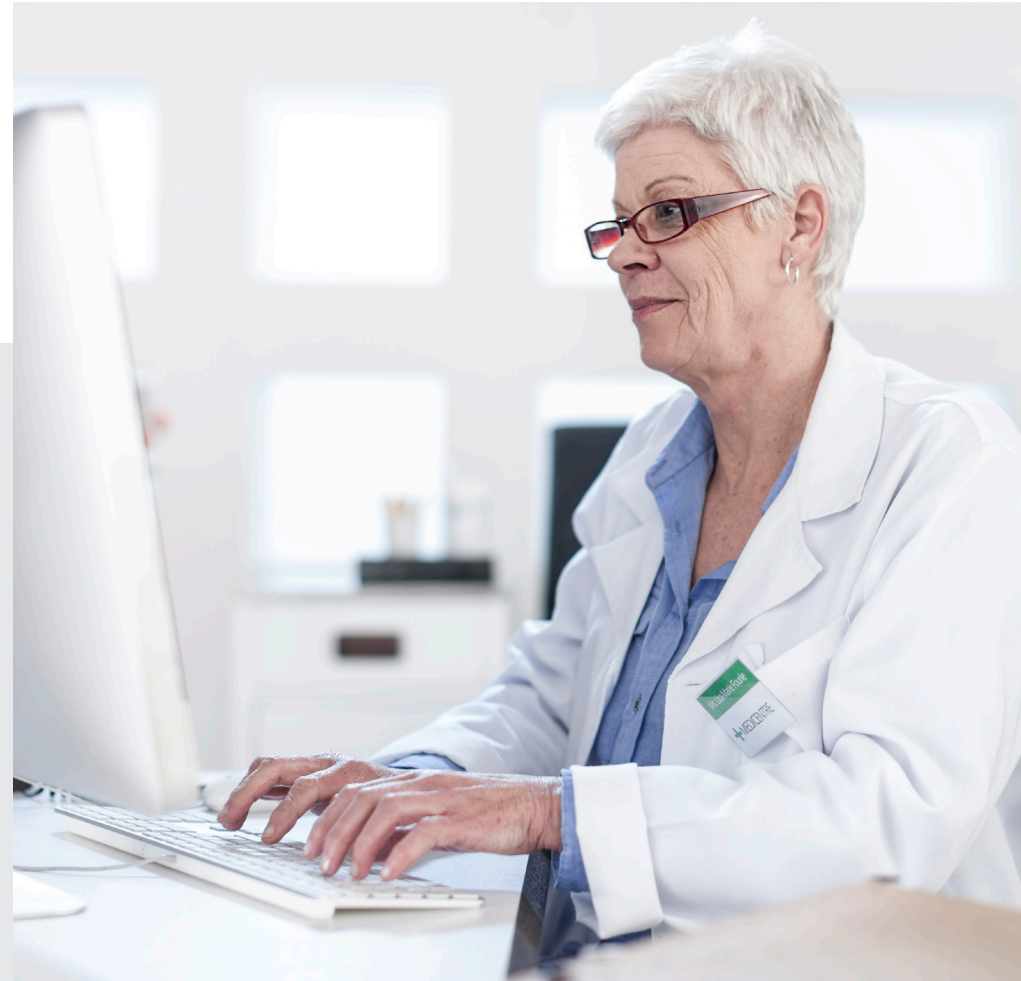


Quality Measures Desktop Reference for Medicaid Providers

HEDIS[®] is a widely used set of performance measures developed and maintained by NCQA. These are used to drive improvement efforts surrounding best practices.



Patient care opportunities

You can find patient care opportunities within the Patient360 application located on Availity Essentials **Payer Spaces**. To access the *Patient360* application, you must have the *Patient360* role assignment. From the Availity home page, select **Payer Spaces**, then choose the health plan from the menu. Choose the **Patient360** tile from the **Payer Space Applications** menu and complete the required information on the screen. Gaps in care are located in the **Active Alerts** section of the *Member Summary*.



Measure	Effectiveness of Care	Eligible population	Occurrence	Description of measurement screening, test, or treatment needed
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)	Prevention and Screening	Ages 3 to 17	Annual	<p>The percentage of members who had an outpatient visit with a PCP or OB/GYN during the measurement year in which the following were documented:</p> <ul style="list-style-type: none"> • BMI Percentile Documentation* • Counseling for Nutrition • Counseling for Physical Activity <p>* Because BMI norms for youth vary with age and gender, this measure evaluates whether BMI percentile is assessed rather than an absolute BMI value.</p>
Immunizations for Adolescents (IMA)	Prevention and Screening	Ages 13	Multiple doses	<p>The percentage of members who had 1 dose of meningococcal vaccine, 1 tetanus, diphtheria toxoids and acellular pertussis (Tdap) vaccine, and have completed the human papillomavirus (HPV) vaccine series by their 13th birthday. The measure calculates a rate for each vaccine and two combination rates:</p> <ul style="list-style-type: none"> • Meningococcal vaccine between 11th and 13th birthday • Tdap vaccine between 10th and 13th birthday • HPV vaccine between 9th and 13th birthday
Lead Screening in Children (LSC)	Prevention and Screening	Ages 0 to 2	Once before age 2	<p>The percentage of members who had one or more capillary or venous lead blood test by their 2nd birthday</p>

