2026 HEDIS ® BCBSKS Coding & Reference Guide

(The timeframe for claims data is Jan. 1, 2026 through Dec. 31, 2026)

BlueCross BlueShield Kansas

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Introduction to NCQA HEDIS® Measures[3]

Why are HEDIS® scores important?
HEDIS® is the gold standard in measuring quality performance in the health care industry. It includes specific measure specifications for physicians that quantify performance in health care to identify improvement that can make a difference in patient's lives.

What benchmarks are NCQA HEDIS® measures scored against?

- Quality Compass®[4] provides online access to health plan HEDIS® and CAHPS® performance data and benchmarks at the national, state, and regional levels to help organizations evaluate individual and competitor performance, identify areas of improvement, and set quality goals.
- Blue Cross and Blue Shield of Kansas utilizes the national benchmarks from Quality Compass®[4].

What is your role as the provider?
By providing high-quality care to patients in a timely manner, providers play a critical role in the quality of patient care. There are different opportunities for providers to engage with patients to help ensure high quality and timely care while helping patients manage their health.
Areas of opportunity to align provider practices with NCQA HEDIS® measures:

- Promote timely and appropriate screenings, tests, and treatment
- Provide education to staff for proper documentation of care delivered
- Strengthening patient and provider relationships through open communication regarding health care needs and quality of care
- Collaborative development of chronic condition care plan
- Follow-up with patients regarding medications
- Assess timeliness of care and work with office staff to optimize scheduling

These practices promote patient safety, preventive medicine, early disease detection and chronic disease management.
Health care Effectiveness Data Information Set – also known as HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

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

Quality Base Reimbursement Program (QBRP)
Alternative Payment Method (APM)

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

Why it matters
Acute bronchitis/bronchiolitis almost always gets better on its own; therefore, individuals without other health problems should not be prescribed antibiotics. Ensuring the appropriate use of antibiotics for individuals with acute bronchitis/bronchiolitis will help them avoid harmful side-effects and possible resistance to antibiotics over time. Antibiotic resistance is a major health concern in the United States, with 2.8 million antibiotic-resistant infections and 35,000 deaths occurring annually.

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

Intake period
July 1, 2025, to the year prior to the measurement period to June 30, 2026, of the measurement period. The intake period captures eligible episodes of treatment.

Continuous enrollment
The person must be continuously enrolled without a gap in coverage from 30 days prior to the episode date through three days after the episode date (34 days total).

Measurement period
Jan. 1 – Dec. 31

2026 NCQA HEDIS tech spec updates
No changes to this measure.

Initial population
Measure item count: Episode
Attribution basis: Enrollment

- *Benefits*: Medical – Person must have Blue Cross and Blue Shield of Kansas medical and pharmacy.
- *Continuous enrollment:* 30 days prior to the episode date through 3 days after episode date (34 days total).
- *Allowable gap:* None.
- *Ages*: 3 months of age or older as of the episode date

Event: **Episodes of acute bronchitis/bronchiolitis diagnosis**

- **Step1**: Identify all persons who had outpatient visit, ED visit, telephone visit, e-visit or virtual check in (Outpatient, ED and Telehealth Value Set) during the intake period, with a diagnosis of acute bronchitis/bronchiolitis (Acute Bronchitis Value Set).
- **Step 2:** Determine all acute bronchitis/bronchiolitis episode dates. For each person identified in step one, determine all outpatient, telephone or ED visits, e-visits and virtual check-ins with a diagnosis of acute bronchitis/bronchiolitis. Exclude visits that result in an inpatient stay (Inpatient Stay Value Set).

