and data on member enrollment, geographic locations served, and other PO characteristics, and must agree to the terms outlined in the PAS Participation Agreement.

POs have the option to download and sign off on the terms outlined in the Business Associate Agreement with the survey vendor for the project, the Center for the Study of Services (CSS).

In addition to participating in the PAS Group Survey, POs may have added supplemental physician-level survey options. These are not required or used for AMP.

[3]CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

PO Requirements

In addition to formal registration, POs must adhere to the following requirements.

- Meet deadlines specified during the registration process.
  - Failure to meet deadlines will result in forfeiture of the PO's participation in the PAS project and no points earned in the Patient Experience domain of the applicable AMP programs.
- Sign up for the PAS at the same reporting level at which the PO will be reported for AMP. All domains must be reported at the same level.
  - The survey vendor may not separate results for groups who have not registered sub-units.
- At the time of registration, sign off on the PAS Participation Agreement.
- At the time of registration, submit (or confirm) the PO logo and executive (i.e., medical director) signature, which will be printed on the survey cover letter and instrument.
- Provide accurate information on the PO's coding practices and provider specialties, as requested in an online survey to be hosted by the survey vendor.
- Submit data files on all eligible patients, patient visits, and providers from which the patient sample will be drawn.
  - POs will be given a set of data specifications that define the layout of the files and the information required in each field. All data submissions must meet the data quality criteria identified by PAS.
- Pay participation fees associated with the survey options elected by the PO within 30 days of invoice receipt.
  - Fees will be listed on the registration site.

Performance Areas

Data is collected on the following key performance areas in AMP:

- Access to Care Composite.
- Provider Communication Composite.
- Care Coordination Composite.
- Office Staff Composite.
- Overall Ratings of Care Composite.

Measurement Year 2020 PAS Patient Experience Questions

Refer to the table below for a list of composites collected and recommended for payment for AMP in MY 2020 and in the MY 2020 measure set. Direct questions regarding the survey instrument to Valerie Kong at vkong@pbgh.org.

Performance Area	Primary Care and Specialist Version	Question #
Access Composite	Timely appt. for care needed right away	**6**
	Timely appt. for check-up or routine care	**8**
	Same day response to office hours contact	**10**
Provider Communication Composite	Doctor explanations easy to understand	**14**
	Doctor listens carefully	**15**
	Doctor shows respect	**17**
	Doctor spends enough time	**18**
Care Coordination Composite	Doctor knows important medical history	**16**
	Office followed up on test results	**20**
	Discussed all Rx medicines	**25**
	Doctor informed about other care	**27**
Office Staff Composite*	Clerks and receptionists helpful	**28**
	Clerks and receptionists courteous and respectful	**29**
Overall Ratings of Care Composite	Overall rating of doctor	**23**
	Overall rating of care	**30**

**Payment is not recommended for the Office Staff Composite performance area in MY 2020 but is recommended for all other key performance areas listed.*

Specifications: Patient Population Surveyed

Only adults are surveyed for multispecialty POs. There are two options for assessing pediatric performance:

1. Conduct a second group-level survey process for pediatric patients, which would be sent to the parent of the patient sample.
2. Select the physician-level survey of pediatricians when completing the registration process.

For more information on assessing pediatric performance, email Valerie Kong at vkong@pbgh.org.

Sampling

To be included in any sample, each group must meet all the data criteria listed in the PAS data specifications. Groups were notified if they failed specific criteria and were provided with assistance to either address the issue or determine whether the group was capable of meeting the requirement. Groups may be exempted from meeting specific data criteria and may be accepted for the project with an explicit waiver from the PAS project manager.

Fielding Surveys

The standard survey protocol consists of three emails (where email addresses are available) to complete the survey via website; two mailed surveys, with a cover letter option to complete the survey via the survey website using a unique web ID; and up to four attempts by Computer Assisted Telephone Interview (CATI), where phone numbers are available. The cover letter is printed with the logo of the patient's PO and is signed by the PO's medical director or other executive signatory.

The emails occur over at least one week in early December. The first mailing occurs in mid-January; the second occurs in mid-February and is sent only to patients who did not respond to the first mailing. Patients who do not respond to the second mailing are contacted by phone in mid-March. As patients respond to the survey, they are removed from further contact attempts.

Mail, web, and phone interviews are available in English and Spanish for all patients, and all mailed cover letters include a message in Spanish inviting patients to request a Spanish version of the survey via a toll-free number.

POs are also given the option to field the survey in English and an alternate language (Spanish, Chinese, Vietnamese, or Korean). Patients receiving the alternate language survey receive a cover letter in English with a translation in the alternate language printed on the back of the letter and a copy of the survey instrument in the alternate language.

Any communications to patients in advance of the survey are prohibited in order to maintain a consistent survey methodology for all participating medical groups. Examples of communication include, but are not limited to, letters or postcards that inform patients of the possible receipt of the PAS. For groups with historically low response rates, additional intervention is included in the survey process to increase response rates, such as oversampling and reminders.

Response File Preparation

When survey fielding is complete, the survey vendor cleans the data (i.e., removes duplicate interviews, merges response data with the original sample data, conducts consistency checks between question items). Response data files from mail, web, and telephone interview sources are cleaned for out-of-range responses for each question. All responses where the patient confirms a visit with the physician in the past 6 months are kept. Respondents to the PCP survey must also confirm that the physician named on the survey is their PCP.

Analysis of Survey Data

If any POs do not have a sufficient number of survey responses to meet the reliability threshold for AMP reporting (overall ratings and composites), CSS will combine the prior year and current measurement year responses into a two-year rollup.

Each PO's results are adjusted for patient case-mix to control for differences across POs. The case-mix adjustment model will control for the following:

- Age.
- Gender.
- Education level.
- Race/ethnicity—primary language of respondent.
- Single-item physical health status.
- Single item mental health status.
- Specialty type of physician that patient rated (44 categories).
- Survey response mode (mail/internet, phone).
- Language in which survey was completed.

Reports

POs receive the following reports of their results, pending fulfillment of participation fees.

- *Summary AMP Report* (May 2021): Question and composite level scores.
- *Full Report* (June 2021): PDF group detailed results, including benchmarks, trending, PCP/specialist scores*, and a comparison of provider group question and composite level scores within geographic region; Excel dataset contains de-identified patient-level records for provider group patients only; records include physician identifier.

  **Specialists are not included in Medi-Cal Managed Care fielding, Medi-Cal Managed Care POs will only receive PCP scores.*

Survey results are made publicly available to consumers through the California Department of Managed Health Care's Office of the Patient Advocate consumer website (www.opa.ca.gov/reportcards).

Key Dates for PAS

Activity or Milestone	Time Frame or Deadline
PAS registration information emailed to POs.	September 25, 2020
PAS registration site live.	October 12, 2020
Legal agreements completed (Participation Agreement, BAA).	October 23, 2020
Deadline to register for RY 2021 PAS.	October 23, 2020
Optional data format check prior to data submission	October 26–November 13, 2020
Submit data for survey sampling.	November 2–13, 2020
Data corrections due.	November 20, 2020
Physician survey participants approve provider list.	December 2, 2020
Survey fielding period.	December 14, 2020–April 1, 2021
Participation fees due to PAS.	30 days after invoicing (~May 2021)
Group survey results sent to groups.	June 2021
Physician survey results sent to groups.	June 2021

For More Information

Email Valerie Kong at vkong@pbgh.org.

Appropriate Resource Use Domain Technical Specifications

For AMP MY 2021

Overview

In recognition of the growing issue of health care affordability, the IHA Governance Committee (formerly the P4P Executive and Steering Committees) charged IHA with developing standardized resource use measures to be implemented as part of the AMP program. Resource Use measures were already used for incentive payments by individual plans and physician groups; incorporating them into AMP aligns measurement across plans for consistent identification of unwarranted variation in care delivery and provides an opportunity to ensure appropriate use of limited health care dollars in delivering quality care.

Measures By Priority Area

- All-Cause Readmissions (PCR).
- Emergency Department Visits.
  - Ambulatory Care (AMB).
  - Emergency Department Utilization (EDU).
- Frequency of Selected Procedures (FSP).
- Generic Prescribing (GRX).
- Inpatient Utilization.
  - Acute Hospital Utilization (AHU).
  - Hospital Average Length of Stay (HALOS).
  - Inpatient Utilization—General Hospital/Acute Care (IPU).
- Outpatient Procedure Utilization – Percentage Done in Preferred Facility (OSU).

Measure Development and Testing

The Resource Use measures were selected by a multi-stakeholder group of AMP Committee and IHA board members, based on Resource Use measures currently in use and their potential to improve efficient delivery of appropriate, quality care. The detailed specifications for the non-HEDIS measures on the following pages were developed by a workgroup of participating POs and health plans, with technical support from Onpoint and NCQA.

These measures are calculated by Onpoint from claims, encounter, eligibility, pharmacy, and appropriate use data submitted by participating health plans. POs and health plans do not self-report Resource Use measures.

Calculating Measure Results

The information included in this section applies to **all** measures in the Appropriate Resource Use domain. Please ensure all measure calculations align with the information below **and** individual measure specifications.

In addition to following the instructions in this section **and** individual measure specifications, calculations for HEDIS Utilization Measures (AMB, FSP, and IPU) also follow *Guidelines for HEDIS Utilization Measures* (p. 193). Calculations for HEDIS Risk Adjusted Measures (PCR, EDU, and AHU) should follow *Guidelines for HEDIS Risk Adjusted Utilization Measures* (p. 218).

Each measure is calculated in two ways:

1. **Results for each contracted health plan.** Rates are run on each health plan's data for each contracted PO. Each plan applies its actual costs for the PO to the utilization results provided, and shares savings generated by a PO's improvement over the previous year's performance.
2. **Results aggregated across all contracted health plans.** A PO's results for each measure is aggregated across all contracted plans. This lets POs understand how their utilization compares with that of other POs.

A confidence interval of 95 percent is provided for all measures, representing the range within which the true rate would appear 95 percent of the time.

Enrollment in Plan and PO

For the service to be counted for any measure in the Appropriate Resource Use domain, members must be enrolled in the plan and the PO on the date of service. For example, for *Outpatient Procedures Utilization—Percentage Done in Preferred Facility*, the procedure is attributed to the PO and plan where the member was enrolled on the date of the procedure. The service is not counted in the measure if an enrollment record does not identify a PO in which a member was enrolled on the date of service.

Note: *Some Appropriate Resource Use measures include additional continuous enrollment requirements, refer to individual measure specifications.*

For measures reported in the Commercial ACO product line, continuous enrollment is determined in the health plan (not the ACO) for Onpoint-generated results using health plan data. The criteria for continuous enrollment follows individual measure specifications. Refer to General Guideline 23 AMP Commercial ACO Continuous Enrollment & Member Attribution for additional guidance on continuous enrollment for Onpoint reporting.

Which Services Count?

Report all services for which the organization actually paid or expects to pay. *Do not include* services or days denied for any reason. If a member is enrolled retroactively, count all services for which the organization has paid or expects to pay. Services should be included regardless of provider location (e.g., in-state or out-of-state) and a health plan's status as primary or secondary coverage for the member. Refer to the *Guidelines for HEDIS Utilization Measures* (p. 193) and *Guidelines for HEDIS Risk Adjusted Utilization Measures* (p. 218) for additional information.

Risk Adjustment

The selected risk-adjustment methodology is indicated in each measure's specification. Risk adjustment was determined to be unnecessary for two measures:

- *For Outpatient Procedures Utilization,* a standard list of outpatient procedures is used, which CMS has determined can be done in an ambulatory outpatient setting, independent of member risk.
- *For Generic Prescribing,* specific therapeutic areas are measured, which makes the eligible population more homogenous.

Observed-to-Expected Ratio

A common characteristic of the measures that include risk adjustment is the use of an "observed-to-expected" ratio (also known as an observed/expected [O/E] ratio). In all calculations, the observed rate (per the specifications) is divided by an expected rate, which considers the risk or illness burden of the

PO's population. POs with higher-risk (i.e., sicker) members are expected to have higher utilization and, therefore, have higher expected rates. Similarly, POs with lower risk scores are expected to have lower utilization and have lower expected rates.

It is important to note that calculation of the expected rate is based on utilization and risk patterns in the AMP population, not on national or other external benchmarks. Specifically, to calculate the expected rate, a statistical model is developed that summarizes the relationship between observed rates and relative risk scores across the AMP population and provides an expected rate for a given level of risk. Because the distribution of observed rates by relative risk score varies by measure, the specific statistical model used to fit the data depends on the measure.

The O/E ratio compares the PO's observed rate to the expected rate and allows straightforward interpretation of how the PO's performance compared with the performance of the AMP population:

- An O/E ratio of 1.0 means the PO's rate was the same as expected, based on the risk of its population.
- An O/E ratio of 1.1 means the rate was 10 percent higher than expected.
- An O/E ratio of 0.9 means the rate was 10 percent lower than expected.

Guidelines for HEDIS Utilization Measures

The following guidelines are specific to the HEDIS utilization measures in the Resource Use Domain:

- Ambulatory Care (AMB).
- Frequency of Selected Procedures (FSP)*.
- Inpatient Utilization—General Hospital/Acute Care (IPU).

**Risk adjustment for age and sex is applied to the measure reported rates.*

GUIDANCE UPDATES JUNE 2021 FOR AMP MY 2021

- None.

GUIDANCE UPDATES SEPTEMBER 2020 FOR AMP MY 2021

- Added note to #6 in Specific Instructions for Utilization Tables to clarify shading in reporting tables.

Specific Instructions for Utilization Tables

1. **Members who switch product lines.** Unless otherwise specified, assign members to the product and product line in which they are enrolled on the date of service for the relevant service. If the service is an inpatient claim/encounter, use the member's discharge date to assign the product line. Assign Medi-Cal Managed Care members to the Medicaid-eligibility category (e.g., Medicaid/Medicare, the disabled) based on the date of service or date of discharge (inpatient) for the relevant service.

2. **Services provided during the measurement year.** Report information on services that occurred during the measurement year in the Utilization tables (unless stated otherwise in the measure specification).

3. **Which services count?** Report all services the organization paid for or expects to pay for (i.e., claims incurred but not paid). *Do not include* services and days denied for any reason. If a member is enrolled retroactively, count all services for which the organization paid or expects to pay.

   The organization may have:

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

   Count the service if:

   - The organization paid the full amount ***or*** a portion of the amount (e.g., 80 percent).
   - 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.

   Do not count the service 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.

When confirming that an ED visit or observation stay does not result in an inpatient stay, all inpatient stays must be considered, regardless of payment status (paid, suspended, pending, denied). For example, if an ED visit is paid but an inpatient stay is denied, the ED visit resulted in an inpatient stay and is not included in the *Ambulatory Care* measure when identifying ED visits.

4. **Medicaid eligibility reporting categories.** For the organization's Medi-Cal Managed Care AMP submission, report certain utilization data separately for each of the following eligibility categories:
   - Medicaid/Medicare Dual-Eligibles.
   - Disabled.
   - Low Income.
   - Total Medicaid.

5. **Stratification by product line/eligibility category.** Members covered by different product lines tend to vary considerably by sociodemographic characteristics and enrollment and utilization patterns. For this reason, report measures separately for each product line (Commercial HMO/POS, Medicare Advantage, Medi-Cal Managed Care).

   Measures will have up to six tables. Complete only the tables relevant to the organization (tables reflecting the product lines the organization serves). Tables that apply to each measure are designated as follows (where **XXX** is the abbreviation for a specific measure).

   1. Table **XXX**-1a Total Medicaid.
   2. Table **XXX**-1b Medicaid/Medicare Dual-Eligibles.
   3. Table **XXX**-1c Medicaid—Disabled.
   4. Table **XXX**-1d Medicaid—Other Low Income.
   5. Table **XXX**-2 Commercial.
   6. Table **XXX**-3 Medicare.

   Medicaid members who have a restricted benefit package are not reported separately but are included in Table XXX-1a (Total Medicaid). Therefore, the sum of Table XXX-1b (Medicaid/Medicare Dual-Eligibles), Table XXX-1c (Disabled), and Table XXX-1d (Other Low Income) does not equal Table XXX-1a (Total Medicaid). Information on the categorization of Medicaid members will be provided to the organization by the state. If the state does not provide these data, the organization may report "Total Medicaid" only.

   Report Medicare/Medicaid members (including "dual eligibles") in Table XXX-1a, Table XXX-1b, and Table XXX-3 only if they are enrolled in the organization's Medicare contract required to report HEDIS and in the organization's Medicaid managed-care contract.

   Commercial members. Report "direct pay" and "group" members as Commercial members. Table XXX-2 reports the organization's Commercial members.

6. **Calculating member months.** A table for reporting member months by age category (and gender category, if required) is provided for most measures. Complete the tables for all members with the relevant benefit during the measurement year using the following guidelines and formulas.

Member months are a member's "contribution" to the total yearly membership.

Note: *Cells in the reporting tables are shaded according to how data are reported:*

- *No shading:* Data are reported by the organization
- *Light gray shading:* Data are calculated by the organization's data reporting system (i.e. Onpoint).
- *Solid black shading:* Data are not used or reported.

Reported by the organization
Calculated by Onpoint
Data not used

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 and Ms. X is enrolled in the organization on January 15, Ms. X contributes one 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 and Ms. X turns 25 on April 3 and is enrolled for the entire year, then she contributes three member months (January, February, and March) to the 20–24 age category and nine member months to the 25–29 age category.

7. **Calculating member years.** Member years will be produced after the organization enters member months data. Medicaid data remain in member months format.

Member years serve as a proxy for annual membership and are calculated as:

X member months/12 months = Y member years

8. **Matching enrollment with utilization.** Run enrollment reports used for member month calculations to determine utilization rates (such as days/1,000 members per year) within 30 days of the claims reports and for the same time period. Include retroactive additions and terminations in the reports.

Organizations that report utilization services must also report benefit enrollment (e.g., pharmacy and mental health member months).

9. **Reporting outpatient services.** To report outpatient procedures and services, count the total number of specified services the organization paid for, or expects to pay for, during the measurement year. Use the formulas and guidelines below to complete the tables:

Age of members	Report age as of the date of service.
Counting multiple services	If a member receives the same service or procedure at two different times (e.g., CABG procedures six months apart), count them as two procedures. Count services, not the frequency of procedure codes billed (e.g., if a surgeon and a hospital submit separate bills pertaining to the same surgical episode with the same date of service, count only one). Organizations must develop their own systems to avoid double counting.
Visits/1,000 member months	(Total visits/member months) x 1,000.
Visits/1,000 member years	(Total visits/member months) x 1,000 x 12.

10. **Reporting inpatient services—discharges.** Identify inpatient utilization and report by discharge date, rather than by admission date, and include all discharges that occurred during the measurement year, using the guidelines and formulas outlined below.