Measure	Effectiveness of Care	Eligible population	Occurrence	Description of measurement screening, test, or treatment needed
Cervical Cancer Screening (CCS)	Prevention and Screening	Age 21 to 64	Varies by age	<p>The percentage of members who were recommended for routine cervical cancer screening and were screened for cervical cancer using any of the following criteria:</p> <ul style="list-style-type: none"> • Members 21 to 64 years of age who were recommended for routine cervical cancer screening and had cervical cytology performed within the last 3 years • Members 30 to 64 years of age who were recommended for routine cervical cancer screening and had cervical high-risk human papillomavirus (hrHPV) testing performed within the last 5 years • Members 30 to 64 years of age who were recommended for routine cervical cancer screening and had cervical cytology/high-risk human papillomavirus (hrHPV) cotesting within the last 5 years
Childhood Immunization Status (CIS)	Prevention and Screening	Ages 0 to 2	Multiple doses	<p>The percentage of members who had appropriate doses of the following vaccines on or before their 2nd birthday:</p> <ul style="list-style-type: none"> • 4 diphtheria, tetanus, and acellular pertussis (DTaP) • 3 polio (IPV) • 1 measles, mumps, and rubella (MMR) (can only be given on or between first and second birthday to close the gap) • 3 haemophilus influenza type B (HiB) • 3 hepatitis B (One of the three vaccinations can be a newborn hepatitis B vaccination during the eight-day period that begins on the date of birth and ends seven days after the date of birth) • 1 chicken pox (VZV) (can only be given on or between first and second birthday to close the gap) • 4 pneumococcal conjugate (PCV) • 1 hepatitis A (HepA) (can only be given on or between first and second birthday to close the gap) • 2 two-dose RV or 3 three-dose rotavirus (RV) (Or 1 two-dose and two three-dose RV combination) • 2 influenza (flu) (Influenza cannot be given until infant is 6 months of age — 1 of the two vaccinations for influenza can be an LAIV administered on the child's second birthday).



Measure	Effectiveness of Care	Eligible population	Occurrence	Description of measurement screening, test, or treatment needed
Chlamydia Screening in Women (CHL)	Prevention and Screening	Ages 16 to 24	Annual	Percentage of members who were identified as sexually active and who had at least one screening test for chlamydia during the measurement year
Oral Evaluation, Dental Services (OED)	Prevention and Screening	Ages 0 to 20	Annual	The percentage of members under 21 years of age who received a comprehensive or periodic oral evaluation with a dental provider during the measurement year
Topical Fluoride for Children (TFC)	Prevention and Screening	Ages 1 to 4	Annual	The percentage of members who received at least two fluoride varnish applications during the measurement year
Appropriate Testing for Pharyngitis (CWP)	Respiratory Conditions	Ages 3 years and older	Each occurrence	The percentage of episodes for members who have been diagnosed with pharyngitis, dispensed an antibiotic, and received group A streptococcus (strep) test for the episode
Pharmacotherapy Management of COPD Exacerbation (PCE)	Respiratory Conditions	Ages 40 and older	Inpatient discharge or ED event	The percentage of COPD exacerbations for members who had an acute inpatient discharge or emergency department (ED) visit on or between January 1 to November 30 of the measurement year and who were dispensed appropriate medications. Two rates are reported: <ul style="list-style-type: none"> • Dispensed a systemic corticosteroid (or there was evidence of an active prescription) within 14 days of the event • Dispensed a bronchodilator (or there was evidence of an active prescription) within 30 days of the event <p>Note: The eligible population for this measure is based on acute inpatient discharges and ED visits, not on members. It is possible for the denominator to include multiple events for the same individual.</p>



- **Dispensed a systemic corticosteroid** (or there was evidence of an active prescription) within 14 days of the event
- **Dispensed a bronchodilator** (or there was evidence of an active prescription) within 30 days of the event

Note: The eligible population for this measure is based on acute inpatient discharges and ED visits, not on members. It is possible for the denominator to include multiple events for the same individual.