- **Step 3:** Test for negative comorbid condition history. Remove episode dates where the person had a claim/encounter with any diagnosis for a comorbid condition (Comorbid Conditions Value Set) during the 365 days prior to or on the episode date. Do not include laboratory claims (with place of service code 81).
- **Step 4:** Test for negative medication history. Remove episode dates where a new or refill prescription for an antibiotic medication **(**Table 1: AAB Antibiotic Medication List) was dispensed 30 days prior to the episode date or was active on the episode date.
- **Step 5:** Test for Negative Competing Diagnosis. Remove episode dates where the person had a claim/encounter with a competing diagnosis (Pharyngitis Value Set. Competing Diagnosis Value Set) or three days after the episode date.
- **Step 6**: Calculate continuous enrollment.
- **Step 7:** Deduplicate eligible episodes. Identify visits chronologically, including only one per 31-day period. If a person has more than one eligible episode in a 31-day period, include only the first eligible episode. *For example*, if a person has an eligible episode on Jan. 1, includes the Jan. 1st visit and does not include eligible episodes that occur on or between Jan. 2 and Jan. 31, then, if applicable, include the next eligible episode that occurs on or after Feb.1.
- Note: The denominator for this measure is based on episodes, not on persons. All eligible episodes that were not removed or deduplicated remain in the denominator.
- Coding Guidance: Do not include laboratory claims (with place of service code 81).

Supplemental data

Supplemental data may be used to identify initial population, denominator, exclusion and numerator events.

Denominator

The initial population minus denominator exclusions.

Numerator

Dispensed prescription for an antibiotic (Table 1: Antibiotic Medication List) on or three days after the Index Episode Start Date (IESD- The date of service for any outpatient or ED visit during the intake period with a diagnosis of acute bronchitis).

This measure is reported as 4 rates:

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

Code[1]	Definition
J20.3	Acute bronchitis due to coxsackievirus
J20.4	Acute bronchitis due to parainfluenza virus
J20.5	Acute bronchitis due to respiratory syncytial virus
J20.6	Acute bronchitis due to rhinovirus
J20.7	Acute bronchitis due to echovirus
J20.8	Acute bronchitis due to other specified organisms
J20.9	Acute bronchitis, unspecified
J21.0	Acute bronchiolitis due to respiratory syncytial virus
J21.1	Acute bronchiolitis due to human metapneumovirus
J21.8	Acute bronchiolitis due to other specified organisms
J21.9	Acute bronchiolitis, unspecified

Denominator exclusions

- Persons who use hospice services or elect to use a hospice benefit any time during the measurement period.
- Persons with a date of death during the measurement period.

Tips for patients

- Chest colds typically improve after a week to ten days.
- Speed up recovery by: Staying hydrated, getting plenty of sleep, and keeping a humidifier in your bedroom.

Tips for providers

Review the side effects of antibiotics:

- Nausea, upset stomach, diarrhea or loss of appetite.
- Kills helpful bacteria in your body.
- Creates antibiotic-resistant bacteria such as MRSA, a type of flesh-eating bacteria.
- May increase the risk of serious diseases (e.g., autoimmune disorder)
- Avoid cigarette smoke
- Suggest over-the-counter treatments to help alleviate some symptoms:
    - Cough suppressants (dextromethorphan)
    - First-generation antihistamines

Definitions

Intake period: July 1 of the year prior to the measurement period to June 30 of the measurement period. The intake period captures eligible episodes of treatment. (Continuous enrollment (without a gap in coverage) 30 days prior to the episode date through three days after the episode date).

Episode date: The date of service for any outpatient, telephone or ED visit, e-visit, or virtual check-in during the intake period with a diagnosis of acute bronchitis/bronchiolitis.

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

- A period of 30 days prior to the episode date when the person had no pharmacy claims for either new or refill prescriptions for a listed antibiotic drug.
- No prescriptions dispensed more than 30 days prior to the episode date that are active on the episode date.
- A prescription is considered active if the “days' supply” indicated on the date when the person was dispensed the prescription is the number of days or more between that date and the relevant service date. The 30-day look-back period for pharmacy data includes the 30 days prior to the intake period.

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

Negative competing diagnosis: The episode date and three days following the episode date when the person had no claims or encounters with a competing diagnosis.