Age of members	Unless otherwise specified, report member age as of the date of service. If the service is an inpatient claim/encounter, use age as of the date of discharge.
Counting multiple services	If a patient receives the same service or procedure at two different times (e.g., CABG procedures six months apart), count them as two procedures. Count services, not the frequency of procedure codes billed (e.g., if a surgeon and a hospital submit separate bills pertaining to the same surgical episode with the same date of service, count only one). Organizations must develop their own systems to avoid double counting.
Counting transfers	Treat transfers *between* institutions as separate admissions. Base transfer reports *within* an institution on the type and level of services provided. Report separate admissions when the transfer is between acute and nonacute levels of service or between mental health/chemical dependency services and non-mental health/ chemical dependency services. Count only one admission when the transfer takes place within the same service category but to a different level of care; for example, from intensive care to a lesser level of care or from a lesser level of care to intensive care.

Mental health and chemical dependency transfers	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).
Discharges	Total discharges associated with specified diagnosis codes. If the organization cannot report by discharge date, report data by admission date and indicate the reason.
Discharges/1,000 member months	(Total discharges/member months) × 1,000.
Discharges/1,000 member years	(Total discharges/member months) × 1,000 × 12.
Discharges/1,000 female member months, stratified	Member months within the particular age and gender category specified in each row of the table. For example, [(total discharges for female members 20–34) ÷ (member months of female members 20–34)] × 1,000.
Discharges/1,000 female member years, stratified	Members within the particular age and gender category specified in each row of the table. For example, [(total discharges for female members 20–34 years) ÷ (member months of female members 20–34)] × 1,000 × 12.

11. **Reporting inpatient services—length of stay and days.** Use the formulas below to report length of stay (LOS), average length of stay (ALOS) and total days:

LOS	All approved days from admission to discharge. The last day of the stay is not counted unless the admission and discharge date are the same. LOS = discharge date – admit date – denied days. ***Note:*** *When an inpatient revenue code (UB or equivalent code) is associated with a stay, the LOS must equal at least one day. If the discharge date and the admission date are the same, then the discharge date minus admission date equals one day, not zero days.*
ALOS	Total days/total discharges.
Total days incurred	The sum of the length of stay for all discharges during a measurement year. The total does not include the last day of the stay (unless the last day of stay is also the admit day) or denied days. *Total days incurred includes* days before January 1 of the measurement year for discharge dates occurring during the measurement year. *Total days incurred does not include* days during the measurement year that are associated with discharge dates in the year after the measurement year. Total days incurred = Sum of LOS for each discharge during the measurement year.

Total days incurred/1,000 member years	(Total days incurred/member months) × 1,000 × 12.

Ambulatory Care (AMB)

MEASURE UPDATES JUNE 2021 FOR AMP MY 2021

- None.

MEASURE UPDATES SEPTEMBER 2020 FOR AMP MY 2021

- None.

MODIFICATIONS FROM HEDIS

- None.

Description

This measure summarizes utilization of ambulatory care in the following categories:

- Outpatient visits including telehealth.
- ED visits.

Note: *Onpoint will run this measure for MY 2021. Health plans and POs are not expected to report it.*

Calculations

Refer to Appropriate Resource Use: Overview – Calculating Measure Results (p. 190) and Guidelines for HEDIS Utilization Measures (p. 193) in addition to measure-specific information below.

Note: *Members in hospice are excluded from this measure. Refer to General Guideline 15: Members in Hospice.*

Product lines

Report the following tables for the Medi-Cal Managed Care product line:

- Table AMB-1a Total Medicaid.
- Table AMB-1b Medicaid/Medicare Dual-Eligibles.
- Table AMB-1c Medicaid—Disabled.
- Table AMB-1d Medicaid—Other Low Income.

Member months

For each table, report all member months for the measurement year. Refer to *Specific Instructions for Utilization Tables* for more information.

Counting multiple services

For combinations of multiple ambulatory services falling in different categories on the same day, report each service that meets the criteria in the appropriate category.

Outpatient visits including telehealth

Identify outpatient visits using any of the following.

- Outpatient visits (Ambulatory Outpatient Visits Value Set).
- Telephone visits (Telephone Visits Value Set).
- E-visits or virtual check-ins (Online Assessments Value Set).

Count multiple codes with the same practitioner on the same date of service as a single visit. Count visits with different practitioners separately (count visits with different providers on the same date of service as different visits).

Report services without regard to practitioner type, training, or licensing.

ED visits Count each visit to an ED once, regardless of the intensity or duration of the visit. Count multiple ED visits on the same date of service as one visit. Identify ED visits using either of the following:

- An ED visit (ED Value Set).
- A procedure code (ED Procedure Code Value Set) with an ED place of service code (ED POS Value Set).

Do not include ED visits that result in an inpatient stay (Inpatient Stay Value Set).

Exclusions *(required)*

The measure does not include mental health or chemical dependency services. Exclude visits for mental health or chemical dependency. Any of the following meet criteria:

- A principal diagnosis of mental health or chemical dependency (Mental and Behavioral Disorders Value Set).
- Psychiatry (Psychiatry Value Set).
- Electroconvulsive therapy (Electroconvulsive Therapy Value Set).

Note

- *This measure provides a reasonable proxy for professional ambulatory encounters. It is neither a strict accounting of all ambulatory resources nor an effort to be all-inclusive.*
- *Supplemental data may not be used for this measure.*

Table AMB-1: Ambulatory Care

Age	Member Months
<1	
1-9	
10-19	
20-44	
45-64	
65-74	
75-84	
85+	
Unknown	
Total	

	OUTPATIENT VISITS		ED VISITS	
Age	Visits	Visits/1,000 Member Months	Visits	Visits/1,000 Member Months
<1				
1-9				
10-19				
20-44				
45-64				
65-74				
75-84				
85+				
Unknown				
Total				

Frequency of Selected Procedures (FSP)

MEASURE UPDATES JUNE 2021 FOR AMP MY 2021

- Added Total hip replacement, Total knee replacement, and Carotid endarterectomy procedures to the FSP-1a and FSP2 tables.

MEASURE UPDATES SEPTEMBER 2020 FOR AMP MY 2021

- Added a *Note* about reporting the three procedures not included in the FSP-1a and FSP-2 tables.
- Updated the "Count as one procedure…" definition in the *Calculations* section.
- Updated the order of procedures to align with HEDIS specifications.
- Removed the Member Months table and Procedures/1,000 Member Months column from the FSP-1a and FSP-2 tables.

MODIFICATIONS FROM HEDIS

- The AMP FSP measure specification includes adjustment for age and sex and adjusted rates of procedures per 1,000 member years.
- Removed the Member Months table and Procedures/1,000 Member Months column from the FSP-1a and FSP-2 tables because they are not used in AMP reporting.

Description

This measure summarizes the utilization of frequently performed procedures that often show wide regional variation and have generated concern regarding potentially inappropriate utilization. This measure is for internal reporting only.

Methodologies for adjusting for age/sex differences will be developed and tested. Adjusted rates of procedures will be reported per 1,000 member years.

The FSP risk adjustment methodology involves calculating an expected rate of procedures based on a member's age and gender that can be compared against the observed rate of procedures. This expected rate is based on a locally estimated scatterplot smoothing (LOESS) regression that is calculated and applied by Onpoint. Once the observed to expected ratio is calculated, this is translated back to a risk-standardized rate by applying the observed average rate of procedures for all of the AMP population. Note that the risk adjustment for FSP does not incorporate diagnosis information.

Note: *Onpoint will run this measure for MY 2021. Health plans and POs are not expected to report it.*

Calculations

Refer to Appropriate Resource Use: Overview – Calculating Measure Results (p. 190) and Guidelines for HEDIS Utilization Measures (p. 193) in addition to measure-specific information below.

Note: *Members in hospice are excluded from the eligible population. Refer to General Guideline 15: Members in Hospice.*

Product lines

Report the following tables for the Commercial HMO/POS and Medi-Cal Managed Care product line:

- Table FSP-1a Total Medicaid*.

- Table FSP-2 Commercial.

Note: *For the Total hip replacement, Total knee replacement, and Carotid endarterectomy procedures in the FSP-1a or FSP-2 tables, include all eligible members.*

**Report this table for Total Medi-Cal Managed Care only; reporting by eligibility category will result in small numbers.*

Member years Determine the PO's total member years of enrollment in a health plan as the sum of the number of days during the measurement year when each eligible member was enrolled in the plan and the PO.

For each PO, calculate member years by dividing the total member days by 365.

Procedures Report counts for the procedures as specified regardless of the site of care (e.g., inpatient or ambulatory setting). Report the number of procedures rather than the number of members who had the procedures. Do not double-count the same procedure.

Count as one procedure… To avoid double counting events, all events must be at least 14 days apart. For example, If the date of service for a CABG is February 1, then the service date for the next CABG must be on or after February 15.

If there are two events within 14 days, include only the first procedure. For example, if the date of service for a CABG is February 1, include the February 1 CABG and do not include CABGs that occur on or between February 2 and February 14.

For procedures that occur during an inpatient stay, use the date of service when identifying that events are at least 14 days apart.

Tonsillectomy Tonsillectomy (Tonsillectomy Value Set). Report tonsillectomy (with or without adenoidectomy).

Do not report adenoidectomy performed alone.

Bariatric weight loss surgery Bariatric weight loss surgery (Bariatric Weight Loss Surgery Value Set). Report the number of bariatric weight loss surgeries.

Hysterectomy Report abdominal and vaginal hysterectomy separately.

- Abdominal Hysterectomy Value Set.
- Vaginal Hysterectomy Value Set.

Cholecystectomy Report open and laparoscopic cholecystectomy separately.

- Open Cholecystectomy Value Set.
- Laparoscopic Cholecystectomy Value Set.

Back surgery Back surgery (Back Surgery Value Set). Report all spinal fusion and disc surgery, including codes relating to laminectomy with and without disc removal.

PCI Percutaneous coronary intervention (PCI Value Set). Report all PCIs performed separately. Do not report PCI or cardiac catheterization performed in conjunction with (on the same date of service as) a CABG in the PCI rate or the cardiac catheterization rate; report only the CABG.

Cardiac catheterization Cardiac catheterization (Cardiac Catheterization Value Set). Report all cardiac catheterizations performed separately. Do not report a cardiac catheterization performed in conjunction with (on the same date of service as) an PCI in the cardiac catheterization rate; report only the PCI.

Do not report PCI or cardiac catheterization performed in conjunction with (on the same date of service as) a CABG in the PCI or the cardiac catheterization rate; report only the CABG.

CABG Coronary artery bypass graft (CABG Value Set). Report each CABG only once for each date of service per patient, regardless of the number of arteries involved or the number or types of grafts involved.

Do not report PCI or cardiac catheterization performed in conjunction with (on the same date of service as) a CABG in the PCI or the cardiac catheterization rate; report only the CABG.

Prostatectomy Prostatectomy (Prostatectomy Value Set). Report the number of prostatectomies.

Total hip replacement Total hip replacement (Total Hip Replacement Value Set). Report the number of total hip replacements.

Total knee replacement Total knee replacement (Total Knee Replacement Value Set). Report the number of total knee replacements.

Carotid endarterectomy Carotid endarterectomy (Carotid Endarterectomy Value Set). Report the number of carotid endarterectomies.

Mastectomy Report the number of mastectomies. Report bilateral mastectomy procedures as two procedures.

Identify unilateral mastectomies using any of the following:

- Unilateral Mastectomy Value Set.
- Unilateral Mastectomy Left Value Set.
- Unilateral Mastectomy Right Value Set.

Identify bilateral mastectomies using either of the following:

- Bilateral mastectomy (Bilateral Mastectomy Value Set).
- Unilateral mastectomy (Unilateral Mastectomy Value Set) with a bilateral modifier (Bilateral Modifier Value Set).
- Both of the following on the same date of service:
  - Unilateral mastectomy (Unilateral Mastectomy Value Set) ***with*** a left-side modifier (Left Modifier Value Set) (same procedure).
  - Unilateral mastectomy (Unilateral Mastectomy Value Set) ***with*** a right-side modifier (Right Modifier Value Set) (same procedure).

Lumpectomy Lumpectomy (Lumpectomy Value Set). Report the number of lumpectomies.

Note

- *Supplemental data may not be used for this measure.*

Table FSP-1a: Frequency of Selected Procedures

Procedure	Age	Sex	Number of Procedures
Bariatric weight loss surgery	0-19	Male	
		Female	
	20-44	Male	
		Female	
	45-64	Male	
		Female	
Tonsillectomy	0-9	Male and Female	
	10-19		
Hysterectomy, abdominal	15-44	Female	
	45-64		
Hysterectomy, vaginal	15-44	Female	
	45-64		
Cholecystectomy, open	30-64	Male	
	15-44	Female	
	45-64		
Cholecystectomy, (laparoscopic)	30-64	Male	
	15-44	Female	
	45-64		
Back surgery	20-44	Male	
		Female	
	45-64	Male	
		Female	
Mastectomy	15-44	Female	
	45-64		
Lumpectomy	15-44	Female	
	45-64		
Total hip replacement	<65	Male	
		Female	
	65-74	Male	
		Female	
	75-84	Male	
		Female	
	85+	Male	
		Female	
Total knee replacement	<65	Male	
		Female	
	65-74	Male	
		Female	
	75-84	Male	

Procedure	Age	Sex	Number of Procedures
		Female	
	85+	Male	
		Female	
Carotid endarterectomy	<65	Male	
		Female	
	65-74	Male	
		Female	
	75-84	Male	
		Female	
	85+	Male	
		Female	

Table FSP-2: Frequency of Selected Procedures

Procedure	Age	Sex	Number of Procedures
Bariatric weight loss surgery	0-19	Male	
		Female	
	20-44	Male	
		Female	
	45-64	Male	
		Female	
	65+	Male	
		Female	
Tonsillectomy	0-9	Male and Female	
	10-19		
Hysterectomy, abdominal	15-44	Female	
	45-64		
	65+		
Hysterectomy, vaginal	15-44	Female	
	45-64		
	65+		
Cholecystectomy, open	30-64	Male	
	15-44	Female	
	45-64		
	65+	Male	
		Female	
Cholecystectomy, (laparoscopic)	30-64	Male	
	15-44	Female	
	45-64		
	65+	Male	
		Female	

Procedure	Age	Sex	Number of Procedures
Back surgery	20-44	Male	
		Female	
	45-64	Male	
		Female	
	65+	Male	
		Female	
PCI	45-64	Male	
		Female	
	65+	Male	
		Female	
Cardiac catheterization	45-64	Male	
		Female	
	65+	Male	
		Female	
CABG	45-64	Male	
		Female	
	65+	Male	
		Female	
Prostatectomy	45-64	Male	
	65+		
Mastectomy	15-44	Female	
	45-64		
	65+		
Lumpectomy	15-44	Female	
	45-64		
	65+		
Total hip replacement	<65	Male	
		Female	
	65-74	Male	
		Female	
	75-84	Male	
		Female	
	85+	Male	
		Female	
Total knee replacement	<65	Male	
		Female	
	65-74	Male	
		Female	

Procedure	Age	Sex	Number of Procedures
	75-84	Male	
		Female	
	85+	Male	
		Female	
Carotid endarterectomy	<65	Male	
		Female	
	65-74	Male	
		Female	
	75-84	Male	
		Female	
	85+	Male	
		Female	

Inpatient Utilization—General Hospital/Acute Care (IPU)

MEASURE UPDATES JUNE 2021 FOR AMP MY 2021

- Updated the description to include a Total inpatient, excluding Maternity (the sum of Surgery and Medicine) rate.

MEASURE UPDATES SEPTEMBER 2020 FOR AMP MY 2021

- None.

MODIFICATIONS FROM HEDIS

- The AMP IPU measure specification includes a Total inpatient, excluding Maternity (the sum of Surgery and Medicine) rate.

Description

This measure summarizes utilization of acute inpatient care and services in the following categories:

- Maternity.
- Surgery.
- Medicine.
- Total inpatient (the sum of Maternity, Surgery, and Medicine).
- Total inpatient, excluding Maternity (the sum of Surgery and Medicine).

Note: *Onpoint will run this measure for MY 2021. Health plans and POs are not expected to report it.*

Calculations

Refer to Appropriate Resource Use: Overview – Calculating Measure Results (p. 190) and Guidelines for HEDIS Utilization Measures (p. 193) in addition to measure-specific information below.

Note: *Members in hospice are excluded from this measure. Refer to General Guideline 15: Members in Hospice.*

Product lines

Report the following tables for the Medi-Cal Managed Care product line:

- Table IPU-1a Total Medicaid.
- Table IPU-1b Medicaid/Medicare Dual-Eligibles.
- Table IPU-1c Medicaid—Disabled.
- Table IPU-1d Medicaid—Other Low Income.

Member months

For each table, report all member months for the measurement year. Refer to *Specific Instructions for Utilization Tables* for more information.

Maternity rates are reported per 1,000 males and per 1,000 female total member months for members 10–64 years in order to capture deliveries as a percentage of the total inpatient discharges.

Days

Count all days associated with the identified discharges. Report days for total inpatient, maternity, surgery, and medicine.

ALOS Refer to *Specific Instructions for Utilization Tables* for the formula. Calculate average length of stay for total inpatient, maternity, surgery, and medicine.

Use the following steps to identify and categorize inpatient discharges.

Step 1 Identify all acute inpatient discharges on or between January 1 and December 31 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.

Step 2 Exclude discharges with a principal diagnosis of mental health or chemical dependency (Mental and Behavioral Disorders Value Set) on the discharge claim.

Exclude newborn care rendered from birth to discharge home from delivery (only include care rendered during subsequent rehospitalizations after the delivery discharge). Identify newborn care by a principal diagnosis of live-born infant (Deliveries Infant Record Value Set). Organizations must develop methods to differentiate between the mother's claim and the newborn's claim, if needed.

Step 3 Report total inpatient, using all discharges identified after completing steps 1 and 2.

Step 4 Report maternity. A delivery is not required for inclusion in the *Maternity* category; any maternity-related stay is included. Include birthing center deliveries and count them as one day of stay.

Starting with all discharges identified in step 3, identify maternity using either of the following:

- A maternity-related principal diagnosis (Maternity Diagnosis Value Set).
- A maternity-related stay (Maternity Value Set).

Step 5 Report surgery. From discharges remaining after removing maternity (identified in step 4) from total inpatient (identified in step 3), identify surgery (Surgery Value Set).

Step 6 Report medicine. Categorize as medicine the discharges remaining after removing maternity (identified in step 4) and surgery (identified in step 5) from total inpatient (identified in step 3).

Note

- *Supplemental data may not be used for this measure.*

Table IPU-1: Inpatient Utilization—General Hospital/Acute Care

Age	Member Months
<1	
1-9	
10-19	
20-44	
45-64	
65-74	
75-84	
85+	
Unknown	
Total	

Age	Discharges	Discharges/1,000 Member Months	Days	Days/1,000 Member Months	Average Length of Stay
Total Inpatient					
<1					
1-9					
10-19					
20-44					
45-64					
65-74					
75-84					
85+					
Unknown					
Total					
Maternity*					
10-19					
20-44					
45-64					
Unknown					
Total					
Surgery					
<1					
1-9					
10-19					
20-44					
45-64					
65-74					
75-84					
85+					
Unknown					
Total					

***The *Maternity* category is calculated using member months for members 10–64 years.

Age	Discharges	Discharges/1,000 Member Months	Days	Days/1,000 Member Months	Average Length of Stay
Medicine					
<1					
1-9					
10-19					
20-44					
45-64					
65-74					
75-84					
85+					
Unknown					
Total					

Generic Prescribing (GRX)

MEASURE UPDATES JUNE 2021 FOR AMP MY 2021

- None.