Measure	Effectiveness of Care	Eligible population	Occurrence	Description of measurement screening, test, or treatment needed
Asthma Medication Ratio (AMR)	Respiratory Conditions	Ages 5 to 64	Annual	The percentage of members who have been 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
Persistence of Beta-Blocker Treatment After a Heart Attack (PBH)	Cardiovascular Conditions	Ages 18 and older	After discharge	The percentage of members who were hospitalized and discharged from July 1 of the year prior to the measurement year to June 30 of the measurement year with a diagnosis of AMI (Acute myocardial infarction) and who received persistent beta-blocker treatment for 180 days (6 months) after discharge
Controlling High Blood Pressure (CBP)	Cardiovascular Conditions	Ages 18 to 85	Annual	The percentage of members who had a diagnosis of hypertension (HTN) and whose blood pressure (BP) was adequately controlled (< 140/90 mm Hg) during the measurement year.



The final BP of the measurement year is captured.

Note: 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.”

Measure	Effectiveness of Care	Eligible population	Occurrence	Description of measurement screening, test, or treatment needed
Statin Therapy for Patients with Cardiovascular Disease (SPC)	Cardiovascular Conditions	Men ages 21 to 75 Women ages 40 to 75	Annual	<p>The percentage of members who are identified as having clinical atherosclerotic cardiovascular disease (ASCVD) and met the following criteria. The following rates are reported:</p> <ul style="list-style-type: none"> • Received Statin Therapy: Members who were dispensed at least one high- or moderate-intensity statin medication during the measurement year • Statin Adherence 80%: Members who remained on a high- or moderate-intensity statin medication for at least 80% of the treatment period (treatment period begins with the earliest dispensing event for any high-intensity or moderate-intensity statin medication during the measurement year).

Cardiac Rehabilitation (CRE)	Cardiovascular Conditions	Ages 18 and older	Annual	<ul style="list-style-type: none"> • The percentage of members who have attended cardiac rehabilitation following a qualified cardiac event including, myocardial infarction, percutaneous coronary intervention, coronary artery bypass grafting, heart and heart/lung transplantation or heart valve repair/replacement. • Four rates are reported: <ul style="list-style-type: none"> – Initiation: the percentage of members who attended 2 or more sessions of cardiac rehabilitation within 30 days after a qualifying event – Engagement 1: the percentage of members who attended 12 or more sessions of cardiac rehabilitation within 90 days after a qualifying event – Engagement 2: the percentage of members who attended 24 or more sessions of cardiac rehabilitation within 180 days after a qualifying event – Achievement: the percentage of members who attended 36 or more sessions of cardiac rehabilitation within 180 days after a qualifying event.
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Measure	Effectiveness of Care	Eligible population	Occurrence	Description of measurement screening, test, or treatment needed
Glycemic Status Assessment for Patients with Diabetes (GSD)	Diabetes	Ages 18 to 75	Annual	<ul style="list-style-type: none"> The percentage of members with diabetes (types 1 and 2) whose most recent glycemic status (hemoglobin A1c [HbA1c] or glucose management indicator [GMI]) was at the following levels during the measurement year: Glycemic Status (< 8%) Glycemic Status (> 9%) <p>Note: Organizations must use the same data collection method (administrative or hybrid) to report these indicators.</p>
Blood Pressure Control Patients with Diabetes (BPD)	Diabetes	Ages 18 to 75	Annual	<p>The percentage of members with diabetes (types 1 and 2) whose blood pressure (BP) was adequately controlled (< 140/90 mm Hg) during the measurement year</p> <p>The final BP of the measurement year is captured.</p>
Eye Exam for Patients with Diabetes (EED)	Diabetes	Ages 18 to 75	Annual	<p>The percentage of members with diabetes (types 1 and 2) who had one of the following:</p> <ul style="list-style-type: none"> 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 any time during the member's history through December 31 of the measurement year



Measure	Effectiveness of Care	Eligible population	Occurrence	Description of measurement screening, test, or treatment needed
Kidney Health Evaluation for Patients with Diabetes (KED)	Diabetes	Ages 18 to 85	Annual	The percentage of members with diabetes (type 1 and type 2) who received a kidney health evaluation, defined by an estimated glomerular filtration rate (eGFR) and a urine albumin-creatinine rate (uACR), during the measurement year.
Statin Therapy for Patients with Diabetes (SPD)	Diabetes	Ages 40 to 75	Annual	The percentage of members with diabetes who do not have clinical atherosclerotic cardiovascular disease (ASCVD) who met the following criteria. Two rates are reported: <ul style="list-style-type: none"> • Received statin therapy: members who were dispensed at least one statin medication of any intensity during the measurement year • Statin adherence 80%: members who remained on a statin medication of any intensity for at least 80% of the treatment period



Measure	Effectiveness of Care	Eligible population	Occurrence	Description of measurement screening, test, or treatment needed
Diagnosed Mental Health Disorders (DMH)	Behavioral Health	1 year or older	Annual	<p>The percentage of members who were diagnosed with a mental health disorder during the measurement year</p> <p>Note: The measure provides information on the diagnosed prevalence of mental health disorders. Neither a higher nor lower rate indicates better performance.</p>
Antidepressant Medication Management (AMM)	Behavioral Health	Ages 18 and older	Per episode	<p>The percentage of members who were treated with antidepressant medication, had a diagnosis of major depression and who remained on an antidepressant medication treatment. Two rates are reported:</p> <ul style="list-style-type: none"> • Effective acute phase treatment: the percentage of members who remained on an antidepressant medication for at least 84 days (12 weeks) • Effective continuation phase treatment: the percentage of members who remained on an antidepressant medication for at least 180 days (6 months)