Table 1: Antibiotic Medications (AAB)[2]			
Description	**Prescription**		
Aminoglycosides	• Amikacin • Gentamicin	• Streptomycin	• Tobramycin
Aminopenicillins	• Amoxicillin	• Ampicillin	
Beta-lactamase inhibitors	• Amoxicillin-clavulanate	• Ampicillin-sulbactam	• Piperacillin-tazobactam
First-generation cephalosporins	• Cefadroxil	• Cefazolin	• Cephalexin
Fourth generation cephalosporins	• Cefepime		
Lincomycin derivatives	• Clindamycin	• Lincomycin	
Macrolides	• Azithromycin	• Clarithromycin	• Erythromycin
Miscellaneous antibiotics	• Aztreonam • Chloramphenicol • Dalfopristin-quinupristin	• Daptomycin • Linezolid	• Metronidazole • Vancomycin
Natural penicillin's	• Penicillin G benzathine-procaine • Penicillin G potassium	• Penicillin G procaine • Penicillin G sodium	• Penicillin V potassium • Penicillin G benzathine
Penicillinase resistant penicillin's	• Dicloxacillin	• Nafcillin	• Oxacillin
Quinolones	• Ciprofloxacin • Gemifloxacin	• Levofloxacin • Moxifloxacin	• Ofloxacin
Rifamycin derivatives	• Rifampin		
Second generation cephalosporin	• Cefaclor • Cefotetan	• Cefoxitin • Cefprozil	• Cefuroxime
Sulfonamides	• Sulfadiazine	• Sulfamethoxazole-trimethoprim	
Tetracyclines	• Doxycycline	• Minocycline	• Tetracycline
Third generation cephalosporins	• Cefdinir • Cefixime • Cefotaxime • Nitrofurantoin	• Cefpodoxime • Ceftazidime • Ceftrixone	

Acute Hospital Utilization (AHU)

Alternative Payment Method (APM)

Description
For persons 18 years of age and older, the risk-adjusted ratio of observed-to-expected acute inpatient and observation stay discharges during the measurement period.

Why it matters
In 2019, 5.9% of people had a hospital stay in the past year. Hospital care accounts for 31% of health spending in the U.S. A study found that inpatient admission costs account for 21% of total Medicare benefit payments. Hospital and inpatient hospitalizations put patients at risk for adverse events and prolonged inpatient stays. One in 25 hospitalized individuals are affected by a health care-associated infection. Older patients are particularly at increased risk for delirium, falls and depressed psycho-physiologic functioning while hospitalized. Some hospitalizations can be avoided with improved access to care, timely delivery of care and appropriate care coordination.

Calculation
The rates are used to calculate a calibrated observed-to-expected (O/E) ratio that assesses whether plans had more, the same or fewer hospitalizations than expected, accounting for incremental improvements across all plans over time. The O/E ratio is multiplied by the hospitalization rate across all health plans to produce a risk-standardized rate that allows national comparison.

Initial population
Measure item count: Person.
Attribution basis: Enrollment.

- *Benefits:* Medical – Person must have Blue Cross and Blue Shield of Kansas medical and pharmacy.
- *Continuous enrollment:* The measurement period and the year prior to the measurement period.
- *Allowable gap:* No more than one gap of ≤45 days during each year of continuous enrollment. No gap on the last day of the measurement period.

Ages:

- *Commercial and Medicare:* 18 years of age and older as of the last day of the measurement period.
- *Medicaid:* 18–64 years of age as of the last day of the measurement period.

Gender/Sex criteria:

- Administrative Gender of Female (AdministrativeGender code female).
- Administrative Gender of Male (AdministrativeGender code male).

Continuous enrollment
The measurement period (Jan. 1, 2025-Dec. 31, 2025) and the year prior to the measurement period (Jan. 1, 2024-Dec. 31, 2024).

Measurement period
Jan. 1 – Dec. 31

2026 NCQA HEDIS tech spec updates

- Integrated the Risk Adjustment General Guidelines into the *Guidance* section.
- Removed the definition of the classification period and added this information into the risk adjustment calculation.
- Added "direct transfer" to the *Definitions* section.
- Added administrative gender codes to the initial population.

Event/Diagnosis – persons in hospice or using hospice services.

Observed events –Count all acute inpatient and observation discharges during the measurement period for non-outlier persons, excluding non-acute inpatient stays or inpatient and observation discharges with any of the following:

- Discharge claim that has a principal diagnosis of mental health or chemical dependency, live-born infant, or maternity-related.
- A planned hospital stay with a principal diagnosis of maintenance chemotherapy, rehabilitation, or organ transplant.
- A potentially planned procedure without a principal acute diagnosis.
- Inpatient and observation stays with a discharge for death.

For discharges with more than one direct transfer, use the last discharge.