MEASURE UPDATES SEPTEMBER 2020 FOR AMP MY 2021

- None.

Description

The level of generic prescribing will be measured as a simple prescription rate for overall generic prescriptions:

Generic Prescribing Rate	Description
Overall	All drugs, excluding injectables

Plan-defined definitions of "brand" and "generic" will be used to calculate the measure, based on how a prescription was paid, and will accommodate plan-specific contracting arrangements that price brand-name drugs at generic rates.

Note: *Onpoint will run this measure for MY 2021. Health plans and POs are not expected to report it.*

Eligible Population

Refer to Appropriate Resource Use: Overview – Calculating Measure Results (p. 190) in addition to measure-specific information below.

Note: *Members in hospice are excluded from the eligible population. Refer to General Guideline 15: Members in Hospice.*

Product lines	Commercial HMO/POS and Medi-Cal Managed Care (report each product line separately).
Ages	All ages.
Continuous enrollment	None. Because the denominator of this measure is based on prescriptions, not on members, there is no continuous enrollment requirement.
Allowable gap	None.
Anchor date	None.
Benefit	Members must have pharmacy benefits coverage on the fill date of the prescription. The measure is based on all pharmacy claims received by participating health plans for members enrolled in the PO at any point in the measurement year. Pharmacy claims are attributed to a PO if the member was enrolled in the PO on the fill date on the pharmacy claim.
Measurement period	Calendar year. The measurement period is January 1–December 31.

Calculations: Overall Generic Prescribing Rate

Overall Generic Prescribing Rate =

$$\frac{\text{Number of Prescriptions for All Generic Drugs}}{\text{Number of Prescriptions for All Drugs}}$$

A prescription reflects a 30-day supply or less. To account for multi-month fills (i.e. days supplied exceeds 30 days) divide the days' supply by 30 and round down to the nearest whole number. For example, a 100-day supply is equal to three prescriptions (100/30 = 3.33, rounded down to 3).

Denominator

Step 1 Identify all *paid* pharmacy claims for members enrolled in the PO at any point during the measurement year.

Step 2 Ensure that the member was enrolled in the PO on the fill date and had pharmacy benefits coverage.

Step 3 Identify the NDC code for the drug filled on the prescription.

Step 4 Identify and exclude claims for self-injectable drugs.

Step 5 All other paid pharmacy claims are included in the denominator.

Numerator

Step 1 *For all prescriptions in the denominator,* determine whether the prescription was filled with a generic version of the drug or with a brand drug priced as a generic for that therapeutic area. This is determined by a flag supplied by the health plan on the pharmacy claim, indicating whether the drug was a generic or a brand drug priced as a generic.

Step 2 Count the prescription in the numerator if it was filled with a generic drug.

Outpatient Procedures Utilization— Percentage Done in Preferred Facility (OSU)

MEASURE UPDATES JUNE 2021 FOR AMP MY 2021

- Added clarifying language to Continuous Enrollment criteria.

MEASURE UPDATES SEPTEMBER 2020 FOR AMP MY 2021

- None.

MODIFICATIONS FROM HEDIS

- None (this is a non-HEDIS measure based on a former HEDIS Utilization measure).

Description

This measure summarizes utilization of preferred facilities for outpatient/ambulatory procedures. (Outpatient surgeries are included in the definition of "procedures.") One metric will be reported for each PO:

- Percentage of outpatient procedures performed in a preferred facility (by plan).

No risk adjustment will be applied.

Note: *Onpoint will run this measure for MY 2021. Health plans and POs are not expected to report it.*

Definitions

Total outpatient procedures

Count the total number of ambulatory surgery/procedure encounters/claims. A claim with a code from any of the following value set combinations meet the criteria.

- Ambulatory Surgery Option A Value Set ***with*** Ambulatory Surgery UBTOB Value Set.

Report only outpatient procedures performed at a hospital outpatient facility or at a free-standing surgery center, which will be identified by Bill Type = 83x or 13x in the medical claims submission by health plans to Onpoint Health Data. Professional claims are not used to identify outpatient procedures.

Count multiple outpatient procedures on the same date of service as one ambulatory procedure.

Eligible Population

Refer to Appropriate Resource Use: Overview – Calculating Measure Results (p. 190) and Guidelines for HEDIS Utilization Measures (p. 193) in addition to measure-specific information below.

Note: *Members in hospice are excluded from the eligible population. Refer to General Guideline 15: Members in Hospice.*

Product lines

Commercial HMO/POS and Medi-Cal Managed Care (report each product line separately).

Ages	All ages.
Continuous enrollment	Include all members who are enrolled in a PO and in the health plan for one day or more during the measurement year.
Allowable gap	None.
Anchor date	None.
Benefit	Medical.
Measurement period	Calendar year. The measurement period is January 1–December 31.

Exclusions *(required)*

- Exclude claims and encounters that indicate the encounter was for mental health or chemical dependency. Any of the following meet criteria.
  - A principal diagnosis of mental health or chemical dependency (Mental and Behavioral Disorders Value Set).
  - Psychiatry (Psychiatry Value Set).
  - Electroconvulsive therapy (Electroconvulsive Therapy Value Set).
- ED visits are not included in the measure. Identify ED visits using either of the following:
  - An ED visit (ED Value Set).
  - An ED procedure code (ED Procedure Code Value Set) ***with*** an ED place of service code (ED POS Value Set).

Calculations: Outpatient Procedures

Step 1 *Identify the denominator.*

1a *Identify the total number of ambulatory surgery/procedure encounters/claims* using the value set below.

- Ambulatory Surgery Option A Value Set ***with*** Ambulatory Surgery UBTOB Value Set.

1b *Report only outpatient procedures performed at a hospital outpatient facility or at a free-standing surgery center.* Ambulatory surgery/procedures performed at a hospital outpatient facility or at a free-standing surgery center are identified by Bill Type = 83x or 13x in the medical claims submission from health plans to Onpoint Health Data.

Step 2 *Identify the numerator.* Count the total number of ambulatory surgery/procedures performed at a preferred facility. A **preferred facility** is a contracted, free-standing ambulatory surgery center (ASC) (i.e., Bill Type = 83x and Contracted Outpatient Facility Flag = 1 in medical claims submission).

Hospital outpatient facilities will be considered “non-preferred.”

Step 3 *Calculate the observed rate for each PO.*

Observed rate = number of ambulatory surgery/procedures performed at a preferred facility divided by the total number of ambulatory surgery/procedure encounters/claims performed at a hospital outpatient facility or at a free-standing surgery center.

Separate rates will be calculated for each health plan and aggregated across all contracted health plans.

Guidelines for HEDIS Risk Adjusted Utilization Measures

The following guidelines are specific to the HEDIS risk adjusted utilization measures in the Resource Use Domain:

- All-Cause Readmissions (PCR).
- Emergency Department Utilization (EDU).
- Acute Hospital Utilization (AHU).

Note: *The HCC Risk Adjustment tables for MY 2021 are available for free order in the NCQA Store here.*

GUIDANCE UPDATES JUNE 2021 FOR AMP MY 2021

- None.

GUIDANCE UPDATES SEPTEMBER 2020 FOR AMP MY 2021

- Renamed the *Utilization Risk Adjustment Determination* section to *Risk Adjustment Comorbidity Category Determination.*
- Added telephone visits to *Risk Adjustment Comorbidity Category Determination.*
- Replaced references to "encounters" with "denominator units" in the *Risk Adjustment Comorbidity Category Determination* section.
- Replaced references to "Table CC-Comorbid" with "Table CC-Mapping" in the *Risk Adjustment Comorbidity Category Determination* section.
- Replaced references to "HCC column" with "Comorbid HCC columns" in step 5 in the *Risk Adjustment Comorbidity Category Determination* section.
- Updated the Example: Table HCC—Comb in step 5 in the *Risk Adjustment Comorbidity Category Determination* section.

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 measures (PCR, AHU, EDU). *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 or observed events in the other risk adjusted utilization measures).

   When confirming that an ED visit does not result in an inpatient stay, all inpatient stays must be considered, regardless of payment status (paid, suspended, pending, denied). For example, if an ED visit is paid but an inpatient stay is denied, the ED visit resulted in an inpatient stay and is not included in the EDU measure when identifying observed ED visits.

   The organization may have:

   - Covered the full amount.
   - Paid only a portion of the amount (e.g., 80 percent).
   - 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 percent).
- 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 these measures. 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 discharge date.** For observation stays (Observation Stay Value Set) that do not have a recorded discharge date, 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 specification 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 (Outpatient Value Set).
- Telephone visits (Telephone Visits Value Set).
- Observation visits (Observation Value Set).
- ED visits (ED Value Set).
- Inpatient events:
  - Nonacute inpatient encounters (Nonacute Inpatient Value Set).
  - Acute inpatient encounters (Acute Inpatient Value Set).
  - Acute and nonacute inpatient discharges (Inpatient Stay Value Set).

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

For PCR, exclude the primary 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* columns 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

Note

- *For the PCR Medi-Cal Managed Care product line only, organizations must use the "RAU Table – PCR Medicaid" risk adjustment table when assigning comorbid and discharge conditions. For all other measures and the Commercial and Medicare Advantage PCR product lines, organizations must use the "RAU Shared Tables" risk adjustment table when assigning comorbid and discharge conditions.*

All-Cause Readmissions (PCR)

MEASURE UPDATES JUNE 2021 FOR AMP MY 2021

- Added "Members must be 18 and older as of the earliest Index Discharge Date" to the Plan Population definition.
- Replaced Step 1 of Reporting: Number of Members in Plan Population with "Determine the member's age as of the earliest Index Discharge Date."
- Replaced Step 1 of Reporting: Number of Outliers with "Determine the member's age as of the earliest Index Discharge Date."
- Added guidance for reporting variance.

MEASURE UPDATES SEPTEMBER 2020 FOR AMP MY 2021

- Revised the measure description.
- Added a *Note* to the definition of "plan population" to clarify that it should be used as a denominator for the outlier rate.
- Removed "Risk Adjustment Tables" from the Definitions.
- Replaced references to "Table HCC-Surg" with references to the "Surgery Procedure Value Set" in the *Risk Adjustment Determination* section.
- Replaced references to "Table PCR-DischCC" with "Table CC_Mapping" in the *Risk Adjustment Determination* section.
- Removed references to specific risk weight tables in the *Risk Adjustment Weighting* section.
- Clarified rounding rules in step 8 of the *Risk Adjustment Weighting* section.
- Revised the data element tables to separate the Medi-Cal Managed Care and Commercial product lines from the Medicare Advantage product line.

MODIFICATIONS FROM HEDIS

- NCQA refers to this measure as "Plan All-Cause Readmissions."
- The 18–64 age band is not reported for Medicare Advantage.
- Expected rates are normalized by Onpoint to reflect the performance of the population being measured (e.g., Commercial HMO/POS or Medicare Advantage).
- The Skilled Nursing Care and SES Stratification for the Medicare Advantage product line is not reported.

Description

For members 18 years of age and older, 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.

POs and health plans are not expected to run this measure. For reporting purposes, expected rates are normalized to reflect the performance of the population being measured (e.g., Commercial HMO/POS or Medicare Advantage). Onpoint will calculate the expected rates and normalize to reflect the performance of the population being measured.

Note: *For Commercial HMO/POS, Commercial ACOs, and Medi-Cal Managed Care, report only members 18–64 years of age. For Medicare Advantage, report only members 65 years of age and older.*

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 Index Hospital Stay. 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. ***Note:*** *The plan population is only used as a denominator for the Outlier Rate.*
Outlier	Medi-Cal Managed Care and Medicare Advantage members in the eligible population with four or more index hospital stays on or between January 1 and December 1 of the measurement year. Commercial members in the eligible population with three or more index hospital stays between January 1 and December 1 of the measurement year. Assign members to the product/product line in which they are enrolled at the start of the continuous enrollment period of their earliest Index Hospital Stay. 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 an Index Discharge Date.

Eligible Population

Refer to Appropriate Resource Use: Overview – Calculating Measure Results (p. 190) and Guidelines for HEDIS Risk Adjusted Utilization Measures (p. 193) in addition to measure-specific information below.

Note: *Members in hospice are excluded from the eligible population. Refer to General Guideline 15: Members in Hospice.*

Product line	Commercial HMO/POS, Commercial ACO, Medicare Advantage, Medi-Cal Managed Care (report each product line separately).
Ages	*For Commercial HMO/POS,* ages 18–64 as of the Index Discharge Date. *For Commercial ACO,* ages 18–64 as of the Index Discharge Date. *For Medicare Advantage,* ages 65 and older as of the Index Discharge Date. *For Medi-Cal Managed Care,* ages 18–64 as of the Index Discharge Date.
Continuous enrollment	365 days prior to the Index Discharge Date through 30 days after the Index Discharge Date in the health plan and PO (parent level).
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 for the health plan and the PO (parent level, or, for eligible POs, subgroup level).
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.

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 two 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.
- Female 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-1/2/3.

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 primary discharge diagnosis, using Table CC_Mapping. For direct transfers, use the primary discharge diagnosis from the last discharge.

Exclude diagnoses that cannot be mapped to Table CC_Mapping.

Comorbidities Refer to the *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 discharges, surgeries, discharge condition, comorbidity, age and gender. Weights are specific to product line (Commercial, Medicare Advantage 65+, Medi-Cal Managed Care). Refer to the reporting indicator column in the risk adjustment tables to ensure that weights are linked appropriately.

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

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

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

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

Step 5 Link the age and gender weights for each IHS.

Step 6 Sum all weights associated with the IHS (i.e., observation stay, presence of surgery, primary discharge diagnosis, comorbidities, age and gender) and use the formula below to calculate the Estimated Readmission Risk for each IHS:

$$\text{Estimated Readmission Risk} = \frac{e^{(\sum \text{WeightsForIHS})}}{1+e^{(\sum \text{WeightsForIHS})}}$$

OR

Estimated Readmission Risk = [exp (sum of weights for IHS)] / [1 + exp (sum of weights for IHS)]

Note: *"Exp" refers to the exponential or antilog function.*

Step 7 Calculate the Count of Expected Readmissions for each age and stratification category. The Count of Expected Readmissions is the sum of the Estimated Readmission Risk calculated in step 6 for each IHS in each age and stratification category.

$$Count\ of\ Expected\ Readmissions = \sum (\text{Estimated Readmission Risk})$$

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

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

Example: If the Estimated Readmission Risk is 0.1518450741 for an IHS, then the variance for this IHS is 0.1518450741 x 0.8481549259 = 0.1287881476.

Note: *When calculating variance at the IHS level, do not round. 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 and observation 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 *Guidelines for Risk Adjusted Utilization Measures*.

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

- Female 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).
- Planned admissions 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 and the overall total. Enter these values in reporting Tables PCR-1/2 and PCR-A-3.

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 and the overall total. Enter these values in reporting Tables PCR-1/2 and PCR-A-3.

Calculated: Outlier Rate

The number of outlier members divided by the number of members in the plan population, displayed as a permillage (multiplied by 1,000), for each age group and the overall total.

Reporting: Denominator

Count the number of IHS among nonoutlier members for each age group and enter these values into the reporting table under Count of Index Stays.

Reporting: Numerator

Count the number of observed IHS among nonoutlier members with a readmission within 30 days of discharge for each age group and enter these values into the reporting tables under Count of Observed 30-Day Readmissions.

Calculated: Observed Readmission Rate

The Count of Observed 30-Day Readmissions divided by the Count of Index Stays.

Reporting: Count of Expected 30-Day Readmissions

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

Step 2 Round to four decimal places using the .5 rule and enter the Count of Expected Readmissions into the reporting tables.

Calculated: Expected Readmission Rate

The Count of Expected 30-Day Readmissions divided by the Count of Index Stays.

Reporting: Variance

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

Step 2 Round to four decimal places using the .5 rule and enter the variance into the reporting tables.

Calculated: O/E Ratio

The Count of Observed 30-Day Readmissions divided by the Count of Expected 30-Day Readmissions.

Note

- *Supplemental data may not be used for this measure.*

Table PCR-1/2: Plan Population and Outlier Rate (Medi-Cal Managed Care, Commercial, 18–64)

Age	Members in Plan Population	Outlier Members	Outlier Rate
18-44			
45-54			
55-64			
18-64 Total			

Table PCR-A-3: Plan Population and Outlier Rate (Medicare Advantage, 65+)

Age	Members in Plan Population	Outlier Members	Outlier Rate
65-74			
75-84			
85+			
65+ Total			

Table PCR-B-1/2: Plan All-Cause Readmissions Rates Among Nonoutlier Members by Age (Medi-Cal Managed Care, Commercial, 18–64)

Age	Count of Index Stays	Count of Observed 30-Day Readmissions	Observed Readmission Rate	Count of Expected 30-Day Readmissions	Expected Readmission Rate	Variance	O/E Ratio
18-44							
45-54							
55-64							
18-64 Total							

Table PCR-C-3: Plan All-Cause Readmissions Rates Among Nonoutlier Members by Age (Medicare Advantage, 65+)

Age	Count of Index Stays	Count of Observed 30-Day Readmissions	Observed Readmission Rate	Count of Expected 30-Day Readmissions	Expected Readmission Rate	Variance	O/E Ratio
65-74							
75-84							
85+							
65+ Total							

Emergency Department Utilization (EDU)

MEASURE UPDATES JUNE 2021 FOR AMP MY 2021

- Added clarifying language to the description to note the normalization of expected rates.

MEASURE UPDATES SEPTEMBER 2020 FOR AMP MY 2021

- Added definitions for "outlier" and "non-outlier."
- Revised step 1 in the calculation of observed events to exclude ED visits that result in an observation stay.
- Added step 3 in the calculation of observed events to remove discharges for outlier members.
- Removed references to specific risk weight tables in the *Risk Adjustment Weighting* section.
- Removed step 3 to identify the base risk weight from the calculation of PPV and PUCV; renumbered subsequent steps.
- Clarified that for categories with a single member the covariance should be set to zero in step 4 of the Expected Count of Visits calculation.
- Added instructions to report outliers separate from non-outliers.
- Revised the data elements tables and added reporting columns for outliers.

MODIFICATIONS FROM HEDIS

- Expected rates are normalized by Onpoint to reflect the performance of the population being measured (e.g., Commercial HMO/POS or Commercial ACO).

Description

For members 18 years of age and older, the risk-adjusted ratio of observed to expected emergency department (ED) visits during the measurement year.

For reporting purposes, expected rates are normalized to reflect the performance of the population being measured (e.g., Commercial HMO/POS or Commercial ACO). Onpoint will calculate the expected rates and normalize to reflect the performance of the population being measured.