Measure	Effectiveness of Care	Eligible population	Occurrence	Description of measurement screening, test, or treatment needed
Follow-Up After Hospitalization for Mental Illness (FUH)	Behavioral Health	Ages 6 and older	Within seven and/or 30 days after discharge	<p>The percentage of discharges for members who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses and who had a follow-up visit with a mental health provider. Two rates are reported:</p> <ul style="list-style-type: none"> • The percentage of discharges for which the member received follow-up within 30 days after discharge • The percentage of discharges for which the member received follow-up within 7 days after discharge
Follow-Up After Emergency Department Visit for Mental Illness (FUM)	Behavioral Health	Ages 6 or older	Within seven and/or 30 days after ED visit	<p>The percentage of emergency department (ED) visits with a principal diagnosis of mental illness or intentional self-harm, who had a follow-up visit for mental illness with any practitioner. Two rates are reported:</p> <ul style="list-style-type: none"> • The percentage of ED visits for which the member received follow-up within 30 days of the ED visit (31 total days) • The percentage of ED visits for which the member received follow-up within 7 days of the ED visit (8 total days)



Measure	Effectiveness of Care	Eligible population	Occurrence	Description of measurement screening, test, or treatment needed
Diagnosed Substance Use Disorders (DSU)	Behavioral Health	Ages 13 years or older	Annual	<p>The percentage of members who were diagnosed with a substance use disorder during the measurement year. Four rates are reported:</p> <ul style="list-style-type: none"> • The percentage of members diagnosed with an alcohol disorder • The percentage of members diagnosed with an opioid disorder • The percentage of members diagnosed with a disorder for other or unspecified drugs • The percentage of members diagnosed with any substance use disorder <p>Note: The measure provides information on the diagnosed prevalence of substance use disorders. Neither a higher nor lower rate indicates better performance.</p>
Follow-Up After High Intensity Care for Substance Use Disorder (FUI)	Behavioral Health	Ages 13 years and older	Within seven and/or 30 days after discharge	<p>Percentage of acute inpatient hospitalizations, residential treatment, or withdrawal management visits for a diagnosis of substance use that result in a follow-up visit or service for substance use disorder. Two rates are reported:</p> <ul style="list-style-type: none"> • The percentage of visits or discharges for which the member received follow-up for substance use disorder within the 30 days after the visit or discharge • The percentage of visits or discharges for which the member received follow-up for substance use disorder within the 7 days after discharge <p>Note: Follow-up visits on the same day of the visit or discharge do not meet this measure.</p>
Follow-Up After Emergency Department Visit for Substance Use (FUA)	Behavioral Health	Ages 13 years and older	Within seven and/or 30 days after ED visit	<p>The percentage of emergency department (ED) visits among members with a principal diagnosis of substance use disorder (SUD), or any diagnosis of drug overdose, for which there was follow-up. Two rates are reported:</p> <ul style="list-style-type: none"> • The percentage of ED visits for which the member received follow-up within 30 days of the ED visit (31 total days) • The percentage of ED visits for which the member received follow-up within seven days of the ED visit (8 total days) <p>Note: Follow-up visits that occur on the same day as the ED discharge meet this measure.</p>



Measure	Effectiveness of Care	Eligible population	Occurrence	Description of measurement screening, test, or treatment needed
Pharmacotherapy for Opioid Use Disorder (POD)	Behavioral Health	Ages 16 years and older	Annual	The percentage of opioid use disorder (OUD) pharmacotherapy events that lasted at least 180 days with a diagnosis of OUD and a new OUD pharmacotherapy event
Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)	Behavioral Health	Ages 18 to 64	Annual	The percentage of members with schizophrenia, schizoaffective disorder, or bipolar disorder, who were dispensed an antipsychotic medication and had a diabetes screening test (glucose test and/or HbA1c test) during the measurement year
Diabetes Monitoring for People with Diabetes and Schizophrenia (SMD)	Behavioral Health	Ages 18 to 64	Annual	Percentage of members with schizophrenia or schizoaffective disorder and diabetes who had both an LDL-C and an HbA1c test during the measurement year
Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia (SMC)	Behavioral Health	Ages 18 to 64	Annual	Percentage of members with schizophrenia, schizoaffective disorder and cardiovascular disease who had an LDL-C test during the measurement year

Note: Indicators of cardiovascular disease include:

- Inpatient discharge for acute myocardial infarction (AMI) or coronary artery bypass grafting (CABG) during the year
- Diagnosis of percutaneous coronary intervention (PCI) in any setting during the year
- Diagnosis of ischemic vascular disease (IVD) during an inpatient or outpatient visit in **both** the current year and the prior year



Measure	Effectiveness of Care	Eligible population	Occurrence	Description of measurement screening, test, or treatment needed
Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA)	Behavioral Health	Ages 18 years and older	Annual	The percentage of members with schizophrenia or schizoaffective disorder who were dispensed and remained on the antipsychotic medication for at least 80% of their treatment period
Use of Opioids from Multiple Providers (UOP)	Overuse/Appropriateness	Ages 18 years and older	Annual	<p>The percentage of members receiving prescription opioids for ≥ 15 days during the measurement year who received opioids from multiple providers. Three rates are reported:</p> <ul style="list-style-type: none"> • Multiple prescribers: the percentage of members receiving prescriptions for opioids from four or more different prescribers during the measurement year • Multiple pharmacies: the percentage of members receiving prescriptions for opioids from four or more different pharmacies during the measurement year • Multiple prescribers and multiple pharmacies: the percentage of members receiving prescriptions for opioids from four or more different prescribers and four or more different pharmacies during the measurement year (for example, the percentage of members who are numerator compliant for both the multiple prescribers and multiple pharmacies rates). <p>Note: A lower rate indicates better performance for all three rates.</p>
Risk of Continued Opioid Use (COU)	Overuse/Appropriateness	Ages 18 years and older	Annual	<p>The percentage of members who have a new episode of opioid use that puts them at risk for continued opioid use. Two rates are reported:</p> <ul style="list-style-type: none"> • The percentage of members with at least 15 days of prescription opioids in a 30-day period • The percentage of members with at least 31 days of prescription opioids in a 62-day period <p>Note: Lower rate indicates higher performance.</p>
Appropriate Treatment for Upper Respiratory Infection (URI)	Overuse/Appropriateness	Ages 3 months and older	Per occurrence	The percentage of episodes for members with a diagnosis of upper respiratory infection (URI) that did not result in an antibiotic dispensing event
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (AAB)	Overuse/Appropriateness	Ages 3 months and older	Per occurrence	The percentage of episodes for members with a diagnosis of acute bronchitis/bronchiolitis that did not result in an antibiotic dispensing event



Measure	Effectiveness of Care	Eligible population	Occurrence	Description of measurement screening, test, or treatment needed
Use of Imaging Studies for Low Back Pain (LBP)	Overuse/Appropriateness	Ages 18 to 75	Not applicable	Percentage of members who had a primary diagnosis of lower back pain and did not have an imaging study (for example, plain X-ray, MRI, or CT scan) within 28 days of the diagnosis
Use of Opioids at High Dosage (HDO)	Overuse/Appropriateness	Ages 18 years and older	Annual	The percentage of members who received prescription opioids at a high dosage (average morphine milligram equivalent dose [MME] \geq 90) for \geq 15 days during the measurement year Note: Lower rate indicates higher performance.
Adults' Access to Preventive/Ambulatory Health Services (AAP)	Access/Availability of Care	Ages 20 and older	Annual	The percentage of members who had an ambulatory or preventive care visit. The organization reports three separate percentages for each product line. <ul style="list-style-type: none"> • Medicaid and Medicare members who had an ambulatory or preventive care visit during the measurement year • Commercial members who had an ambulatory or preventive care visit during the measurement year or the two years prior to the measurement year



Measure	Effectiveness of Care	Eligible population	Occurrence	Description of measurement screening, test, or treatment needed
Initiation and Engagement of Substance Use Disorder Treatment (IET)	Access/Availability of Care	Ages 13 and older	Per episode	<p>The percentage of new substance use disorder (SUD) episodes that result in treatment initiation and engagement. Two rates are reported:</p> <ul style="list-style-type: none"> • Initiation of SUD treatment: the percentage of new SUD episodes that result in treatment initiation through an inpatient SUD admission, outpatient visit, intensive outpatient encounter, partial hospitalization, telehealth visit, or medication treatment within 14 days • Engagement of SUD treatment: the percentage of new SUD episodes that have evidence of treatment engagement within 34 days of initiation
Prenatal and Postpartum Care (PPC)	Access/Availability of Care	Live birth	Per occurrence	<p>The percentage of deliveries of live births on or between October 8 of the year prior to the measurement year and October 7 of the measurement year. For these members, the measure assesses the following facets of prenatal and postpartum care:</p> <ul style="list-style-type: none"> • 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
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)	Access/Availability of Care	Ages 1 to 17	Annual	The percentage of members who had a new prescription for an antipsychotic medication and had documentation of psychosocial care as first-line treatment
Well-Child Visits in the First 30 Months of Life (W30)	Utilization and Risk Adjusted Utilization	Ages 0 to 15 months Ages 15 to 30 months	6 visits 2 visits	<p>Members who had the following number of well-child visits with a PCP during the last 15 months. The following rates are reported:</p> <ul style="list-style-type: none"> • Well-child visits in the first 15 months: children who turned 15 months old during the measurement year: six or more well-child visits • Well-child visits for age 15 to 30 months: children who turned 30 months old during the measurement year: two or more well-child visits
Child and Adolescent Well-Care Visits (WCV)	Utilization and Risk Adjusted Utilization	Ages 3 to 21	Annual	Members who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year