Expected events -For each of those non-outlier persons in the initial population, identify the HCC category, age and gender to which they belong. With this information there are two calculations made that are made using risk weights associated with the HCC and with the age-gender categories: Predicted Probability of Discharge (PPD) and Predicted Unconditional Count of Discharge (PUCD). NCQA® defines the risk weights. The final Expected Events calculation is derived from multiplying these two numbers together.

Supplemental data

Supplemental data may be used to identify initial population and all events.

Denominator

The initial population minus denominator exclusions.

Calculated: O/E Ratio

The number of Observed Discharges Among Nonoutlier Persons (Observed Count) divided by Number of Expected Discharges Among Nonoutlier Persons (Expected Count) for each age group and totals. Calculated by IDSS as the OE.

Denominator exclusions

- Persons in hospice or using hospice services anytime during the measurement period.
- Excluded nonacute inpatient stays

Tips for patients

- Preventive care is a core aspect of many HEDIS measures, including screenings, vaccinations, and health education. By understanding the importance of regular screenings (like mammograms, colorectal cancer screenings, and immunizations), you can take proactive steps to protect your health.
- Enroll in disease management programs: If you have a chronic condition (e.g., diabetes, hypertension), many health plans offer disease management programs that provide education and support. These programs can help you better understand your condition, improve your treatment adherence, and manage symptoms effectively.
- Take medications as prescribed: Make sure you understand how to take your medications, when to take them, and the potential side effects. If you have trouble with medications (e.g., affordability, side effects), discuss options with your provider.
- Ensure that you're up to date on vaccinations, such as the flu shot, pneumonia vaccine, and others based on your age and health status.
- Don't hesitate to speak up if you have concerns, if you don't understand something, or if you need more information. Being an active participant in your health care helps ensure you receive the best care.

Tips for providers

- Discuss the discharge summary with patients and ask if they understand the instructions and filled any new prescriptions.
- Complete a thorough medication reconciliation and ask patients and caregivers to recite their new medication regimen back to you.
- Develop an action plan for chronic conditions. The plan should include what symptoms would trigger the patient to:
    - Start as needed (PRN) medications.
    - Call their doctor during after-office hours.
    - Go to the emergency room.
- Have patients and caregivers repeat the care plan back to you to demonstrate understanding.
- Provide a written home management plan or after-visit summary the patient or caregiver can use to make notes during the visit and reference their plan of care.
- Ask about barriers or issues that might have contributed to patients' hospitalization and discuss how to prevent them in the future.

Definitions

Outlier:
Medicare - persons with four or more inpatient or observation stay discharges during the measurement period.
Medicaid - persons with six or more inpatient or observation stay discharges during the measurement period.
Commercial – persons with three or more inpatient or observation stay discharges during the measurement period.

Non-outlier:
Medicare -persons with three or fewer inpatient or observation stay discharges during the measurement period.
Medicaid - persons with five or fewer inpatient or observation stay discharges during the measurement period.

Classification period: The year prior to the measurement period.

Planned hospital stay: A hospital stay is considered planned if it meets criteria as described in step three of calculation of observed events.

PPD: Predicted probability of discharge. The predicted probability of a person having any discharge in the measurement period.

PUCD: Predicted unconditional count of discharge. The predicted unconditional count of discharges for persons during the measurement period.

Breast Cancer Screening (BCS-E)

Quality Base Reimbursement Program (QBRP)
Alternative Payment Method (APM)
Medicare Advantage (MA)

Description
The percentage of women 40-74 years of age who were recommended for routine breast cancer screening and had a mammogram to screen for breast cancer.

Why it matters
Aside from some forms of skin cancer, breast cancer is the most common cancer among American women, regardless of race or ethnicity. Screening can improve outcomes: Early detection reduces the risk of dying from breast cancer and can lead to a greater range of treatment options and lower health care costs.

Calculation:
- Numerator: One or more mammograms (Mammography Value Set) any time on or between Oct.1 two years prior to the measurement period and the end of the measurement period.
- Denominator: The initial population, minus exclusions.