Note: *Onpoint will run this measure for MY 2021. Health plans and POs are not expected to report it.*

Definitions

Outlier	Commercial members 18 years of age and older with four or more ED visits during the measurement year
Non-outlier	Commercial members 18 years of age and older with three or less ED visits during the measurement year.
Classification Period	The year prior to the measurement year.
PPV	Predicted probability of a visit. The predicted probability of a member having an emergency department visit in the measurement year.

PUCV	Predicted unconditional count of visits. The unconditional count of emergency department visits for members during the measurement year.

Eligible Population

Refer to Appropriate Resource Use: Overview – Calculating Measure Results (p. 190) and Guidelines for HEDIS Risk Adjusted Utilization Measures (p. 193) in addition to measure-specific information below.

Note: *Members in hospice are excluded from the eligible population. Refer to General Guideline 15: Members in Hospice.*

Product lines	Commercial HMO/POS and Commercial ACO.
Ages	18 years and older as of December 31 of the measurement year.
Continuous enrollment	The measurement year and the year prior to the measurement year in the health plan and PO (parent level).
Allowable gap	No more than one gap in enrollment of up to 45 days during each year of continuous enrollment.
Anchor date	December 31 of the measurement year for the health plan and the PO (parent level, or, for eligible POs, subgroup level).
Benefit	Medical.
Event/diagnosis	None.

Calculation of Observed Events

Step 1 Count each visit to an ED once, regardless of the intensity or duration of the visit. Count multiple ED visits on the same date of service as one visit. Identify all ED visits during the measurement year using either of the following:

- An ED Visit (ED Value Set).
- A procedure code (ED Procedure Code Value Set) ***with*** an ED place of service code (ED POS Value Set).

Do not include ED visits that result in an inpatient stay (Inpatient Stay Value Set) or an observation stay (Observation Stay Value Set).

Step 2 Exclude encounters with any of the following:

- A principal diagnosis of mental health or chemical dependency (Mental and Behavioral Disorders Value Set).
- Psychiatry (Psychiatry Value Set).
- Electroconvulsive therapy (Electroconvulsive Therapy Value Set).

Step 3 For the remaining ED visits, calculate the number of visits per member and remove visits for outlier members. Report these members as outliers in Table EDU-A-2/3.

Step 4 Calculate the total using all ED visits identified after completing steps 1–3. Assign each remaining ED visit to an age and stratification category using the reporting instructions below.

Risk Adjustment Determination

For each non-outlier member in the eligible population, use the steps in the *Risk Adjustment Comorbidity Category Determination* in the *Guidelines for Risk Adjusted Utilization Measures* to identify risk adjustment categories based on presence of comorbidities.

Risk Adjustment Weighting and Calculation of Expected Events

Calculation of risk-adjusted outcomes (counts of ED visits) uses predetermined risk weights generated by two separate regression models. Weights from each model are combined to predict how many visits each member might have during the measurement year.

For each non-outlier member in the eligible population, assign Predicted Probability of a Visit (PPV) risk weights.

Step 1 For each member with a comorbidity HCC Category, link the PPV weights.

Step 2 Link the age-gender PPV weights for each member.

Step 3 Sum all PPV weights associated with the member (HCC, age, and gender).

Step 4 Calculate the predicted probability of each member having at least one visit based on the sum of the weights for each member using the formula below.

$$\text{PPV} = \frac{e^{(\sum \text{PPV WeightsForEachMember})}}{1+e^{(\sum \text{PPV WeightsForEachMember})}}$$

Truncate intermediate calculations to 10 decimal places.

For each member in the eligible population, assign Predicted Unconditional Count of Visits (PUCV) risk weights.

Step 1 For each member with a comorbidity HCC Category, link the PUCV weights. If a member does not have any comorbidities to which weights can be linked, assign a weight of 1.

Step 2 Link the age-gender PUCV weights for each member.

Step 3 Calculate the predicted unconditional count of visits in the measurement year, by multiplying all PUCV weights (HCC, age and gender). Use the following formula:

PUCV = Age/gender Weight * HCC Weight

Note: *Multiply by each HCC associated with the member. For example, assume a member with HCC-2, HCC-10, HCC-47. The formula would be:*

*PUCV = Age/gender Weight * HCC-2 * HCC-10 * HCC-47*

Note: *Truncate intermediate calculations to 10 decimal places.*

Expected count of ED visits Report the final member-level expected count of ED visits for each category using the formula below. Round to four decimal places using the .5 rule and enter these values into the reporting table.

Expected Count of ED Visits = PPV x PUCV

Step 4 Use the formula below to calculate the covariance of the predicted outcomes for each category (i.e., gender and age group). For categories with a single member (n_c=1), set the covariance to zero. Do not round the covariance before using it in step 6.

$$COV_c = \frac{\sum_{m=1}^{n_c}(PPV_m - mean(PPV)_c) \times (PUCV_m - mean(PUCV)_c)}{n_c - 1}$$

Where:

c	denotes an individual category
n_c	is the number of members in the category indicated by c
m	is an individual member within the category indicated by c
PPV_m	is the unrounded PPV for the member denoted by m
$mean(PPV)_c$	is the unrounded mean PPV in the category indicated by c
$PUCV_m$	is the unrounded PUCV for the member denoted by m
$mean(PUCV)_c$	is the unrounded mean PUCV in the category indicated by c

Step 5 Once the covariance between PPV and PUCV for a given category is calculated, it can be used as indicated in the formula below to calculate the variance for that category.

$$Variance_c = \sum_{m=1}^{n_c}(PPV_m \times PUCV_m)^2 \times \left(1 + (1 - PPV_m)^2 + \left(\frac{2 \times COV_c}{PPV_m \times PUCV_m}\right)\right)$$

Where:

c	denotes an individual category
n_c	is the number of members in the category indicated by c
m	is an individual member within the category indicated by c
PPV_m	is the unrounded PPV for the member denoted by m
$PUCV_m$	is the unrounded PUCV for the member denoted by m
n_c	is the number of members in the category indicated by c

Round the variance for reporting to 4 decimal places using the .5 rule.

Calculated: Number of Members in the Eligible Population

The number of members in the eligible population (including outliers) for each age and gender group and enter these values into the reporting table (Table EDU-A-2/3).

Reporting: Number of Non-Outliers

The number of non-outlier members for each age and gender group and the overall total. Enter these values in the reporting table (Table EDU-A-2/3).

Reporting: Number of Outliers

The number of outlier members for each age and gender group and the overall total. Enter these values in the reporting table (Table EDU-A-2/3).

Calculated: Outlier Rate

The number of outlier members divided by the number of members in the eligible population, displayed as permillage (multiplied by 1,000), for each age and gender group and the overall total.

Reporting: Number of Observed Events Among Non-Outlier Members

The number of observed ED visits within each age and gender group and total.

Calculated: Observed Visits per 1,000 Non-Outlier Members

The number of observed ED visits divided by the number of non-outlier members in the eligible population, multiplied by 1,000 within each age and gender group and total.

Reporting: Number of Expected Events Among Non-Outlier Members

The number of expected ED visits within each age and gender group and total.

Calculated: Expected Visits per 1,000 Non-Outlier Members

The number of expected ED visits divided by the number of non-outlier members in the eligible population, multiplied by 1,000 within each age and gender group and total.

Reporting: Variance Among Non-Outlier Members

The variance (from Risk Adjustment Weighting and Calculation of Expected Events, PUCV, step 6) within each age and gender group and total.

Note

- *Supplemental data may not be used for this measure.*

Table EDU-A-2/3: Eligible Population and Outlier Rate

Age	Sex	Members in the Eligible Population	Non-Outlier Members	Outlier Members	Outlier Rate
18-44	Male				
	Female				
	Total				
45-54	Male				
	Female				
	Total				
55-64	Male				
	Female				
	Total				
65-74	Male				
	Female				
	Total				
75-84	Male				
	Female				
	Total				
85+	Male				
	Female				
	Total				
18-64 Total	Male				
	Female				
	Total				
65+ Total	Male				
	Female				
	Total				
Total	Male				
	Female				
	Total				

Table EDU-B-2/3: Non-Outlier Member Number of ED Visits by Age and Risk Adjustment

Age	Sex	Observed ED Visits	Observed ED Visits/ 1,000 Members	Expected ED Visits	Expected ED Visits/ 1,000 Members	Variance	O/E Ratio
18-44	Male						
	Female						
	Total						
45-54	Male						
	Female						
	Total						
55-64	Male						
	Female						
	Total						
65-74	Male						
	Female						
	Total						
75-84	Male						
	Female						
	Total						
85+	Male						
	Female						
	Total						
18-64 Total	Male						
	Female						
	Total						
65+ Total	Male						
	Female						
	Total						
Total	Male						
	Female						
	Total						

Acute Hospital Utilization (AHU)

MEASURE UPDATES JUNE 2021 FOR AMP MY 2021

- Added clarifying language to the description to note the normalization of expected rates.

MEASURE UPDATES SEPTEMBER 2020 FOR AMP MY 2021

- Removed references to specific risk weight tables in the *Risk Adjustment Weighting* section.
- Clarified that for categories with a single member the covariance should be set to zero in step 4 of the Expected Count of Hospitalization calculation.

MODIFICATIONS FROM HEDIS

- Expected rates are normalized by Onpoint to reflect the performance of the population being measured (e.g., Commercial HMO/POS).

Description

For members 18 years of age and older, the risk-adjusted ratio of observed-to-expected acute inpatient and observation stay discharges during the measurement year reported by Surgery, Medicine and Total.

For reporting purposes, expected rates are normalized to reflect the performance of the population being measured (e.g., Commercial HMO/POS). Onpoint will calculate the expected rates and normalize to reflect the performance of the population being measured.

Note: *Onpoint will run this measure for MY 2021. Health plans and POs are not expected to report it.*

Definitions

Outlier	Commercial members with three or more inpatient or observation stay discharges during the measurement year.
Non-outlier	Commercial members with two or less inpatient or observation stay discharges during the measurement year.
Classification period	The year prior to the measurement year.
PPD	Predicted probability of discharge. The predicted probability of a member having any discharge in the measurement year.
PUCD	Predicted unconditional count of discharge. The predicted unconditional count of discharges for members during the measurement year.

Eligible Population

Refer to Appropriate Resource Use: Overview – Calculating Measure Results (p. 190) and Guidelines for HEDIS Risk Adjusted Utilization Measures (p. 193) in addition to measure-specific information below.

Note: *Members in hospice are excluded from the eligible population. Refer to General Guideline 15: Members in Hospice.*

Product lines	Commercial HMO/POS.

Ages	18 years and older as of December 31 of the measurement year.
Continuous enrollment	The measurement year and the year prior to the measurement year in the health plan and PO (parent level).
Allowable gap	No more than one gap in enrollment of up to 45 days during each year of continuous enrollment.
Anchor date	December 31 of the measurement year for the health plan and the PO (parent level, or, for eligible POs, subgroup level).
Benefit	Medical.
Event/diagnosis	None

Calculation of Observed Events

Use the following steps to identify and categorize acute inpatient and observation stay discharges.

Step 1 Identify all acute inpatient and observation discharges during the measurement year. To identify acute inpatient and observation 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.

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.*

Step 3 For the remaining observation and inpatient discharges, exclude inpatient and observation discharges with:

- A principal diagnosis of mental health or chemical dependency (Mental and Behavioral Disorders Value Set).
- A principal diagnosis of live-born infant (Deliveries Infant Record Value Set).
- A maternity-related principal diagnosis (Maternity Diagnosis Value Set).
- A maternity-related stay (Maternity Value Set).
- Inpatient and observation stays with a discharge for death.

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 the remaining observation and inpatient discharges, remove discharges for outlier members and report these members as outliers in Table AHU-A-2/3.

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

Step 5 Calculate the total using all discharges identified after completing steps 1–4.

Step 6 Calculate surgery. Identify the surgery discharges (Surgery Value Set) from the total discharges (step 5).

Step 7 Calculate medicine. Categorize as Medicine the discharges remaining after removing surgery (step 6) from the total discharges (step 5).

Risk Adjustment Determination

For each non-outlier member in the eligible population, use the steps in the *Risk Adjustment Comorbidity Category Determination* section in the *Guidelines for Risk Adjusted Utilization Measures* to identify risk adjustment categories based on presence of comorbidities.

Risk Adjustment Weighting and Calculation of Expected Events

Calculation of risk-adjusted outcomes (counts of discharges) uses predetermined risk weights generated by two separate regression models. Weights from each model are combined to predict how many discharges each member might have during the measurement year, given age, gender and presence or absence of a comorbid condition.

For each non-outlier member in the eligible population, assign Predicted Probability of Discharge (PPD) risk weights. Calculate the PPD for each service utilization category: Surgery, Medicine, Total.

Step 1 For each member with a comorbidity HCC category, link the PPD weights.

Step 2 Link the age-gender PPD weights for each member.

Step 3 Sum all PPD weights (HCC, age and gender) associated with the member for each category (Medicine, Surgery, Total).

Step 4 Calculate the predicted probability of having at least one discharge in the measurement year based on the sum of the weights for each member, for each category (Surgery, Medicine, Total), using the formula below.

$$\text{PPD} = \frac{e^{(\sum \text{PPD WeightsForEachMember})}}{1+e^{(\sum \text{PPD WeightsForEachMember})}}$$

Truncate intermediate calculations to 10 decimal places.

For each non-outlier member in the eligible population assign Predicted Unconditional Count of Discharge (PUCD) risk weights.

Step 1 For each member with a comorbidity HCC Category, link the PUCD weights. If a member does not have any comorbidities to which a weight could be linked, assign a weight of 1.

Step 2 Link the age-gender PUCD weights for each member.

Step 3 Calculate the predicted unconditional count of discharges in the measurement year, by multiplying all PUCD weights (HCC, age and gender) associated with the member for each category (Surgery, Medicine, Total). Use the following formula:

PUCD = Age/Gender Weight * HCC Weight

Note: *Multiply by each HCC associated with the member. For example, assume a member with HCC-2, HCC-10, HCC-47. The formula would be:*

*PUCD = Age/Gender Weight * HCC-2 * HCC-10 * HCC-47*

Truncate intermediate calculations to 10 decimal places.

Expected count of hospitalization

Report the final member-level expected count of discharges for each category using the formula below. Round to four decimal places using the .5 rule and enter these values in the reporting table.

Expected Count of Discharges = PPD x PUCD

Step 4 Use the formula below to calculate the covariance of the predicted outcomes for each category (gender, age group and type of hospital stay). For categories with a single member (n_c=1), set the covariance to zero. Do not round the covariance before using it in step 5.

$$COV_c = \frac{\sum_{m=1}^{n_c}(PPD_m - mean(PPD)_c) \times (PUCD_m - mean(PUCD)_c)}{n_c - 1}$$

Where:

c	denotes an individual category
n_c	is the number of members in the category indicated by c
m	is an individual member within the category indicated by c
PPD_m	is the unrounded PPD for the member denoted by m
$mean(PPD)_c$	is the unrounded mean PPD in the category indicated by c
$PUCD_m$	is the unrounded PUCD for the member denoted by m
$mean(PUCD)_c$	is the unrounded mean PUCD in the category indicated by c

Step 5 Once the covariance between PPD and PUCD for a given category is calculated, it can be used as indicated in the formula below to calculate the variance for that category.

$$Variance_c = \sum_{m=1}^{n_c}(PPD_m \times PUCD_m)^2 \times \left(1 + (1 - PPD_m)^2 + \left(\frac{2 \times COV_c}{PPD_m \times PUCD_m}\right)\right)$$

Where:

c	denotes an individual category
n_c	is the number of members in the category indicated by c
m	is an individual member within the category indicated by c
PPD_m	is the unrounded PPD for the member denoted by m
$PUCD_m$	is the unrounded PUCD for the member denoted by m

Round the variance for reporting to 4 decimal places using the .5 rule

Calculated: Number of Members in the Eligible Population

The number of members in the eligible population (including outliers) for each age and gender group and the overall total.

Reporting: Number of Nonoutliers

The number of nonoutlier members for each age and gender group and the overall total. Enter these values in the reporting table (Table AHU-A-2/3).

Reporting: Number of Outliers

The number of outlier members for each age and gender group and the overall total. Enter these values in the reporting table (Table AHU-A-2/3).

Calculated: Outlier Rate

The number of outlier members divided by the number of members in the eligible population, displayed as permillage (multiplied by 1,000), for each age and gender group and the overall total.

Reporting: Number of Observed Events Among Nonoutlier Members

The number of observed discharges within each age and gender group and the overall total for each category (Surgery, Medicine, Total).

Calculated: Observed Discharges per 1,000 Nonoutlier Members

The number of observed discharges divided by the number of non-outlier members in the eligible population, multiplied by 1,000 within each age and gender group and the overall total for each category (Surgery, Medicine, Total).

Reporting: Number of Expected Events Among Nonoutlier Members

The number of expected discharges within each age and gender group and the overall total for each category (Surgery, Medicine, Total).

Calculated: Expected Discharges per 1,000 Nonoutlier Members

The number of expected discharges divided by the number of nonoutlier members in the eligible population, multiplied by 1,000 within each age and gender group and the overall total for each category (Surgery, Medicine, Total).

Reporting: Variance Among Nonoutlier Members

The variance (from Risk Adjustment Weighting and Calculation of Expected Events, PUCD, step 5) within each age and gender group and the overall total for each category (Surgery, Medicine, Total).

Note

- *Supplemental data may not be used for this measure.*

Table AHU-A-2/3: Eligible Population and Outlier Rate

Age	Sex	Members in Eligible Population	Non-Outlier Members	Outlier Members	Outlier Rate
18-44	Male				
	Female				
	Total				
45-54	Male				
	Female				
	Total				
55-64	Male				
	Female				
	Total				
65-74	Male				
	Female				
	Total				
75-84	Male				
	Female				
	Total				
85+	Male				
	Female				
	Total				
18-64 Total	Male				
	Female				
	Total				
65+ Total	Male				
	Female				
	Total				
Total	Male				
	Female				
	Total				

Table AHU-B-2/3: Non-Outlier Member Acute Inpatient and Observation Stay Discharges by Age and Risk Adjustment: Surgery

Age	Sex	Observed Discharges	Observed Discharges/ 1,000 Members	Expected Discharges	Expected Discharges/ 1,000 Members	Variance	O/E Ratio
18-44	Male						
	Female						
	Total						
45-54	Male						
	Female						
	Total						
55-64	Male						
	Female						
	Total						
65-74	Male						
	Female						
	Total						
75-84	Male						
	Female						
	Total						
85+	Male						
	Female						
	Total						
18-64 Total	Male						
	Female						
	Total						
65+Total	Male						
	Female						
	Total						
Total	Male						
	Female						
	Total						

Table AHU-C-2/3: Non-Outlier Member Acute Inpatient and Observation Stay Discharges by Age and Risk Adjustment: Medicine

Age	Sex	Observed Discharges	Observed Discharges/ 1,000 Members	Expected Discharges	Expected Discharges/ 1,000 Members	Variance	O/E Ratio
18-44	Male						
	Female						
	Total						
45-54	Male						
	Female						
	Total						
55-64	Male						
	Female						
	Total						
65-74	Male						
	Female						
	Total						
75-84	Male						
	Female						
	Total						
85+	Male						
	Female						
	Total						
18-64 Total	Male						
	Female						
	Total						
65+ Total	Male						
	Female						
	Total						
Total	Male						
	Female						
	Total						

Table AHU-D-2/3: Non-Outlier Member Acute Inpatient and Observation Stay Discharges by Age and Risk Adjustment: Total

Age	Sex	Observed Discharges	Observed Discharges/ 1,000 Members	Expected Discharges	Expected Discharges/ 1,000 Members	Variance	O/E Ratio
18-44	Male						
	Female						
	Total						
45-54	Male						
	Female						
	Total						
55-64	Male						
	Female						
	Total						
65-74	Male						
	Female						
	Total						
75-84	Male						
	Female						
	Total						
85+	Male						
	Female						
	Total						
18-64 Total	Male						
	Female						
	Total						
65+ Total	Male						
	Female						
	Total						
Total	Male						
	Female						
	Total						

Hospital Average Length of Stay (HALOS)

MEASURE UPDATES JUNE 2021 FOR AMP MY 2021

- Added clarifying language to the description to note the normalization of expected rates.
- Added clarifying language to Continuous Enrollment criteria.
- Added Ages, Allowable Gap, Anchor Date, Benefit, and Event/diagnosis criteria for clarification.