Measure	Effectiveness of Care	Eligible population	Occurrence	Description of measurement screening, test, or treatment needed
Antibiotic Utilization for Respiratory Conditions (AXR)	Utilization and Risk Adjusted Utilization	Ages 3 months and older	Per episode	The percentage of episodes for members with a diagnosis of a respiratory condition that resulted in an antibiotic dispensing event
Plan All-Cause Readmissions (PCR)	Risk Adjusted Utilization	Ages 18 to 64 years	Per occurrence	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.
Childhood Immunization Status (CIS-E)	Measures Reported Using Electronic Clinical Data Systems	Ages 0 to 2	Multiple doses	<p>The percentage of members who had appropriate doses of the following vaccines on or before their 2nd birthday:</p> <ul style="list-style-type: none"> • Four diphtheria, tetanus, and acellular pertussis (DTaP) • Three polio (IPV) • One measles, mumps, and rubella (MMR) (can only be given on or between first and second birthday to close the gap) • Three haemophilus influenza type B (HiB) • Three hepatitis B (hepB) (One of the three vaccinations can be a newborn hepatitis B vaccination during the eight-day period that begins on the date of birth and ends seven days after the date of birth.) • One chicken pox (VZV) (can only be given on or between first and second birthday to close the gap) • Four pneumococcal conjugate (PCV) • One hepatitis A (HepA) (can only be given on or between first and second birthday to close the gap) • Two 2-dose rotavirus (RV) or three 3-dose rotavirus (RV) (Or one two-dose and two three-dose RV combination) • Two influenza (flu) (influenza cannot be given until infant is six months of age — One of the two vaccinations for influenza can be an LAIV administered on the child's second birthday)
Immunizations for Adolescents (IMA-E)	Measures Reported Using Electronic Clinical Data Systems	Ages 13	Multiple doses	<p>The percentage of members who had one dose of meningococcal vaccine, one tetanus, diphtheria toxoids and acellular pertussis (Tdap) vaccine, and have completed the human papillomavirus (HPV) vaccine series by their 13th birthday:</p> <ul style="list-style-type: none"> • Meningococcal vaccine between 11th and 13th birthday • Tdap vaccine between 10th and 13th birthday • HPV vaccine between 9th and 13th birthday



Measure	Effectiveness of Care	Eligible population	Occurrence	Description of measurement screening, test, or treatment needed
Breast Cancer Screening (BCS-E)	Measures Reported Using Electronic Clinical Data Systems	Ages 50 to 74	Annual	The percentage of members who were recommended for routine breast cancer screening and had a mammogram to screen for breast cancer
Cervical Cancer Screening (CCS-E)	Measures Reported Using Electronic Clinical Data Systems	Ages 21 to 64	Varies by age	The percentage of members who had appropriate screening for colorectal cancer. Screenings are defined by one of the following: <ul style="list-style-type: none"> Members 21 to 64 years of age who were recommended for routine cervical cancer screening and had cervical cytology performed within the last 3 years. Members 30 to 64 years of age who were recommended for routine cervical cancer screening and had cervical high-risk human papillomavirus (hrHPV) testing performed within the last 5 years. Members 30 to 64 years of age who were recommended for routine cervical cancer screening and had cervical cytology/high-risk human papillomavirus (hrHPV) testing within the last 5 years



Measure	Effectiveness of Care	Eligible population	Occurrence	Description of measurement screening, test, or treatment needed
Colorectal Cancer Screening (COL-E)	Measures Reported Using Electronic Clinical Data Systems	Ages 45 to 75	Dependent on screening type	<p>The percentage of members who had appropriate screening for colorectal cancer. Screenings are defined by one of the following:</p> <ul style="list-style-type: none"> • Fecal occult blood test (FOBT) during the measurement period • Flexible sigmoidoscopy during the measurement period or the four years prior to the measurement period • Colonoscopy during the measurement year or the 9 years prior to the measurement period • CT colonography during the measurement period or the four years prior to the measurement period • Stool DNA (sDNA) with FIT test during the measurement period or the two years prior to the measurement period