Initial population:
Persons 40–74 years of age by the end of the measurement period who were recommended for routine breast cancer screening and meet the criteria for participation.
Measure item count: Person.
Attribution basis: Enrollment.
- *Benefits:* Medical – Person must have Blue Cross and Blue Shield of Kansas medical and pharmacy.
- *Continuous enrollment:* Oct.1 two years prior to the measurement period through the last day of the measurement period.
- *Allowable gap:*
    - *Measurement period*: No more than one gap of ≤45 days. No gaps on the last day of the measurement period.
    - *Year prior to the measurement period:* No more than one gap of ≤45 days.
    - *October 1 two years prior to the measurement period through Dec.31 two years prior to the measurement period*: None.

Ages: 40–74 years of age as of the last day of the measurement period.

Include persons recommended for routine breast cancer screening with any of the following criteria:
- Administrative Gender of Female (Administrative Gender code female) at any time in the person's history.
- Sex Assigned at Birth (LOINC code 76689-9) of Female (LOINC code LA3-6) at any time in the person's history.
- Sex Parameter for Clinical Use of Female (Sex Parameter for Clinical Use code female-typical) during the measurement period.

Continuous enrollment
- The person must be enrolled with a medical benefit Oct.1 two years prior to the measurement period through the end of the measurement period.
- No more than one gap in enrollment of up to 45 days for each full calendar year.
- No gaps in enrollment are allowed from Oct. 1st two years prior to the measurement period through Dec. 31 two years prior to the measurement period.
- The person must be enrolled on the last day of the measurement period.

Measurement period
Jan. 1 – Dec. 31

2026 NCQA HEDIS tech spec updates

- Updated the race and ethnicity stratification categories to align with OMB SPD 15 2024.
- Removed the definitions of "participation" and "participation period."
- Removed the SSoR data elements from the data element tables.
- The combination of unilateral mastectomy with a bilateral modifier was removed.
- Added instructions on allowable adjustments to the race and ethnicity and SES stratifications.

Event/Diagnosis

Nothing defined.

Supplemental data

No special requirements. NOTE: Remember to code for history of bilateral mastectomy as appropriate at least once each calendar year.

Denominator

The initial population minus denominator exclusions.

Numerator

One or more mammograms any time on or between Oct. 1 (two years prior to the measurement period) and Dec. 31 of the measurement period.

Code[1]	Definition
Z90.12	Acquired absence of left breast and nipple
Z90.11	Acquired absence of right breast and nipple
85.42	Bilateral simple mastectomy
85.44	Bilateral extended simple mastectomy
85.46	Bilateral radical mastectomy
85.48	Bilateral extended radical mastectomy
Z90.13	Acquired absence of bilateral breasts and nipples
77061	Diagnostic Digital Breast Tomosynthesis; Unilateral
77062	Diagnostic Digital Breast Tomosynthesis; Bilateral
77063	Screening Digital Breast Tomosynthesis, Bilateral
77065	Diagnostic Mammography, including computer-Aided Detection (CAD) when performed; Unilateral
77066	Diagnostic Mammography, including computer-Aided Detection (CAD) when performed; Bilateral
77067	Screening Mammography, bilateral (2-view study of each breast), including Computer-Aided Detection (CAD) when performed
19180 (termed)	Removal of Breast
19240 (termed)	Removal of Breast
19303	Mastectomy, Simple, Complete
19304 (termed)	Mastectomy, Subcutaneous
19305	Mastectomy, Radical, Including Pectoral Muscles, Axillary Lymph Nodes
19306	Mastectomy, Radical, Including Pectoral Muscles, Axillary and Internal Mammary Lymph Nodes (Urban Type Operation)
19307	Mastectomy, Modified Radical, Including Axillary Lymph Nodes, with or without Pectoralis minor muscle, but excluding pectoralis major muscle
0HTU0ZZ	Resection of Left Breast, Open Approach
0HTT0ZZ	Resection of Right Breast, Open Approach
0HTV0ZZ	Resection of Bilateral Breast, Open Approach