MEASURE UPDATES SEPTEMBER 2020 FOR AMP MY 2021

- None.

MODIFICATIONS FROM HEDIS

- None (this is a non-HEDIS measure based on a former HEDIS risk-adjusted measure).

Description

This measure calculates a risk-adjusted inpatient average length of stay (ALOS) for maternity and non-maternity admissions. The numerator for this measure is the number of inpatient days and the denominator is the number of inpatient discharges. The final reported metrics are:

- Risk-adjusted ALOS for maternity inpatient discharges.
- Risk-adjusted ALOS for non-maternity inpatient discharges.

Risk adjustment for ALOS will be calculated using Medicare Severity-Diagnosis Related Group (MS-DRG).

For reporting purposes, expected rates are normalized to reflect the performance of the population being measured (e.g., Commercial HMO/POS, Commercial ACO or Medi-Cal Managed Care). Onpoint will calculate the expected rates and normalize to reflect the performance of the population being measured.

Note: *Onpoint will run this measure for MY 2021. Health plans and POs are not expected to report it.*

Definitions

ALOS — Refer to *Specific Instructions for Utilization Tables* in the *Guidelines for HEDIS Utilization Measures* for the formula. Calculate average length of stay for maternity and non-maternity (e.g., surgery and medicine).

Eligible Population

Refer to Appropriate Resource Use: Overview – Calculating Measure Results (p. 190) and Guidelines for HEDIS Risk Adjusted Utilization Measures (p. 193 in addition to measure-specific information below.

Note: *Members in hospice are excluded from the eligible population. Refer to General Guideline 15: Members in Hospice.*

Product lines — Commercial HMO and POS, Commercial ACO and Medi-Cal Managed Care (report each product line separately).

Ages — All ages.

Continuous enrollment	Include all members who are enrolled in a PO and in the health plan for one day or more during the measurement year.
Allowable gap	None.
Anchor date	None.
Benefit	Medical.

ALOS Calculation

Step 1 Identify all acute inpatient discharges on or between January 1 and December 31 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.

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 following guidelines for counting transfers.

Count 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.

Step 3 Exclude discharges with a principal diagnosis of mental health or chemical dependency (Mental and Behavioral Disorders Value Set) on the discharge claim.

Exclude newborn care rendered from birth to discharge home from delivery (only include care rendered during subsequent rehospitalizations after the delivery discharge). Identify newborn care by a principal diagnosis of live-born infant (Deliveries Infant Record Value Set). Organizations must develop methods to differentiate between the mother's claim and the newborn's claim, if needed.

Step 4 Report ALOS for maternity. A delivery is not required for inclusion in the *Maternity* category; any maternity-related stay is included. Include birthing center deliveries and count them as one day of stay.

Starting with all discharges identified in step 3, identify maternity using either of the following:

- A maternity-related principal diagnosis (Maternity Diagnosis Value Set).
- A maternity-related stay (Maternity Value Set).

Step 5 Report ALOS for non-maternity. Calculate based on all discharges remaining after removing maternity (identified in step 4) from total inpatient (identified in step 3).

Note

- Supplemental data may not be used for this measure.

Risk Adjustment Calculation

Step 1 *Calculate expected ALOS for each MS-DRG by product line.* Collect ALOS values for all discharges into MS-DRG-specific "bins". The expected ALOS for each DRG is the arithmetic mean of all ALOS values attributed to that DRG-bin.

Step 2 *Calculate population ALOS.* The population ALOS is defined as the arithmetic mean of ALOS scores across all discharges, within each DRG bin.

Step 3 *Calculate the observed/expected ratio for ALOS.* Divide the Observed ALOS by the Expected ALOS; multiply the observed to expected ratio by the population ALOS.

Step 4 *Calculate risk-adjusted ALOS.*

Risk-adjusted ALOS = [Σ Observed ALOS/Σ Expected ALOS] * population ALOS.

The same process is followed for the maternity and non-maternity risk adjusted ALOS calculations. For the maternity ALOS adjustment, DRGs are limited to maternity DRGs during the DRG case-mix adjustment.

Total Cost of Care Domain Technical Specifications

For AMP MY 2021

Total Cost of Care (TCOC)

MEASURE UPDATES JUNE 2021 FOR AMP MY 2021

- None.

MEASURE UPDATES SEPTEMBER 2020 FOR AMP MY 2021

- Clarified normalization of relative-risk scores in step 3 of Risk-Adjustment Determination.
- Clarified the reporting time frame in the definition of "Member months."

MODIFICATIONS FROM HEALTHPARTNERS

- AMP includes ages greater than 1 for this measure.
- AMP uses a $250,000 truncation level amount, whereas HealthPartners uses $125,000.
- AMP applies a geographic adjustment in addition to risk adjustment.
- AMP includes capitated costs in the measure.
- AMP includes exclusion criteria for select services and payments.

**This is a non-HEDIS NQF-endorsed measure developed by HealthPartners.*

Description

The average geography- and risk-adjusted costs per member per month (PMPM) for the care provided to a PO's members. Reported indicators include:

- Observed costs PMPM
- Risk-adjusted costs PMPM
- Geography and risk-adjusted costs PMPM

The endorsed specifications are available here and have been reproduced below with permission from HealthPartners for use in AMP. This measure will only be generated by Onpoint from data submitted by health plans and will not be reported by physician organizations. Participating health plans provide to Onpoint member-level total payments, along with member eligibility, claims, and encounter detail, for each contracted PO. This measure is based on actual costs associated with care for members enrolled to a PO, including all covered professional, pharmacy, hospital and ancillary care, as well as administrative payments and adjustments. Health plans include both capitation payments and FFS payments, including member copayments, paid to the PO or other providers caring for members of the PO. It does not include costs associated with mental health/chemical dependency, chiropractic, acupuncture, vision or dental services. Per member annual costs above $250,000 are truncated.

The total paid amount is then risk adjusted, adjusted for geography, and divided by the sum of the member months attributed to the PO. Risk adjustment will be performed using the Johns Hopkins' Adjusted Clinical Grouper (ACG). Geographic adjustment is performed using the geographic adjustment factors published by CMS and based on the hospital wage index.

Eligible Population

Product line	Commercial HMO/POS, Commercial ACO, Medicare Advantage, Medi-Cal Managed Care (report each product line separately).
Ages	>1 to 64 years of age for Commercial HMO, Commercial ACO, and Medi-Cal Managed Care, and >64 years of age for Medicare Advantage. Determine age based on the last day of the measurement period (i.e., December 31 of the measurement year).
Continuous enrollment	For Commercial HMO/POS, Medicare Advantage, and Medi-Cal Managed Care, include members with at least 9 months of enrollment in the health plan and the PO during the measurement period. For Commercial ACO, include members with at least 9 months of enrollment in the health plan and at least 1 attributed month to an ACO during the measurement period.
Allowable gap	None.
Anchor date	None.
Benefit	Medical.
Measurement period	The measurement period is January 1–December 31 of the measurement year. Include services with a date of service between January 1 and December 31 of the measurement year, and a date of payment between January 1 of the measurement year, and March 31 of the reporting year.
Member months	Member Months is the basis for reporting this measure. Member months come from a member's eligibility records (which are submitted by health plans to Onpoint in the Member Identifier file). Determine the number of months during the measurement year that the eligible member was enrolled in both the health plan and PO. For Commercial ACO reporting, member months is determined by the days enrolled with the health plan only. Sum the monthly medical membership and pharmacy membership counts to the member level. ***Note:*** *A member cannot have more pharmacy member months than medical member months. Each member will have a medical member month total and a pharmacy member monthly total.*

Total Cost of Care Calculation

Step 1 Identify the eligible population as defined above.

Step 2 *Obtain member-level observed cost.* This is the payment supplied by the health plan for a member's cost while enrolled with a specific PO. It includes all professional, facility (inpatient and outpatient), pharmacy (including drug rebates), and other payments for services provided to amember.

The following services and payments are excluded from the observed cost amount:

- Mental health.
- Chemical dependency.
- Dental.
- AMP quality incentive payments.
- Vision.
- Chiropractic.
- Acupuncture.

If any of these services are included in a PO's capitation agreement, the plan uses its own actuarial method to exclude.The following payments made to a PO that are not directly related to the delivery of services to individuals are included and attributed to members on a prorated basis:

- Capital infusions.
- Capitation administrative fee.
- Capitation deductions and adjustments.
- Capitation floors and guarantees.
- Non-AMP incentive payments.
- Shared risk payments.
- Special case rates for particular populations.
- Stop loss provisions.
- Non-claim bulk adjustments, including drug rebates.
- Non-claim payments (other).

Step 3 *Calculate observed costs PMPM.*

Total observed costs PMPM = (Total Medical Cost/Medical Member Months) + (Total Pharmacy Cost/Pharmacy Member Months)

Total observed costs above $250,000 per member are truncated.

Step 4 *Report Total Cost of Care service category costs PMPM.* For each member, report the following subcategories of cost:

Overall	TCOC Service Categories	Service Category Breakdown
Total Cost of Care	Cost: Total Facility	IHA generates this measure which is the sum of Total Inpatient Facility plus Total Outpatient Facility plus Other Facility costs
	Cost: Total Inpatient Facility	Maternity Related
		Newborn
		Non-Maternity Related
	Cost: Total Outpatient Facility	Hospital
		Ambulatory Surgery Center
		Emergency Department
		Other Outpatient Facility
	Cost: Other Facility FFS	NA
	Cost: Professional FFS	NA
	Cost: Total Pharmacy FFS	Pharmacy Cost: Specialty
		Pharmacy Cost: All Other
	Cost: Total Capitation	Capitation Cost: Global
		Capitation Cost: Professional Services
		Capitation Cost: Facility Services
	Cost: Other	NA

Overall	TCOC Service Categories	Service Category Breakdown
	**This cost is not accounted for in any other service categories and excludes behavioral health cost.*	
(Exclude from TCOC)	Cost: Behavioral Health	NA

Risk-Adjustment Determination

Step 1 *Calculate risk scores.* For each member in the eligible population, a member-level relative risk score (RRS) will be calculated using the Johns Hopkins' ACG concurrent inputs (based on the claims/encounters submitted by the health plan).

- Age.
- Gender.
- ICD-10 Dx codes.
- Revenue code.
- RVN CPT4, CPT4, and CPT/Revenue CPT4 Modifier.
- Place of service.

The RRS are then normalized for the AMP HMO/POS population (i.e., across all POs and plans) to a benchmark of 1.0, incorporating partial year enrollment, to generate a member-level RRS. Commercial ACO, Medicare Advantage, and Medi-Cal Managed Care risk scores are not normalized.

Step 2 Calculate the average population cost PMPM.

Average Population Cost PMPM = (sum of member level medical cost/sum of member medical months) + (sum of member level pharmacy cost/sum of member pharmacy months)

This average population cost PMPM will be used for both plan-specific and all-plan calculations.

Step 3 *Calculate the risk-adjusted total cost of care PMPM.*

Risk-adjusted total cost of care PMPM = PO-level observed total PMPM/risk score

Geographic Adjustment Determination

Calculate the geography and risk-adjusted total cost of care PMPM

Geography and risk-adjusted total cost of care PMPM = Risk adjusted total cost of care PMPM/geographic adjustment factor, where the geographic adjustment factor is based on the CMS Hospital Wage Index (HWI).

The CMS HWI is normalized by dividing it by the average PO HWI to create the geographic adjustment factor (GAF).

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Testing Measures

Overview

The following measures have been selected for MY 2021 testing in the AMP Commercial ACO program (barring any issues that may impact testing timeline). If tested, health plans and self-reported POs are strongly encouraged to participate in testing in order to get a first look at their performance and help assess the validity of the measures for use in AMP.

Clinical	*Preventive Care and Screening: Screening for Depression and Follow-Up Plan (PREV-12)* is being added as a MY 2021 testing measure for the Commercial ACO product line. *Depression Screening and Follow-Up for Adolescents and Adults (DSF-E)* is being added as a MY 2021 testing measure for the Commercial ACO product line. *Utilization of the PHQ-9 to Monitor Depression Symptoms for Adolescents and Adults (DMS-E)* is being added as a MY 2021 testing measure for the Commercial ACO product line. *Depression Remission or Response for Adolescents and Adults (DRR-E)* is being added as a MY 2021 testing measure for the Commercial ACO product line.
Data Quality	None.
Advancing Care Information	None.
Patient Experience	None.
Appropriate Resource Use	None.
Cost	None.

Guidelines for Measures Reported Using Electronic Clinical Data Systems (ECDS)

GUIDANCE UPDATES JUNE 2021 FOR AMP MY 2021

- None.

GUIDANCE UPDATES SEPTEMBER 2020 FOR AMP MY 2021

- None.

Description

Quality measures in the Electronic Clinical Data Systems (ECDS) reporting domain inspire innovative use of electronic clinical data to document high-quality patient care that demonstrates commitment to evidence-based practice. Organizations that report using ECDS encourage exchange of the information needed to provide high-quality services, ensuring it reaches the right people when it is most useful.

The ECDS reporting standard represents a step forward in adapting the AMP program to accommodate the expansive information available in electronic clinical datasets used for quality improvement.

ECDS are the network of data containing a 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 members.

Health plans and POs 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.

To qualify for ECDS reporting, the data must use standard layouts, meet the measure technical specification requirements and be accessible by the care team upon request. For additional information on ECDS measures, see the Guidelines section below and NCQA's ECDS website.

Guidelines

ECDS measures follow the *General Guidelines for Data Collection and Reporting*.

1. Initial Population

The initial population for any ECDS measure includes all members who satisfy criteria, including age and participation criteria.

2. 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 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.

Structured data	Health care data residing in discrete, static fields using internationally recognized vocabulary standards are accepted as structured clinical data for ECDS reporting if it can be electronically extracted by a digital measure specification from an integrated data warehouse in a consistent and reliable fashion.
Semistructured data	Semistructured health care data are acceptable for use in ECDS reporting, if each QDE conforms to a uniform semantic structure and prescribed hierarchy, as prescribed by the logical definitions and attributes contained within each digital measure specification.
Member-reported data	Member-reported data from the legal health record are acceptable as member responses to a standardized assessment, delivered in a structured form through a secure application programming interface (API). Web APIs are remote applications communicating over the internet which transfer data between a client's software (e.g., member's mobile device) and a server system (e.g., healthcare database). Every member-reported QDE must contain adequate metadata specificity, as defined by each measure's technical specifications (e.g., date, service type, medication type, assessment type, modality).

Data sources are categorized using the following criteria:

EHR/PHR	Electronic health record/personal health record. 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 and a PHR includes both the standard clinical data collected within a provider's office or other care setting, in addition to information curated directly within the PHR by the patient though an API. This data category includes biometric information and clinical samples obtained directly from a patient as well as clinical findings generated as a result of 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.[1] HIEs used for ECDS reporting must use standard protocols to ensure security, privacy, data integrity, sender and receiver authentication and confirmation of delivery.

[1] https://www.healthit.gov/providers-professionals/health-information-exchange/what-hie

	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.[2]
Case management system	A shared database of member information collected through a collaborative process of member assessment, care planning, care coordination or monitoring of a member's functional status and care experience. Case management systems eligible for this category of ECDS reporting include any system developed to support the organization's case/disease management activities, including activities performed by delegates.
Administrative	Includes data from administrative claims processing systems for all services incurred (paid, suspended, pending and denied) during the period defined by each measure's participation as well as member management files, member eligibility and enrollment files, electronic member rosters, internal audit files, and member call service databases.

[2]https://www.nih.gov/health-information/nih-clinical-research-trials-you/list-registries

Preventive Care and Screening: Screening for Depression and Follow-Up Plan (PREV-12)

MEASURE UPDATES JUNE 2021 FOR AMP MY 2021

- None.

MEASURE UPDATES SEPTEMBER 2020 FOR AMP MY 2021

- Added as a Commercial ACO testing measure for MY 2021.

MODIFICATIONS FROM CMS

- None.

Specifications

e-Measure identifier	2	**e-Measure[3] version number**	10.2.000
NQF Number	0418e	**GUID**	9a031e24-3d9b-11e1-8634-00237d5bf174
Measurement Period	January 1–December 31, 2021		
Measure Steward	Centers for Medicare & Medicaid Services (CMS)		
Measure Developer	PCPI(R) Foundation (PCPI[R])		
Endorsed By	National Quality Forum		
Description	Percentage of patients aged 12 years and older screened for depression on the date of the encounter or up to 14 days prior to the date of the encounter using an age-appropriate standardized depression screening tool, ***and*** if positive, a follow-up plan is documented on the date of the eligible encounter.		
Copyright	Limited proprietary coding is contained in the measure specifications for convenience. Users of the proprietary code sets should obtain all necessary licenses from the owners of these code sets. Quality Insights, Inc. disclaims all liability for use or accuracy of any Current Procedural Terminology (CPT[R]) or other coding contained in the specifications. CPT(R) contained in the Measure specifications is copyright 2007–2021 American Medical Association.		

[3] This measure specification is based on the most recent version of the *eCQM Specifications for Eligible Professionals Update*, published by CMS in May 2020. These specifications are available on the *eCQM Library* page of the CMS website (https://ecqi.healthit.gov/ep-ec-ecqms). AMP does not specify which version of the measure specification POs comply with.