Measure	Effectiveness of Care	Eligible population	Occurrence	Description of measurement screening, test, or treatment needed
Follow-Up Care for Children Prescribed ADHD Medication (ADD-E)	Measures Reported Using Electronic Clinical Data Systems	Ages 6 to 12	Varies by phase	<p>The percentage of children newly prescribed attention-deficit/hyperactivity disorder (ADHD) medication who had at least three follow-up care visits within a 10-month period, one of which was within 30 days of when the first ADHD medication was dispensed. Two rates are reported:</p> <ul style="list-style-type: none"> • Initiation phase: the percentage of members 6 to 12 years of age with a prescription dispensed for ADHD medication, who had one follow-up visit with a practitioner with prescribing authority during the 30-day initiation phase • Continuation and maintenance (C&M) phase: the percentage of members 6 to 12 years of age with a prescription dispensed for ADHD medication, who remained on the medication for at least 210 days and who, in addition to the visit in the Initiation Phase, had at least two follow-up visits with a practitioner within 270 days (nine months) after the initiation phase ended.
Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM-E)	Measures Reported Using Electronic Clinical Data Systems	Ages 1 to 17	Annual	<p>Members who had two or more antipsychotic prescriptions and had metabolic testing during the year. Three rates are reported:</p> <ul style="list-style-type: none"> • The percentage of children and adolescents on antipsychotics who received blood glucose testing • The percentage of children and adolescents on antipsychotics who received cholesterol testing • The percentage of children and adolescents on antipsychotics who received both blood glucose and cholesterol testing.



Measure	Effectiveness of Care	Eligible population	Occurrence	Description of measurement screening, test, or treatment needed
Depression Screening and Follow-up for Adolescents and Adults (DSF-E)	Measures Reported Using Electronic Clinical Data Systems	Ages 12 and older	Per episode	<p>The percentage of members who were screened for clinical depression using a standardized instrument and, if screened positive, received follow-up care:</p> <ul style="list-style-type: none"> • 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.
Unhealthy Alcohol Use Screening and Follow-Up (ASF-E)	Measures Reported Using Electronic Clinical Data Systems	Ages 18 years and older	Per episode	<p>The percentage of members who were screened for unhealthy alcohol use using a standardized instrument and, if screened positive, received appropriate follow-up care.</p> <ul style="list-style-type: none"> • Unhealthy Alcohol Use Screening: The percentage of members who had a systematic screening for unhealthy alcohol use • Follow-Up Care on Positive Screen: The percentage of members receiving brief counseling or other follow-up care within 60 days (2 months) of screening positive for unhealthy alcohol use
Depression Remission or Response for Adolescents and Adults (DRR-E)	Measures Reported Using Electronic Clinical Data Systems	Ages 12 and older	Per episode	<p>The percentage of members with a diagnosis of depression and an elevated PHQ-9 score, who had evidence of response or remission within 120 to 240 days (4 to 8 months) of the elevated score:</p> <ul style="list-style-type: none"> • Follow-Up PHQ-9: The percentage of members who have a follow-up PHQ-9 score documented within 120 to 240 days (4 to 8 months) after the initial elevated PHQ-9 score • Depression Remission: The percentage of members who achieved remission within 120 to 240 days (4 to 8 months) after the initial elevated PHQ-9 score • Depression Response: The percentage of members who showed response within 120 to 240 days (4 to 8 months) after the initial elevated PHQ-9 score



Measure	Effectiveness of Care	Eligible population	Occurrence	Description of measurement screening, test, or treatment needed
Adult Immunization Status (AIS-E)	Measures Reported Using Electronic Clinical Data Systems	Ages 19 and older	Annual	The percentage of members who are up to date on recommended routine vaccines for influenza, tetanus and diphtheria (Td) or tetanus, diphtheria and acellular pertussis (Tdap), zoster and pneumococcal.
Prenatal Immunization Status (PRS-E)	Measures Reported Using Electronic Clinical Data Systems	N/A	Annual	The percentage of deliveries in the measurement period in which members had received influenza and tetanus, diphtheria toxoids and acellular pertussis (Tdap) vaccinations.
Prenatal Depression Screening and Follow-up (PND-E)	Measures Reported Using Electronic Clinical Data Systems	N/A	Annual	<p>The percentage of deliveries in which members were screened for clinical depression while pregnant and, if screened positive, received follow-up care:</p> <ul style="list-style-type: none"> • Depression screening: The percentage of deliveries in which members were screened for clinical depression during pregnancy using a standardized instrument • Follow-up on positive screen: The percentage of deliveries in which members received follow-up care within 30 days of a positive depression screen finding
Postpartum Depression Screening and Follow-up (PDS-E)	Measures Reported Using Electronic Clinical Data Systems	N/A	Annual	<p>The percentage of deliveries in which members were screened for clinical depression during the postpartum period, and if screened positive, received follow-up care:</p> <ul style="list-style-type: none"> • Depression screening: The percentage of deliveries in which members were screened for clinical depression using a standardized instrument during the postpartum period • Follow-up on positive screen: The percentage of deliveries in which members received follow-up care within 30 days of a positive depression screen finding