Denominator exclusions

- Exclude persons who have had a bilateral mastectomy any time during the person's history through Dec. 31st of the measure year. Do not include laboratory claims (with place of service code 81) for absence of the left or right breast value sets. That includes:
    - Bilateral mastectomy
    - Unilateral mastectomy with a bilateral modifier
    - Clinical unilateral mastectomy with a bilateral modifier
    - History of bilateral mastectomy
- Persons with a history of acquired mastectomy can be documented administratively on claims via ICD-10 code: Z90.13.
- Persons who had gender-affirming chest surgery (CPT code 19318) with a diagnosis of gender dysphoria any time during the person's history through the end of the measurement period. (Sex Assigned at Birth (LOINC code 76689-9) of Female (LOINC code LA3-6) at any time in the person's history.)
- Persons with a date of death during the measurement period.
- Persons 66 years of age and older by end of the measurement period with two indications of frailty with two different dates of service AND advanced illness or dispensed dementia medication. Do not include laboratory claims (with place of service code 81).
- Persons receiving or had an encounter for palliative care (ICD-10 code Z51.5) anytime during the measurement period.
- Persons in hospice or using hospice services anytime during the measurement period.

Tips for success

- Create a standing order to mail to patients for mammography.
- Provide a list of locations where mammogram screenings can be performed.
- If telehealth, telephone, or e-visits are used instead of face-to-face visits, discuss the need for breast cancer screening and mail a mammogram order with location of testing facility and phone number.

Tips for talking with patients

- Educate patients about the importance of routine screening:
    - Many women with breast cancer do not have symptoms, which is why regular breast cancer screenings are so important.
    - Mammograms are an effective method for detecting breast cancer in early stages, when it is most treatable.
    - The recommended frequency of routine mammograms is at least once every 24 months for all women ages 50–74. Depending on risk factors, mammograms may be done more frequently.

Definitions

Intake period:

One or more mammograms any time on or between Oct. 1, two years prior to the measurement period and Dec. 31 with continuous enrollment from the measurement period and the year prior to the measurement period. The person must be enrolled on the last day of the measurement period.

Blood Pressure Control for Patients with Diabetes (BPD-E)

Alternative Payment Method (APM)

Description
The percentage of persons 18–75 years of age with diabetes (types 1 and 2) whose blood pressure (BP) was adequately controlled (<140/90 mm Hg) during the measurement period.

Why it matters
People with diabetes are especially prone to high blood pressure because of the amount of insulin in their body. Proper blood pressure management is essential to avoid further complications, including heart attacks, stroke, kidney disease and blindness.

Calculation
- Numerator: The number of patients whose blood pressure is adequately controlled (<140/90 mmHg).
- Denominator: The total number of patients eligible (those diagnosed with hypertension).

Initial population
Measure item count: Person.
Attribution basis: Enrollment.
- *Benefits:* Medical – Person must have Blue Cross and Blue Shield of Kansas medical and pharmacy.
- *Continuous enrollment:* The measurement period.
- *Allowable gap:* No more than one gap of ≤45 days during the measurement period. No gaps on the last day of the measurement period.

Ages: 18–75 years of age as of the last day of the measurement period.

Continuous enrollment
The measurement period.

Measurement period
Jan. 1 – Dec. 31

2026 NCQA HEDIS tech spec updates
This is the first year this measure is reported using ECDS and the measure will be in first year status for measurement year 2026.

Event/Diagnosis – Identify persons with a diagnosis of diabetes.
There are two ways to identify persons with diabetes: by claim/encounter data and by pharmacy data. The organization must use both methods to identify the initial population, but a person only needs to be identified by one method to be included in the measure. Persons may be identified as having diabetes during the measurement period or the year prior to the measurement period.
- Claim/encounter data. Persons who had at least two diagnoses of diabetes on different dates of service during the measurement period or the year prior to the measurement period. Do not include laboratory claims (with place of service code 81).
- Pharmacy data. Persons who were dispensed insulin or hypoglycemics/ antihyperglycemics during the measurement period or the year prior to the measurement period and have at least one diagnosis of diabetes (Diabetes Value Set) during the measurement period or the year prior to the measurement period. Do not include laboratory claims (with place of service code 81).

Supplemental data
No special requirements. NOTE: If a combination of administrative, supplemental or hybrid data are used, the most recent BP result must be used, regardless of data source.

Denominator
The initial population minus denominator exclusions.

Numerator
- The most recent BP reading taken during the measurement period.
- The person is numerator compliant if the BP is <140/90 mm Hg.
- The person is not compliant if the BP is ≥140/90 mm Hg, if there is no BP reading during the measurement period, or if the reading is incomplete (e.g., the systolic or diastolic level is missing).
- If 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.
- Do not include BPs taken in an acute inpatient setting or during 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, except for fasting blood tests.