Full measure specifications are located at https://ecqi.healthit.gov/sites/default/files/ecqm/measures/CMS2v10.html

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Measure Scoring Proportion

Measure Type Process

Stratification None

Risk Adjustment None

Rate Aggregation None

Rationale

Depression is a serious medical illness associated with higher rates of chronic disease, increased health care utilization, and impaired functioning (Katon, 2003; Wells et al., 1989). 2016 U.S. survey data indicate that 12.8% of adolescents (3.1 million adolescents) had a major depressive episode (MDE) in the past year, with 9% of adolescents (2.2 million adolescents) having one MDE with severe impairment. The same data indicate that 6.7% of adults aged 18 or older (16.2 million adults) had at least one MDE, with 4.3% of adults (10.3 million adults) having one MDE with severe impairment in the past year (Substance Abuse and Mental Health Services Administration, 2017).

Data indicate that severity of depressive symptoms factor into having difficulty with work, home, or social activities. For example, as the severity of depressive symptoms increase, rates of having difficulty with work, home, or social activities related to depressive symptoms increase. For those 12 and older with mild depressive symptoms, 45.7% reported difficulty with activities; for those with severe depressive symptoms, 88.0% reported difficulty (Pratt & Brody, 2014).

Children and teens with major depressive disorder (MDD) have been found to have difficulty carrying out their daily activities, relating to others, and growing up healthy, and also are at an increased risk of suicide (Siu on behalf of the U.S. Preventive Services Task Force [USPSTF], 2016).

Additionally, perinatal depression (considered here as depression arising in the period from conception to the end of the first postnatal year) affects up to 12% of women (Woody, Ferrari, Siskind, Whiteford, & Harris, 2017). Depression and other mood disorders, such as bipolar disorder and anxiety disorders, especially during the perinatal period, can have devastating effects on women, infants, and families (American College of Obstetricians and Gynecologists, 2018). Maternal suicide rates rise over hemorrhage and hypertensive disorders

as a cause of maternal mortality (Palladino, Singh, Campbell, Flynn, & Gold, 2011).

Negative outcomes associated with depression make it crucial to screen in order to identify and treat depression in its early stages. While Primary Care Providers (PCP) serve as the first line of defense in detection of depression, studies show that PCPs fail to recognize up to 50% of depressed patients (Borner, Braunstein, St. Victor, & Pollack, 2010). “In nationally representative U.S. surveys, about 8% of adolescents reported having major depression in the past year. Only 36% to 44% of children and adolescents with depression receive treatment, suggesting that the majority of depressed youth are undiagnosed and untreated” (Siu on behalf of USPSTF, 2016, p. 360 & p. 364).

Evidence supports that screening for depression in pregnant and postpartum women is of moderate net benefit and treatment options for positive depression screening should be available for patients 12 and older, including pregnant and postpartum women.

If preventing negative patient outcomes is not enough, the substantial economic burden of depression for individuals and society alike makes a case for screening for depression on a regular basis. Depression imposes economic burden through direct and indirect costs: “In the United States, an estimated $22.8 billion was spent on depression treatment in 2009, and lost productivity cost an additional estimated $23 billion in 2011” (Siu & USPSTF, 2016, p. 383-384).

This measure seeks to align with clinical guideline recommendations as well as the Healthy People 2020 recommendation for routine screening for mental health problems as a part of primary care for both children and adults (U.S. Department of Health and Human Services, 2014) and makes an important contribution to the quality domain of community and population health.

Clinical Recommendation Statement

Adolescent Recommendation (12–18 years): “The USPSTF recommends screening for MDD in adolescents aged 12 to 18 years. Screening should be implemented with adequate systems in place to ensure accurate diagnosis, effective treatment, and appropriate follow-up (B recommendation).” (Siu on behalf of USPSTF, 2016, p. 360).

Adult Recommendation (18 years and older): “The USPSTF recommends screening for depression in the general adult population, including pregnant and postpartum women. Screening should be implemented with adequate systems in place to ensure accurate diagnosis, effective treatment, and appropriate follow-up (B recommendation).” (Siu & USPSTF, 2016, p. 380).

The Institute for Clinical Systems Improvement (ICSI) health care guideline, Adult Depression in Primary Care, provides the following recommendations:

1. “Clinicians should routinely screen all adults for depression using a standardized instrument.”
2. “Clinicians should establish and maintain follow-up with patients.”
3. “Clinicians should screen and monitor depression in pregnant and post-partum women.” (Trangle, 2016 p.p. 8–10)

Improvement Notation

Higher score indicates better quality

Reference American College of Obstetricians and Gynecologists, Committee on Obstetric Practice. (2018). ACOG Committee Opinion Number 757: Screening for perinatal depression. Obstetrics and Gynecology, 132(5), e208-e212. doi: 10.1097/AOG.0000000000002927

Reference Borner, I., Braunstein, J. W., St. Victor, R., et al. (2010). Evaluation of a 2-Question Screening Tool for Detecting Depression in Adolescents in Primary Care. Clinical Pediatrics, 49(10), 947-995. doi: 10.1177/0009922810370203

Reference Katon, W. J. (2003). Clinical and Health Services Relationships Between Major Depression, Depressive Symptoms, and General Medical Illness. Biological Psychiatry, 54(3), 216-226. doi: 10.1016/s0006-3223(03)00273-7

Reference Palladino, C. L., Singh, V., Campbell, J., Flynn, H., & Gold, K. (2011). Homicide and Suicide During the Perinatal Period: Findings from the National Violent Death Reporting System. Obstetrics and Gynecology, 118(5), 1056-1063. doi:10.1097/AOG.0b013e31823294da

Reference Pratt, L. A., & Brody, D. J. (2014). Depression in the U.S. Household Population, 2009-2012. NCHS Data Brief No. 172. Hyattsville, MD: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Health Statistics.

Reference Siu, A. L., on behalf of USPSTF. (2016). Screening for Depression in Children and Adolescents: U.S. Preventive Services Task Force Recommendation Statement. Annals of Internal Medicine, 164(5), 360-366. Retrieved from http://annals.org/article.aspx?articleid=2490528

Reference Siu, A. L., & USPSTF. (2016). Screening for Depression in Adults: U.S. Preventive Services Task Force Recommendation Statement. JAMA, 315(4), 380-387. doi:10.1001/jama.2015.18392. Retrieved from http://jama.jamanetwork.com/article.aspx?articleid=2484345

Reference Substance Abuse and Mental Health Services Administration. (2017). Key Substance Use and Mental Health Indicators in the United States: Results from the 2016 National Survey on Drug Use and Health. Rockville, MD: Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration. Retrieved from https://www.samhsa.gov/data/sites/default/files/NSDUH-FFR1-2016/NSDUH-FFR1-2016.htm

Reference Trangle, M., Gursky, J., Haight, R., et al. (2016, March). Adult Depression in Primary Care. Bloomington, MN: Institute for Clinical Systems Improvement.

Reference U.S. Department of Health and Human Services. (2014). Healthy People 2020: Mental Health and Mental Disorders. Washington, DC: U.S. Department of Health and Human Services. Retrieved from http://www.healthypeople.gov/2020/topicsobjectives2020/objectiveslist.aspx?topicId=28

Reference Wells, K. B., Stewart, A., Hays, R. D., Burnam, M. A., Rogers, W., Daniels, M., … Ware, J. (1989). The Functioning and Well-Being of Depressed Patients. Results from the Medical Outcomes Study. Journal of the American Medical Association, 262(7), 914-919. Abstract retrieved from https://www.ncbi.nlm.nih.gov/pubmed/2754791

Reference

Woody, C. A., Ferrari, A. J., Siskind, D. J., Whiteford, H. A., & Harris, M. G. (2017). A Systematic Review and Meta-Regression of the Prevalence and Incidence of Perinatal Depression. Journal of Affective Disorders, 219, 88-92. doi:10.1016/j.jad.2017.05.003

Definitions

Screening Completion of a clinical or diagnostic tool used to identify people at risk of developing or having a certain disease or condition, even in the absence of symptoms.

Standardized depression screening tool A normalized and validated depression screening tool developed for the patient population in which it is being utilized.

Examples of depression screening tools include, but are not limited to:

- Adolescent screening tools (12–17 years):
  - Patient Health Questionnaire for Adolescents (PHQ-A).
  - Beck Depression Inventory-Primary Care Version (BDI-PC).
  - Mood Feeling Questionnaire (MFQ).
  - Center for Epidemiologic Studies Depression Scale (CES-D).
  - Patient Health Questionnaire (PHQ-9).
  - Pediatric Symptom Checklist (PSC-17).
  - PRIME MD-PHQ2.
- Adult screening tools (18 years and older):
  - Patient Health Questionnaire (PHQ-9).
  - Beck Depression Inventory (BDI or BDI-II).
  - Center for Epidemiologic Studies Depression Scale (CES-D).
  - Depression Scale (DEPS).
  - Duke Anxiety-Depression Scale (DADS).
  - Geriatric Depression Scale (GDS).
  - Cornell Scale Screening for Depression in Dementia (CSDD).
  - PRIME MD-PHQ2.
  - Hamilton Rating Scale for Depression (HAM-D).
  - Quick Inventory of Depressive Symptomatology Self-Report (QID-SR).
  - Computerized Adaptive Testing Depression Inventory (CAT-DI).
  - Computerized Adaptive Diagnostic Screener (CAD-MDD).
- Perinatal Screening Tools
  - Edinburgh Postnatal Depression Scale.
  - Postpartum Depression Screening Scale.
  - Patient Health Questionnaire 9 (PHQ-9).
  - Beck Depression Inventory.
  - Beck Depression Inventory-II.
  - Center for Epidemiologic Studies Depression Scale.
  - Zung Self-rating Depression Scale.

Follow-up plan Documented follow-up for a positive depression screening must include one or more of the following:

- Referral to a practitioner who is qualified to diagnose and treat depression.
- Pharmacological interventions.
- Other interventions or follow-up for the diagnosis or treatment of depression.

Guidance

A depression screen is completed on the date of the encounter or up to 14 days prior to the date of the encounter using an age appropriate standardized depression screening tool *and* if positive, a follow-up plan is documented on the date of the encounter, such as referral to a practitioner who is qualified to treat depression, pharmacological interventions, or other interventions for treatment of depression.

This eCQM is a patient-based measure. Depression screening is required once per measurement period, not for all encounters.

The intent of the measure is to screen for depression in patients who have never had a diagnosis of depression or bipolar disorder prior to the eligible encounter used to evaluate the numerator. Patients who have ever been diagnosed with depression or bipolar disorder will be excluded from the measure.

Screening Tools:

- An age-appropriate, standardized, and validated depression screening tool must be used for numerator compliance.
- The name of the age-appropriate, standardized depression screening tool utilized must be documented in the medical record.
- The depression screening must be reviewed and addressed in the office of the provider filing the code on the date of the encounter. Positive pre-screening results indicating a patient is at high risk for self-harm should receive more urgent intervention, as determined by the provider practice.
- The screening should occur during a qualified encounter or up to 14 days prior to the date of the qualifying encounter.
    - The measure assesses the most recent depression screening completed either during the eligible encounter or within the 14 days prior to the encounter. A clinician would not be able to complete another screening at the time of the encounter to count toward a follow-up, because that would serve as the most recent screening. In order to satisfy the follow-up requirement for a patient screening positive, the eligible clinician would need to provide an aforementioned follow-up action, which does not include use of a standardized depression screening tool.

Follow-Up Plan:

The follow-up plan must be related to a positive depression screening; for example: “Patient referred for psychiatric evaluation due to positive depression screening.”

Examples of a follow-up plan include, but are not limited to:

- Referral to a practitioner or program for further evaluation for depression; for example, referral to a psychiatrist, psychologist, social worker, mental health counselor, or other mental health service such as family or group therapy, support group, depression management program, or other service for treatment of depression.
- Other interventions designed to treat depression such as behavioral health evaluation, psychotherapy, pharmacological interventions, or additional treatment options.

If a patient screens positive for depression, the clinician should opt to complete a suicide risk assessment, when appropriate and based on individual patient characteristics; however, for the purposes of this measure, a suicide risk assessment or additional screening using a standardized tool does not qualify as a follow-up plan.

This version of the eCQM uses QDM version 5.5. Refer to the eCQI resource center (https://ecqi.healthit.gov/qdm) for more information on the QDM.

Transmission Format	TBD
Initial Population	All patients aged 12 years and older at the beginning of the measurement period with at least one eligible encounter during the measurement period
Denominator	The Initial Population
Denominator Exclusions	Patients who have been diagnosed with depression or bipolar disorder.
Numerator	Patients screened for depression on the date of the encounter or up to 14 days prior to the date of the encounter using an age appropriate standardized tool ***and***, if positive, a follow-up plan was documented on the date of the eligible encounter.
Numerator Exclusions	Not Applicable
Denominator Exceptions	**Patient reason(s):** • Patient refuses to participate, ***or*** **Medical reason(s):** • Documentation of medical reason for not screening patient for depression (e.g., cognitive, functional, or motivational limitations that may impact accuracy of results; patient is in an urgent or emergent situation where time is of the essence and to delay treatment would jeopardize the patient's health status).
Supplemental Data Elements	For every patient evaluated by this measure also identify payer, race, ethnicity and sex

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

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

MEASURE UPDATES JUNE 2021 FOR AMP MY 2021

- None.

MEASURE UPDATES SEPTEMBER 2020 FOR AMP MY 2021

- Added as a Commercial ACO testing measure for MY 2021.

MODIFICATIONS FROM HEDIS

- None.

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 of the measurement year.
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. The USPSTF also recommends that screening be implemented with adequate systems in place to ensure accurate diagnosis, effective treatment and appropriate follow-up.
Reference	U.S. Preventive Services Task Force. 2016. "Screening for Depression in Children and Adolescents: U.S. Preventive Services Task Force Recommendation Statement." *Annals of Internal Medicine* 164:360–6. U.S. Preventive Services Task Force. 2016. "Screening for Major Depressive Disorder in Adults: US Preventive Services Task Force Recommendation Statement." *Journal of the American Medical Association* 315(4):380–7.

Characteristics	
Scoring	Proportion.

Type	Process.
Item count	Person.
Stratification	1. 12–17 years. 2. 18–64 years. 3. 65 years and older. 4. Total.
Risk adjustment	None.
Improvement notation	A higher rate indicates better performance.
Definitions	
Participation (Continuous Enrollment)	The identifiers and descriptors for each organization's coverage used to define members' eligibility for measure reporting. Allocation for AMP reporting is based on eligibility during the Participation Period. For self-reporting POs: The Participation Period in the PO (parent level). For health plans: The Participation Period in the health plan and the PO (parent level).
Participation Period	The Measurement Period.
Allowable Gap	No more than one gap in enrollment of up to 45 days during the measurement period.
Anchor Date	December 31 of the measurement year.
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 (12–17 years)	**Positive Finding**
Patient Health Questionnaire (PHQ-9)®	Total Score ≥10
Patient Health Questionnaire Modified for Teens (PHQ-9M)®	Total Score ≥10

	Patient Health Questionnaire-2 (PHQ-2)®,[2]	Total Score ≥3
	Beck Depression Inventory-Fast Screen (BDI-FS)®,[1,2]	Total Score ≥8
	Center for Epidemiologic Studies Depression Scale-Revised (CESD-R)	Total Score ≥17
	Edinburgh Postnatal Depression Scale (EPDS)	Total Score ≥10
	PROMIS Depression	Total Score (T Score) ≥60
	Instruments for Adults (18+ years)	**Positive Finding**
	Patient Health Questionnaire (PHQ-9)®	Total Score ≥10
	Patient Health Questionnaire-2 (PHQ-2)®,[2]	Total Score ≥3
	Beck Depression Inventory-Fast Screen (BDI-FS)®,[1,2]	Total Score ≥8
	Beck Depression Inventory (BDI-II)	Total Score ≥20
	Center for Epidemiologic Studies Depression Scale-Revised (CESD-R)	Total Score ≥17
	Duke Anxiety-Depression Scale (DADS)®,[1]	Total Score ≥30
	Geriatric Depression Scale Short Form (GDS)[2]	Total Score ≥5
	Geriatric Depression Scale Long Form (GDS)	Total Score ≥10
	Edinburgh Postnatal Depression Scale (EPDS)	Total Score ≥10
	My Mood Monitor (M-3)®	Total Score ≥5
	PROMIS Depression	Total Score (T Score) ≥60
	Clinically Useful Depression Outcome Scale (CUDOS)	Total Score ≥31
	[1]Proprietary; may be cost or licensing requirement associated with use. [2]Brief screening instrument. All other instruments are full-length.	
Initial Population	Members 12 years of age and older at the start of the Measurement Period who also meet criteria for Participation.	
Exclusions	• Members with bipolar disorder in the year prior to the Measurement Period. • Members with depression that starts during the year prior to the Measurement Period. • Members in hospice or using hospice services during the Measurement Period.	

Denominator	**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.
Rate—Depression Screening (Population Criteria 1)	**Numerator 1** Members with a documented result of a depression screening performed using an age-appropriate standardized instrument between January 1 and December 1 of the Measurement Period.
Rate—Follow-Up on Positive Screen (Population Criteria 2)	**Numerator 2** Members who received follow-up care on or up to 30 days after the date of the first positive screen. Any of the following on or 30 days after the first positive screen: • An outpatient, telephone, e-visit or virtual check-in follow-up visit with a diagnosis of depression or other behavioral health condition. • A depression case management encounter that documents assessment for symptoms of depression or a diagnosis of depression or other behavioral health condition. • A behavioral health encounter, including assessment, therapy, collaborative care or medication management. • A dispensed antidepressant medication. ***OR*** • Documentation of additional depression screening on a full-length instrument indicating either no depression or no symptoms that require follow-up (i.e., a negative screen) on the same day as a positive screen on a brief screening instrument. ***Note:*** *For example, if there is a positive screen resulting from a PHQ-2 score, documentation of a negative finding from a PHQ-9 performed on the same day qualifies as evidence of follow-up.*

*Utilization of the PHQ-9 to Monitor Depression Symptoms for Adolescents and Adults (DMS-E)**

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

MEASURE UPDATES JUNE 2021 FOR AMP MY 2021

- None.

MEASURE UPDATES SEPTEMBER 2020 FOR AMP MY 2021

- Added as a Commercial ACO testing measure for MY 2021.

MODIFICATIONS FROM HEDIS

- None.

Description	The percentage of members 12 years of age and older with a diagnosis of major depression or dysthymia, who had an outpatient encounter with a PHQ-9 score present in their record in the same assessment period as the encounter.
Measurement period	January 1–December 31 of the measurement year. The Measurement Period is divided into three assessment periods with specific dates of service: • *Assessment Period 1:* January 1–April 30. • *Assessment Period 2:* May 1–August 31. • *Assessment Period 3:* September 1–December 31.
Clinical recommendation statement	Standardized instruments are useful in identifying meaningful change in clinical outcomes over time. Guidelines for adults recommend that providers establish and maintain regular follow-up with patients diagnosed with depression and use a standardized tool to track symptoms (Trangle, 2016). For adolescents, guidelines recommend systematic and regular tracking of treatment goals and outcomes, including assessing depressive symptoms (Cheung, 2018). The PHQ-9 tool assesses the nine DSM, Fourth Edition, Text Revision (DSM-IV-TR) criteria symptoms and effects on functioning, and it has been shown to be highly accurate in discriminating between patients with persistent major depression, partial remission and full remission (Kroenke, 2001).
Reference	Cheung, A.H., R.A. Zuckerbrot, P.S. Jensen, D. Laraque, R.E.K. Stein, GLAD-PC STEERING GROUP. 2018. “Guidelines for Adolescent Depression in

	Primary Care (GLAD-PC): II. Treatment and Ongoing management." *Pediatrics* 141(3):e20174082. Kroenke, K, R.L. Spitzer, J.B.W. Williams. 2001. The PHQ-9: Validity of a brief depression severity measure. *Journal of General Internal Medicine* 16(9): 606-13. Trangle, M., Gursky, J., Haight, R., Hardwig, J., Hinnenkamp, T., Kessler, D., Mack, N., Myszkowski, M. Institute for Clinical Systems Improvement. *Adult Depression in Primary Care.* Updated March 2016.