Measure	Effectiveness of Care	Eligible population	Occurrence	Description of measurement screening, test, or treatment needed
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Social Need Screening and Intervention (SNS-E)	Measures Reported Using Electronic Clinical Data Systems	Any age	Annual	The percentage of members who were screened, using prespecified instruments, at least once during the measurement period for unmet food, housing, and transportation needs, and received a corresponding intervention if they screened positive:
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- **Food screening:** The percentage of members who were screened for food insecurity.
- **Food intervention:** The percentage of members who received a corresponding intervention within 30 days (1 month) of screening positive for food insecurity.
- **Housing screening:** The percentage of members who were screened for housing instability, homelessness, or housing inadequacy.
- **Housing intervention:** The percentage of members who received a corresponding intervention within 30 days (1 month) of screening positive for housing instability, homelessness, or housing inadequacy.
- **Transportation screening:** The percentage of members who were screened for transportation insecurity.
- **Transportation intervention:** The percentage of members who received a corresponding intervention within 30 days (1 month) of screening positive for transportation insecurity.

Measure	Effectiveness of Care	Eligible population	Occurrence	Description of measurement screening, test, or treatment needed
Medical Assistance with Smoking and Tobacco Use Cessation (MSC) — CAHPS®	Experience of Care	Ages 18 and older	Annual	<p>The following components of this measure assess different facets of providing medical assistance with smoking and tobacco use cessation:</p> <ul style="list-style-type: none"> • Advising smokers and tobacco users to quit: a rolling average represents the percentage of members 18 years of age and older who were current smokers or tobacco users and who received advice to quit during the measurement year • Discussing cessation medications: a rolling average represents the percentage of members 18 years of age and older who were current smokers or tobacco users and who discussed or were recommended cessation medications during the measurement year • Discussing cessation strategies: a rolling average represents the percentage of members 18 years of age and older who were current smokers or tobacco users and who discussed or were provided cessation methods or strategies during the measurement year



Health Plan Survey 5.1H, Adult Version (CPA) — CAHPS	Experience of Care	Members who have been with the plan through the year	Annual	<p>Five composite scores summarize responses in key areas:</p> <ol style="list-style-type: none"> 1. Claims processing (commercial only) 2. Customer service 3. Getting care quickly 4. Getting needed care 5. How well doctors communicate
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Item-specific question summary rates are reported for the rating questions and each composite question. Question summary rates are also reported individually for one item summarizing the following concept:

1. Coordination of care

Measure	Effectiveness of Care	Eligible population	Occurrence	Description of measurement screening, test, or treatment needed
Health Plan Survey 5.1H, Child Version (CPC) — CAHPS	Experience of Care	Members who have been with the plan through the year	Annual	<p>This measure provides information on parents' experience with their child's Medicaid organization. Results summarize member experiences through ratings, composites, and individual question summary rates.</p> <p>Four global rating questions reflect overall satisfaction:</p> <ol style="list-style-type: none"> 1. Rating of All health care 2. Rating of health plan 3. Rating of personal doctor 4. Rating of specialist seen most often <p>Four composite scores summarize responses in key areas:</p> <ol style="list-style-type: none"> 1. Customer service 2. Getting care quickly 3. Getting needed care 4. How well doctors communicate. <p>Item-specific question summary rates are reported for the rating questions and each composite question. Question summary rates are also reported individually for one item summarizing the following concept:</p> <ol style="list-style-type: none"> 1. Coordination of care
Children With Chronic Conditions (CCC) — CAHPS	Experience of Care	Members who have been with the plan through the year	Annual	<p>This measure provides information on parents' experience with their child's Medicaid organization for the population of children with chronic conditions.</p> <p>Three composites summarize satisfaction with basic components of care essential for successful treatment, management, and support of children with chronic conditions:</p> <ol style="list-style-type: none"> 1. Access to specialized services 2. Family centered care: personal doctor who knows child 3. Coordination of care for children with chronic conditions <p>Item-specific question summary rates are reported for each composite question. Question summary rates are also reported individually for two items summarizing the following concepts:</p> <ol style="list-style-type: none"> 1. Access to prescription medicines 2. Family centered care: getting needed information



Measure	Effectiveness of Care	Eligible population	Occurrence	Description of measurement screening, test, or treatment needed
Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program	EPSDT	Ages 0 to 20	Multiple	<p>Screening must include:</p> <ul style="list-style-type: none"> • Comprehensive health development history (inclusive both physical and mental health) • Comprehensive unclothed physical exam or appropriately draped • Appropriate immunizations • Laboratory tests • Lead toxicity screening • Health education including anticipatory guidance • Vision services • Dental services • Hearing services • Other necessary health care — diagnostic services and treatment to correct or ameliorate defects, physical and mental illnesses, and conditions discovered by the screening services



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