Characteristics	
Scoring	Proportion.
Type	Process.
Item count	Person.
Stratification	1. 12–17 years. 2. 18–44 years. 3. 45–64 years. 4. 65 years and older. 5. Total.
Risk adjustment	None.
Improvement notation	A higher rate indicates better performance.

Definitions	
Participation (Continuous Enrollment)	The identifiers and descriptors for each organization's coverage used to define members' eligibility for measure reporting. Allocation for AMP reporting is based on eligibility during the Participation Period. For self-reporting POs: The Participation Period in the PO (parent level). For health plans: The Participation Period in the health plan and the PO (parent level).
Participation Period	The Measurement Period.

Allowable Gap	No more than one gap in enrollment of up to 45 days during the measurement period.
Anchor Date	December 31 of the measurement year.
Interactive Outpatient Encounter	A bidirectional communication that is face-to-face, phone based, an e-visit or virtual check-in, or via secure electronic messaging. This does not include communications for scheduling appointments.
Initial Population	**Initial Population 1** Members 12 years and older at the start of the Measurement Period who also meet the criteria for Participation, with at least one Interactive Outpatient Encounter that starts during Assessment Period 1 (January 1–April 30), with a diagnosis of major depression or dysthymia. **Initial Population 2** Members 12 years and older at the start of the Measurement Period who also meet the criteria for Participation, with at least one Interactive Outpatient Encounter that starts during Assessment Period 2 (May 1–August 31), with a diagnosis of major depression or dysthymia. **Initial Population 3** Members 12 years and older at the start of the Measurement Period who also meet the criteria for Participation, with at least one Interactive Outpatient Encounter that starts during Assessment Period 3 (September 1–December 31), with a diagnosis of major depression or dysthymia.
Exclusions	Members with any of the following at any time during the Measurement Period: • Bipolar disorder. • Personality disorder. • Psychotic disorder. • Pervasive developmental disorder. • In hospice or using hospice services.
Denominator	**Denominator 1** The Initial Population 1, minus Exclusions. **Denominator 2** The Initial Population 2, minus Exclusions. **Denominator 3** The Initial Population 3, minus Exclusions.

Rate—Utilization of PHQ-9 Period 1 (Population Criteria 1)	**Numerator 1** A PHQ-9 score in the member's record during Assessment Period 1 (January 1–April 30).
Rate—Utilization of PHQ-9 Period 2 (Population Criteria 2)	**Numerator 2** A PHQ-9 score in the member's record during Assessment Period 2 (May 1–August 31).
Rate—Utilization of PHQ-9 Period 3 (Population Criteria 3)	**Numerator 3** A PHQ-9 score in the member's record during Assessment Period 3 (September 1–December 31).

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

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

MEASURE UPDATES JUNE 2021 FOR AMP MY 2021

- None.

MEASURE UPDATES SEPTEMBER 2020 FOR AMP MY 2021

- Added as a Commercial ACO testing measure for MY 2021.

MODIFICATIONS FROM HEDIS

- None.

Description	The percentage of members 12 years of age and older with a diagnosis of depression and an elevated PHQ-9 score, who had evidence of response or remission within 4–8 months of the elevated score. • *Follow-Up PHQ-9.* The percentage of members who have a follow-up PHQ-9 score documented within 4–8 months after the initial elevated PHQ-9 score. • *Depression Remission.* The percentage of members who achieved remission within 4–8 months after the initial elevated PHQ-9 score. • *Depression Response.* The percentage of members who showed response within 4–8 months after the initial elevated PHQ-9 score.
Measurement period	January 1–December 31 of the measurement year.
Clinical recommendation statement	The Institute for Clinical Systems Improvement recommends that clinicians establish and maintain follow-up with adult patients who have depression. Appropriate, reliable follow-up is highly correlated with improved response and remission scores (Kessler, 2016). The American Academy of Pediatrics recommends that adolescents with depression should be assessed for treatment response and remission of symptoms using a depression assessment tool such as the PHQ-9 Modified for Teens (Cheung, 2018).
Reference	Cheung A. H., R. A. Zuckerbrot, P. S. Jensen, K. Ghalib, D. Laraque, and R.E.K. Stein. "Guidelines for Adolescent Depression in Primary Care (GLAD-PC): II. Treatment and Ongoing Management." *Pediatrics* 120, no. 5 (January 2007). https://doi.org/10.1542/peds.2006-1395.

	Trangle, M., J. Gursky, R. Haight, J. Hardwig, T. Hinnenkamp, D. Kessler, N. Mack, M. Myszkowski. Institute for Clinical Systems Improvement. *Adult Depression in Primary Care*. Updated March 2013.
Characteristics	
Scoring	Proportion.
Type	Outcome.
Item count	Person.
Stratification	1. 12–17 years. 2. 18–44 years. 3. 45–64 years. 4. 65 years and older. 5. Total.
Risk adjustment	None.
Improvement notation	A higher rate indicates better performance.
Definitions	
Participation (Continuous Enrollment)	The identifiers and descriptors for each organization's coverage used to define members' eligibility for measure reporting. Allocation for AMP reporting is based on eligibility during the Participation Period. For self-reporting POs: The Participation Period in the PO (parent level). For health plans: The Participation Period in the health plan and the PO (parent level).
Participation Period	May 1 of the year prior to the Measurement Period through December 31 of the Measurement Period.
Allowable Gap	No more than one gap in enrollment of up to 45 days during the measurement period. No gaps in enrollment are allowed from May 1 of the year prior to the Measurement Period through December 31 of the year prior to the Measurement Period.
Anchor Date	December 31 of the measurement year.

Intake Period	May 1 of the year prior to the Measurement Period through April 30 of the Measurement Period.
Depression Follow-Up Period	The 120−240 day period after the IESD.
IESD	Index Episode Start Date. The earliest date during the Intake Period where a member has a diagnosis of major depression or dysthymia ***and*** a PHQ-9 total score >9 documented.
Initial Population	Members 12 years and older as of the start of the Intake Period who meet ***all*** the following criteria: • A diagnosis of major depression or dysthymia that starts before and overlaps or starts when the PHQ-9 total score >9 is documented during the Intake Period. • Participation.
Exclusions	Members with any of the following at any time during the Intake Period or during the Measurement Period. • Bipolar disorder. • Personality disorder. • Psychotic disorder. • Pervasive developmental disorder. ***OR*** • In hospice or using hospice services during the Measurement Period.
Denominator	The Initial Population, minus Exclusions.
Rate—Depression Follow-Up (Population Criteria 1)	**Numerator 1** A PHQ-9 total score in the member's record during the Depression Follow-Up Period.

Rate—Depression Remission (Population Criteria 2)	**Numerator 2** Members who achieve remission of depression symptoms, as demonstrated by the most recent PHQ-9 score of <5 during the Depression Follow-Up Period.
Rate—Depression Response (Population Criteria 3)	**Numerator 3** Members who indicate a response to treatment for depression, as demonstrated by the most recent PHQ-9 total score being at least 50 percent lower than the PHQ-9 score associated with the IESD, documented during the Depression Follow-Up Period.

Appendices

APPENDIX 1

SUMMARY OF MY 2021 AMP MEASURE SPECIFICATION CHANGES

MY 2021 Measures	Date of Update/ Modification from the Measure Steward	Measure Specification Update
Controlling High Blood Pressure (CBP)	June 2021	• None.
	September 2020	• Revised the time frame in the event/diagnosis criteria to look for two outpatient visits with a diagnosis of hypertension in the first six months of the measurement year and the year prior to the measurement year. • Removed the restriction that only one of the two visits with a hypertension diagnosis be an outpatient telehealth, telephone visit, e-visit, or virtual check-in when identifying the event/diagnosis. • Added palliative care as a required exclusion. • Added telephone visits, e-visits, and virtual check-ins to the advanced illness exclusion. • Added Donepezil-memantine to the "Dementia combinations" description in the Dementia Medications List. • Added telephone visits, e-visits, and virtual check-ins to the Administrative Specification as appropriate settings for BP readings.
	Modifications from HEDIS	• The exclusion for members living long-term in an institution is optional for POs that do not have access to the LTI flag in the Monthly Membership Detail Data File.
Statin Therapy for Patients with Cardiovascular Disease (SPC)	June 2021	• Removed reference to reporting two age/gender stratifications in the Eligible Population 'Age' section for each indicator (i.e., AMP reports one total rate for each indicator).
	September 2020	• Updated rules for allowable gap for the Medi-Cal Managed Care product line. • Removed the restriction that only one of two visits with an IVD diagnosis may be an outpatient telehealth, telephone visit, e-visit ,or virtual check-in when identifying the event/diagnosis. • Added telephone visits, e-visits, and virtual check-ins to the advanced illness exclusion. • Added palliative care as a required exclusion. • Added Donepezil-memantine to the "Dementia combinations" description in the Dementia Medications List.
	Modifications from HEDIS	• The gender and age stratifications for each indicator are not reported for AMP (i.e., AMP reports one total rate for each indication. • The exclusion for members living long-term in an institution is optional for POs that do not have access to the LTI flag in the Monthly Membership Detail Data File.

MY 2021 Measures	Date of Update/ Modification from the Measure Steward	Measure Specification Update
Proportion of Days Covered by Medications (PDC): • Renin Angiotensin System (RAS) Antagonists • Statins • Diabetes All Class	June 2021	• Changed Diabetic Medication class name from Incretin Mimetic Agents to GLP-1 Receptor Agonists. • Updated language for Index Prescription Start Date (IPSD) definition. • Updated language for Treatment Period. • Added clarifying language for the PDC Threshold definition. • Added clarifying language in Step 2 of the numerator calculation for PDC-RASA, PDC-STA & PDC-DR. • Added clarifying language for the additional eligible population criteria for PDC-STA, PDC-STA & PDC-DR. • Added note about exclusion of products only for weight loss to Table GLP1: GLP-1 Receptor Agonists.
	September 2020	• Updated language in Treatment period. • Updated language in Continuous Enrollment criteria to include a 1-day allowable gap. • Added "Prescription claims" definition. • Clarified step 3 of the numerator calculation. • Changed Medication table names. • Added niacinamide to insulin medications.
	Modifications From PQA	• None.
Comprehensive Diabetes Care (CDC): • One HbA1c Test • HbA1c Poor Control (>9.0%) • HbA1c Control (<8.0%) • Eye Exam • Medical Attention for Nephropathy • Blood Pressure Control (<140/90)	June 2021	• Removed the following bullet from the Eye Exam numerator: "Any code in the Diabetic Retinal Screening Value Set billed by an eye care professional (optometrist or ophthalmologist) during the year prior to the measurement year, with a negative result (negative for retinopathy)." • Added "or Automated Eye Exam Value Set" to the following bullet in the Eye Exam numerator: "Any code in the Eye Exam With Evidence of Retinopathy Value Set or Eye Exam Without Evidence of Retinopathy Value Set billed by any provider type during the measurement year."
	September 2020	• Updated rules for allowable gap for the Medi-Cal Managed Care product line. • Removed the restriction that only one of two visits with a diabetes diagnosis may be an outpatient telehealth, telephone visit, e-visit, or virtual check-in when identifying the event/diagnosis. • Added telephone visits, e-visits, and virtual check-ins to the advanced illness exclusion. • Added palliative care as a required exclusion. • Deleted the HbA1c Level 7.0-9.0 Value Set.

MY 2021 Measures	Date of Update/ Modification from the Measure Steward	Measure Specification Update
• Optimal Diabetes Care (HbA1c Control; BP Control; Medical Attention for Nephropathy; Eye Exam)		• Updated the Administrative Specification logic and value sets for the Eye Exam indicator. • Added telephone visits, e-visits, and virtual check-ins to the Administrative Specification as appropriate settings for BP readings. • Added Nebivolol-valsartan to the "Antihypertensive combinations" description in the ACE inhibitor and ARB Medications List. • Added Donepezil-memantine to the "Dementia combinations" description in the Dementia Medications List. • Added polycystic ovary syndrome to the optional exclusions.
	Modifications From HEDIS	• Optimal Diabetes Care Combination Rate is a non-HEDIS measure that is an "all or none" combination rate composed of four indicators. • AMP does not include the Medicare SES Stratifications for the Eye Exam indicator. • The exclusion for members living long-term in an institution is optional for POs that do not have access to the LTI flag in the Monthly Membership Detail Data File.

MY 2021 Measures	Date of Update/ Modification from the Measure Steward	Measure Specification Update
Statin Therapy for Patients With Diabetes (SPD)	June 2021	• None.
	September 2020	• Updated rules for allowable gap for the Medi-Cal Managed Care product line. • Added polycystic ovary syndrome to the optional exclusions. • Removed the restriction that only one of two visits with a diabetes diagnosis may be an outpatient telehealth, telephone visit, e-visit, or virtual check-in when identifying the event/diagnosis. • Removed the restriction that only one of two visits with an IVD diagnosis may be an outpatient telehealth, telephone visit, e-visit, or virtual check-in when identifying the event/diagnosis, step 2 required exclusions. • Added telephone visits, e-visits, and virtual check-ins to the advanced illness exclusion. • Added palliative care as a required exclusion. • Added Donepezil-memantine to the "Dementia combinations" description in the Dementia Medications List. • Added Pitavastatin 1 mg to the Pitavastatin Moderate Intensity Medications List and deleted the Pitavastatin Low Intensity Medications List.
	Modifications From HEDIS	• The exclusion for members living long-term in an institution is optional for POs that do not have access to the LTI flag in the Monthly Membership Detail Data File.
Statin Use in Persons with Diabetes (SUPD)	June 2021	• Added definition for Index Prescription Start Date (IPSD). • Added clarifying language for Exclusions. • Added clarifying language to "Event/Diagnosis." • Added clarifying language to Numerator. • Added clarifying language to the note on exclusion of products only approved for weight loss to Table DIABETES: Diabetes Medications.
	September 2020	• Added FERTILITY: Fertility Medications to the Medication Table. • Changed Medication Table to Table SUPD-A: Diabetes Medications to DIABETES: Diabetes Medications and Table SUPD-B: Statin Medications to STATINS: Statin Medications. • Added insulin aspart and niacinamide (DIABETES) to statins medications. • Added requirement that IPSD occurs ≥ 90 days prior to the end of the measurement year. • Added exclusions for rhabdomyolysis or myopathy, pregnancy, lactation, or fertility, liver disease, pre-diabetes, and polycystic ovary syndrome.
	Modifications From PQA	• None.

MY 2021 Measures	Date of Update/ Modification from the Measure Steward	Measure Specification Update
Disease-Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis (ART)	June 2021	• None – this measure was retired from HEDIS MY 2021.
	September 2020	• Removed the restriction that only one of two visits with a rheumatoid arthritis diagnosis may be an outpatient telehealth, telephone visit, e-visit, or virtual check-in when identifying the event/diagnosis. • Added telephone visits, e-visits, and virtual check-ins to the advanced illness exclusion. • Added Upadacitinib to the "Janus kinase (JAK)" description in the DMARD Medications List. • Added Donepezil-memantine to the "Dementia combinations" description in the Dementia Medications List. • Added Mycophenolic acid to the "Immunosuppressive agents" description in the DMARD Medications List.
	Modifications From HEDIS	• The exclusion for members living long-term in an institution is optional for POs that do not have access to the LTI flag in the Monthly Membership Detail Data File.
Osteoporosis Management in Women Who Had a Fracture (OMW)	June 2021	• None.
	September 2020	• Updated the instructions for excluding visits that result in an inpatient stay (steps 1 and 2). • Added telephone visits, e-visits, and virtual check-ins to the advanced illness exclusion. • Added palliative care as a required exclusion. • Added Donepezil-memantine to the "Dementia combinations" description in the Dementia Medications List. • Added Romosozumab to the "Other agents" description in the Osteoporosis Medications List.
	Modifications From HEDIS	• The exclusion for members living long-term in an institution is optional for POs that do not have access to the LTI flag in the Monthly Membership Detail Data File.
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)	June 2021	• None.
	September 2020	• None.
	Modifications From HEDIS	• The AMP WCC measure only includes the BMI percentile indicator.
Child and Adolescent Well-Care Visits (WCV)	June 2021	• None.
	September 2020	• This measure is a combination measure that replaces the former "Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life" and "Adolescent Well-Care Visits" HEDIS measures. • Added members age 7-11 years.

MY 2021 Measures	Date of Update/ Modification from the Measure Steward	Measure Specification Update
		• Added age stratifications. • Removed the telehealth exclusion.
	Modifications From HEDIS	• None.
Childhood Immunization Status (CIS)	June 2021	• None.
	September 2020	• Updated rules for allowable gap for the Medi-Cal Managed Care product line. • Added a requirement that LAIV (influenza) vaccination must occur on the child's second birthday.
	Modifications From HEDIS	• The AMP CIS measure only includes one combination rate (Combination 10).
Immunizations for Adolescents (IMA)	June 2021	• None.
	September 2020	• Updated rules for allowable gap for the Medi-Cal Managed Care product line.
	Modifications From HEDIS	• None.
Chlamydia Screening in Women (CHL)	June 2021	• None.
	September 2020	• Added Dienogest-estradiol (multiphasic) and removed Estradiol-medroxyprogesterone and Ethinyl estradiol-folic acid-levonorgestrel from the "Contraceptives" description in the Contraceptive Medications List.
	Modifications From HEDIS	• None.
Cervical Cancer Screening (CCS)	June 2021	• None.
	September 2020	• Added palliative care as a required exclusion.
	Modifications From HEDIS	• The measure exclusion is required.
Cervical Cancer Overscreening (CCO)	June 2021	• None.
	September 2020	• Added palliative care as a required exclusion.
	Modifications From HEDIS	• None (this is a non-HEDIS measure based on a HEDIS measure).
Breast Cancer Screening (BCS)	June 2021	• None.
	September 2020	• Added palliative care as a required exclusion. • Added telephone visits, e-visits, and virtual check-ins to the advanced illness exclusion.

MY 2021 Measures	Date of Update/ Modification from the Measure Steward	Measure Specification Update
		• Added *Donepezil-memantine* to the "Dementia combinations" description in the Dementia Medications List.
	Modifications From HEDIS	• AMP does not include the Medicare SES Stratifications. • The exclusion for members living long-term in an institution is optional for POs that do not have access to the LTI flag in the Monthly Membership Detail Data File.
Colorectal Cancer Screening (COL)	June 2021	• None.
	September 2020	• Added palliative care as a required exclusion. • Added telephone visits, e-visits, and virtual check-ins to the advanced illness exclusion. • Added Donepezil-memantine to the "Dementia combinations" description in the Dementia Medications List.
	Modifications From HEDIS	• AMP does not include the Medicare SES Stratifications. • AMP specifies the Continuous enrollment separately for the Medi-Cal Managed Care product line. • The exclusion for members living long-term in an institution is optional for POs that do not have access to the LTI flag in the Monthly Membership Detail Data File.
Prenatal and Postpartum Care (PPC)	June 2021	• None.
	September 2020	• Revised the definition of "last enrollment segment." • Clarified that visits that occur prior to the enrollment start date (during the pregnancy) meet criteria. • Added telephone visits (Telephone Visits Value Set) e-visits and virtual check-ins (Online Assessments Value Set) to the Timeliness of Prenatal Care rate (administrative specification) and clarified in the *Notes* that services provided via telephone, e-visit, or virtual check-in are eligible for use in reporting both rates.
	Modifications From HEDIS	• None.
Asthma Medication Ratio (AMR)	June 2021	• None.
	September 2020	• Removed the restriction that only three of four visits with an asthma diagnosis may be an outpatient telehealth, telephone visit, e-visit, or virtual check-in when identifying the event/diagnosis. • Clarified in step 1 when the diagnosis must be on the discharge claim. • Added Dupilumab to the "Anti-interleukin-4" description in the Dupilumab Medications List. • Clarified NDC code mapping requirement in the *Notes*.

MY 2021 Measures	Date of Update/ Modification from the Measure Steward	Measure Specification Update
	Modifications From HEDIS	• None.
Appropriate Testing for Pharyngitis (CWP)	June 2021	• Added a denominator note to the Event/diagnosis.
	September 2020	• Updated the instructions for excluding visits that result in an inpatient stay. • Removed Sulfisoxazole from the "Sulfonamides" description in the CWP Antibiotic Medications List. • Deleted step 8; this step is unnecessary because these members are removed in step 5.
	Modifications From HEDIS	• None.
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (AAB)	June 2021	• Added Anchor Date criteria for clarification and to align with native specification.
	September 2020	• Updated the instructions for excluding visits that result in an inpatient stay. • Removed Ticarcillin-clavulanate from the "Beta-lactamase inhibitors" description, Erythromycin-sulfisoxazole from the "Miscellaneous antibiotics" description and Norfloxacin from the "Quinolones" description in the AAB Antibiotic Medications List.
	Modifications From HEDIS	• None.

Use of Opioids at High Dosage (HDO)	June 2021	• Added the following medications to Table HDO-A: Opioid Medications:
		  • Meperidine 75 mg Medications List
		  • Meperidine 150 mg Medications List
		  • Acetaminophen Oxycodone 1 MGPML Medications List
		  • Acetaminophen Oxycodone 2 MGPML Medications List
		  • Tramadol 5 MGPML Medications List
		• Deleted the following medications from Table HDO-A: Opioid Medications:
		  • Levorphanol 1 mg Medications List
		  • Morphine 70 mg Medications List
		  • Morphine 130 mg Medications List
		  • Morphine 150 mg Medications List

	September 2020	• Clarified the instructions for calculating covered days for the denominator. • Clarified the instructions for treatment period.

MY 2021 Measures	Date of Update/ Modification from the Measure Steward	Measure Specification Update
		• Added palliative care as a required exclusion. • Added medications lists for acetaminophen benzhydrocodone, aspirin codeine, and codeine phosphate. • Removed Acetaminophen Hydrocodone 7.5 mg Medications List from the Hydrocodone description in Table HDO-A: Opioid Medications.
	Modifications From HEDIS	• None.
Concurrent Use of Opioids and Benzodiazepines (COB)	June 2021	• Updated language for the measure description. • Added clarifying language to "Event/Diagnosis." • Added clarifying language to Numerator.
	September 2020	• None.
	Modifications From PQA	• None.
Encounter Rate by Service Type (ENRST)	June 2021 September 2020	• Added clarifying language for health plans to report the denominator as total member months. • Clarified that health plans should submit the denominator as total member months. • Added a calculation for overall rate.
Encounter Format (ENFMT)	June 2021	• Added clarifying note in Step 2 of Encounter Format Calculation: Standard Provider Identifiers.
	September 2020	• Defined "service line," "claims," "institutional claims," "institutional encounters," "professional claims," "professional encounter," "pharmacy claims/encounters." • Clarified the definition of "visits." • Clarified step 3 of *Encounter Format Calculation:* Procedure Modifier and Rendering Provider Identifier Per Service Line.
Encounter Timeliness (ENLAG)	June 2021	• None.
	September 2020	• Added reported Categories of Lagtime for "Zero to 180 days" and "Zero to 364 days." • Clarified Average Lagtime by Service Date and Average Lagtime by Paid/Remittance Date. • Defined "service line," "claims," "institutional claims," "institutional encounters," "professional claims," "professional encounter," "pharmacy claims/encounters." • Clarified the time frame for included service dates in step 4 of Encounter Timeliness Lagtime Categories Calculation.

MY 2021 Measures	Date of Update/ Modification from the Measure Steward	Measure Specification Update
		• Clarified the time frame for included service dates in steps 1 and 2 of Encounter Timeliness Average Lagtime Calculation.
Controlling High Blood Pressure (e-Measure)	June 2021	• Updated the Description and Initial population to capture "or the year prior to the measurement period." • Captured minor updates to the Initial population and Numerator to align with the native specification.
	September 2020	• Updated eCQM Version Number. • Updated copyright. • Updated the clinical recommendations statement to remove outdated references and update with the most recent clinical recommendations. • Updated references. • Added text to identify the Quality Data Model (QDM) version used in the measure specification. • Added text to indicate whether the measure is patient-based or episode-based. • Updated denominator exclusions to add the word "consecutive" to clarify that the Long-Term Illness (LTI) exclusion should be for 90 consecutive days.
Screening for Depression and Follow-Up Plan (PREV-12)	June 2021	• Removed the following from the Follow-up plan Definitions to align with the native specification, "Additional evaluation or assessment for depression." and "Suicide risk assessment.".
	September 2020	• Updated the eCQM Version Number. • Updated the measure developer field. • Revised the description to improve alignment with measure intent and initial population language. • Updated the copyright and the disclaimer. • Revised the rationale to align with updated guidelines and evidence. • Removed the clinical recommendation statement from an outdated guideline and removed the reference to the guideline. • Updated references to align with American Psychological Association (APA) formatting. • Removed guidance related to additional evaluation or assessment for depression and suicide risk assessment as appropriate follow-up. • Added guidance about the importance of escalating patient care or circumstances that are not captured in the measure. • Added guidance about the intent of the denominator exclusions. • Added guidance to clarify the measure's use of the most recent depression screening.

MY 2021 Measures	Date of Update/ Modification from the Measure Steward	Measure Specification Update
		• Added text to identify the Quality Data Model (QDM) version used in the measure specification. • Clarified that the measure is patient-based. • Removed guidance inconsistent with the measure intent. • Revised guidance related to examples of appropriate follow-up plans. • Revised guidance to consolidate and more accurately reflect the intent of using a standardized age-appropriate depression screening tool. • Revised denominator exclusions language based upon subject matter experts' feedback to reflect that any patient with a current or historical diagnosis of bipolar disorder or depression should be excluded from the measure. • Revised denominator exception language to follow a similar format as other eCQMs.
Patient Experience	June 2021	• None.
	September 2020	• None.
Ambulatory Care (AMB)	June 2021	• None.
	September 2020	• None.
	Modifications From HEDIS	• None.
Frequency of Selected Procedures (FSP)	June 2021	• Added Total hip replacement, Total knee replacement, and Carotid endarterectomy procedures to the FSP-1a and FSP2 tables.
	September 2020	• Added a *Note* about reporting the three procedures not included in the FSP-1a and FSP-2 tables. • Updated the "Count as one procedure…" definition in the *Calculations* section. • Updated the order of procedures to align with HEDIS specifications. • Removed the Member Months table and Procedures/1,000 Member Months column from the FSP-1a and FSP-2 tables.
	Modifications From HEDIS	• The AMP FSP measure specification includes adjustment for age and sex and adjusted rates of procedures per 1,000 member years. • Removed the Member Months table and Procedures/1,000 Member Months column from the FSP-1a and FSP-2 tables they are not used in AMP reporting.

MY 2021 Measures	Date of Update/ Modification from the Measure Steward	Measure Specification Update
Inpatient Utilization—General Hospital/Acute Care (IPU)	June 2021	• Updated the description to include a Total inpatient, excluding Maternity (the sum of Surgery and Medicine) rate.
	September 2020	• None.
	Modifications From HEDIS	• The AMP IPU measure specification includes reporting a Total inpatient, excluding Maternity (the sum of Surgery and Medicine) rate.
Generic Prescribing (GRX)	June 2021	• None.
	September 2020	• None.
Outpatient Procedures Utilization—Percentage Done in Preferred Facility (OSU)	June 2021	• Added clarifying language to Continuous Enrollment criteria.
	September 2020	• None.
	Modifications From HEDIS	• None (this is a non-HEDIS measure based on former HEDIS Utilization measure).

MY 2021 Measures	Date of Update/ Modification from the Measure Steward	Measure Specification Update
All-Cause Readmissions (PCR)	June 2021	• Added "Members must be 18 and older as of the earliest Index Discharge Date" to the Plan Population definition. • Replaced Step 1 of Reporting: Number of Members in Plan Population with "Determine the member's age as of the earliest Index Discharge Date." • Replaced Step 1 of Reporting: Number of Outliers with "Determine the member's age as of the earliest Index Discharge Date." • Added guidance for reporting variance.
	September 2020	• Revised the measure description. • Added a *Note* to the definition of "plan population" to clarify that it should be used as a denominator for the outlier rate. • Removed "Risk Adjustment Tables" from the Definitions. • Replaced references to "Table HCC-Surg" with references to the Surgery Procedure Value Set in the *Risk Adjustment Determination* section. • Replaced references to "Table PCR-DischCC" with "Table CC Mapping" in the *Risk Adjustment Determination* section. • Removed references to specific risk weight tables in the *Risk Adjustment Weighting* section. • Clarified rounding rules in step 8 of the *Risk Adjustment Weighting* section. • Revised the data element tables to separate the Medicaid and Commercial product lines from the Medicare product line.
	Modifications From HEDIS	• NCQA refers to this measure as "Plan All-Cause Readmissions." • The 18-64 age band is not reported for Medicare. • Expected rates are normalized by IHA data aggregator to reflect the performance of the population being measured (i.e., Commercial HMO or Medicare Advantage). • The Skilled Nursing Care and SES Stratification for the Medicare Advantage product line is not reported.
Emergency Department Utilization (EDU)	June 2021	• Added clarifying language to the description to note the normalization of expected rates.
	September 2020	• Added definitions for "outlier" and "non-outlier." • Revised step 1 in the calculation of observed events to exclude ED visits that result in an observation stay. • Added step 3 in the calculation of observed events to remove discharges for outlier members. • Removed reference to specific risk weight tables in the *Risk Adjustment Weighting* section.

MY 2021 Measures	Date of Update/ Modification from the Measure Steward	Measure Specification Update
		• Removed step 3 to identify the base risk weight from the calculation of PPV and PUCV; renumbered subsequent steps. • Clarified that for categories with a single member the covariance should be set to zero in step 4 of the Expected Count of Visits calculation. • Added instructions to report outliers separate from non-outliers. • Revised the data elements tables and added reporting columns for outliers.
	Modifications From HEDIS	• Expected rates are normalized by Onpoint to reflect the performance of the population being measured (e.g., Commercial HMO/POS or Commercial ACO).
Acute Hospital Utilization (AHU)	June 2021	• Added clarifying language to the description to note the normalization of expected rates.
	September 2020	• Removed references to specific risk weight tables in the *Risk Adjustment Weighting* section. • Clarified that for categories with a single member the covariance should be set to zero in step 4 of the Expected Count of Hospitalization calculation.
	Modifications From HEDIS	• Expected rates are normalized by Onpoint to reflect the performance of the population being measured (e.g., Commercial HMO/POS).
Hospital Average Length of Stay (HALOS)	June 2021	• Added clarifying language to the description to note the normalization of expected rates. • Added clarifying language to Continuous Enrollment criteria. • Added Ages, Allowable Gap, Anchor Date, Benefit, and Event/diagnosis criteria for clarification.
	September 2020	• None.
	Modifications From HEDIS	• None (this is a non-HEDIS measure based on a former HEDIS risk adjusted measure).
Total Cost of Care (TCOC)	June 2021	• None.
	September 2020	• Clarified normalization of relative-risk scores in step 3 of Risk-Adjustment Determination. • Clarified the reporting time frame in the definition of "Member months."
	Modifications From HealthPartners	• AMP includes ages greater than 1 for this measure. • AMP uses a $250,000 truncation level amount, whereas HealthPartners uses $125,000. • AMP applies a geographic adjustment in addition to risk adjustment. • AMP includes capitated costs in the measure. • AMP includes exclusion criteria for select services and payments.

Summary of MY 2021 AMP Testing Measures

Measures	Date of Modification	Measure Specification Update
Preventive Care and Screening: Screening for Depression and Follow-Up Plan (PREV-12)	June 2021	• None.
	September 2020	• Added as a Commercial ACO testing measure for MY 2021.
	Modifications from HEDIS	• None.
Depression Screening and Follow-Up for Adolescents and Adults (DSF-E)	June 2021	• None.
	September 2020	• Added as a Commercial ACO testing measure for MY 2021.
	Modifications From HEDIS	• None.
Utilization of the PHQ-9 to Monitor Depression Symptoms for Adolescents and Adults (DMS-E)	June 2021	• None.
	September 2020	• Added as a Commercial ACO testing measure for MY 2021.
	Modifications From HEDIS	• None.
Depression Remission or Response for Adolescents and Adults (DRR-E)	June 2021	• None.
	September 2020	• Added as a Commercial ACO testing measure for MY 2021.
	Modifications From HEDIS	• None.

Summary Table of MY 2021 AMP Measure Removals

No measures were removed in AMP for MY 2021.

APPENDIX 2
PRACTITIONER TYPES

clinical pharmacist	A pharmacist with extensive education in the biomedical, pharmaceutical, socio-behavioral and clinical sciences. Clinical pharmacists are experts in the therapeutic use of medications and are a primary source of scientifically valid information and advice regarding the safe, appropriate, and cost-effective use of medications. Most clinical pharmacists have a Doctor of Pharmacy (PharmD) degree and many have completed one or more years of post-graduate training (e.g., a general and/or specialty pharmacy residency). In some states, clinical pharmacists have prescriptive authority.
dental practitioner	A practitioner who holds a Doctor of Dental Surgery (DDS) or a Doctor of Dental Medicine (DMD) degree from an accredited school of dentistry and is licensed to practice dentistry by a state board of dental examiners. Certified and licensed dental hygienists are considered dental practitioners.
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 his/her state of practice, if required by the state of practice. • An individual who is certified in clinical social work by the American Board of Examiners; who is listed on the National Association of Social Worker's Clinical Register; or who has a master's degree in social work and is licensed or certified to practice as a social worker, if required by the state of practice. • A registered nurse (RN) who is certified by the American Nurses Credentialing Center (a subsidiary of the American Nurses Association) as a psychiatric nurse or mental health clinical nurse specialist, or who has a master's degree in nursing with a specialization in psychiatric/ mental health and two years of supervised clinical experience and is licensed to practice as a psychiatric or mental health nurse, if required by the state of practice. • An individual (normally with a master's or a doctoral degree in marital and family therapy and at least two years of supervised clinical experience) who is practicing as a marital and family therapist and is licensed or a certified counselor by the state of practice, or if licensure or certification is not required by the state of practice, who is eligible for clinical membership in the American Association for Marriage and Family Therapy.

	• An individual (normally with a master's or doctoral degree in counseling and at least two years of supervised clinical experience) who is practicing as a professional counselor and who is licensed or certified to do so by the state of practice, or if licensure or certification is not required by the state of practice, is a National Certified Counselor with a Specialty Certification in Clinical Mental Health Counseling from the National Board for Certified Counselors (NBCC). • A physician assistant who is certified by the National Commission on Certification of Physician Assistants to practice psychiatry. • A certified Community Mental Health Center (CMHC), or the comparable term (e.g., behavioral health organization, mental health agency, behavioral health agency) used within the state in which it is located, or a Certified Community Behavioral Health Clinic (CCBHC). – Only authorized CMHCs are considered mental health providers. To be authorized as a CMHC, an entity must meet one of the following criteria: ▪ The entity has been certified by CMS to meet the conditions of participation (CoPs) that community mental health centers (CMHCs) must meet in order to participate in the Medicare program, as defined in the Code of Federal Regulations Title 42. CMS defines a CMHC as an entity that meets applicable licensing or certification requirements for CMHCs in the State in which it is located and provides the set of services specified in section 1913(c)(1) of the Public Health Service Act (PHS Act). ▪ The entity has been licensed, operated, authorized, or otherwise recognized as a CMHC by a state or county in which it is located. – Only authorized CCBHCs are considered mental health providers. To be authorized as a CCBHC, an entity must meet one of the following criteria: ▪ Has been certified by a State Medicaid agency as meeting criteria established by the Secretary for participation in the Medicaid CCBHC demonstration program pursuant to Protecting Access to Medicare Act § 223(a) (42 U.S.C. § 1396a note); or as meeting criteria within the State's Medicaid Plan to be considered a CCBHC. ▪ Has been recognized by the Substance Abuse and Mental Health Services Administration, through the award of grant funds or otherwise, as a CCBHC that meets the certification criteria of a CCBHC.
OB/GYN and other prenatal care practitioner	Includes: • Physicians certified as obstetricians or gynecologists by the American Medical Specialties Board of Obstetrics or Gynecology or the American Osteopathic Association; or, if not certified, who successfully completed an accredited program of graduate medical or osteopathic education in obstetrics and gynecology. • Certified nurse midwives, nurse practitioners, or physician assistants who deliver prenatal care services in a specialty setting (under the direction of an OB/GYN certified or accredited provider).
ongoing care provider	The practitioner who assumes responsibility for the member's care.

PCP

Primary care practitioner. A physician or nonphysician (e.g., nurse practitioner, physician assistant, certified nurse midwives) who offers primary care medical services.

Includes:

- General or family practice physicians.
- Geriatricians.
- General internal medicine physicians.
- General pediatricians.
- OB/GYNs.

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 and 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 RHC are considered PCPs. This must be reviewed and approved by an auditor.
    - To be certified as a RHC, the entity must meet CMS requirements to qualify for payment via an all-inclusive rate (AIR) for medically-necessary primary health services and qualified preventive health services furnished by an RHC practitioner.

prescribing practitioner

A practitioner with prescribing privileges, including nurse practitioners, physician assistants, and other non-MDs who have the authority to prescribe medications.