Code[1]

3074F	Most recent systolic blood pressure less than 130 mm Hg
3075F	Most recent systolic blood pressure 130-139 mm Hg
3077F	Most recent systolic blood pressure greater than or equal to 140 mm Hg
3078F	Most recent diastolic blood pressure less than 80 mm Hg
3079F	Most recent diastolic blood pressure 80-89 mm Hg
3080F	Most recent diastolic blood pressure greater than or equal to 90 mm Hg

Denominator exclusions
- Persons who use hospice services or elect to use a hospice benefit any time during the measurement period
- Persons with a date of death during the measurement period.
- Persons receiving palliative care any time during the measurement period
- Persons who had an encounter for palliative care anytime during the measurement period
- Persons 66 years of age and older as of Dec. 31 of the measurement period (all product lines) with frailty and advanced illnesses (persons must meet both frailty and advanced illness criteria to be excluded).

Tips for patients
- High blood pressure is often called the “silent killer” because there are typically no warning signs or symptoms. The best way to know if you have high blood pressure is to visit your doctor and have your numbers checked on a regular basis.
- Limit salt intake
- Consider the DASH (Dietary Approach to Stop Hypertension) eating plan
- Maintain a healthy weight
- Increase your physical activity and exercise
- Quit smoking
- Limit your alcohol consumption
- Know your numbers – talk to your health care provider about your blood pressure and start tracking your numbers to help lower your risk for serious health conditions.

Tips for providers[7,8]

- Educate your patients that their blood pressure reading is made up of two numbers: The top number measures systolic pressure, the pressure when the heart beats while pumping blood. The bottom number measures diastolic pressure, the pressure when the heart is at rest between beats. Normal: Less than 120 mmHg/less than 80 mmHg Elevated: 120–129 mmHg/less than 80 mmHg Hypertension Stage One: 130–139 mmHg/80–89 mmHg Hypertension Stage Two: 140 mmHg/90 mmHg or higher.
- Having high blood pressure significantly increases your risk for serious health conditions, such as heart attack, stroke, heart failure and kidney disease. While some risk factors, including age and family history, cannot be controlled, there are things you can do to help.

Best practices:

- Document BP readings at every visit
- BP readings that are 140/90 or greater should be re-taken
- Schedule follow-up visits for blood pressure control after diagnosis or medication adjustment
- Consider referral to cardiologist for those whose BP goal cannot be attained, or for complicated patients
- Make sure the proper cuff size is used
- Ensure patients do not cross their legs and have their feet flat on the floor during the reading
- Make sure the elbow is at the same level as the heart
- Take it twice: if the patient has high blood pressure reading at the beginning of the visit, retake and record it at the end of the visit and consider switching arms for subsequent readings
- Educate patients about the risks of uncontrolled blood pressure
- Reinforce the importance of medication adherence and encourage patients to report side effects.

Table 3: Diabetes Medications[2]			
Description	**Prescription**		
Alpha-glucosidase inhibitors	• Acarbase • Miglitol		
Amylin analogs	• Pramlintide		
Antidiabetic combinations	• Alogliptin-metformin • Alogliptin-pioglitazone • Canagliflozin-metformin • Dapagliflozin-metformin • Dapagliflozin-saxagliptin • Empagliflozin-linagliptin • Empagliflozin-linagliptin-metformin	• Empagliflozi-metformin • Ertugliflozin-metformin • Ertugliflozin-sitagliptin • Glimepiride-pioglitazone • Glipizide-metformin • Glyburide-metformin • Linagliptin-metformin	• Metformin-pioglitazone • Metformin-rosiglitazone • Metformin-saxagliptin • Metformin-sitagliptin
Insulin	• Insulin aspart • Insulin degludec • Insulin glargine • Insulin isophane-insulin regular • Insulin regular human	• Insulin glulisine • Insulin degludec-liraglutide • Insulin glargine-lixisenatide • Insulin lispro • Insulin human inhaled	• Insulin aspart-inslin aspart protamine • Insulin detemir • Insulin isophane human • Insulin lispro-insulin lispro protamine
Meglitinides	• Nateglinide	• Repaglinide	
Biguanides	• Metformin		
Glucagon-like peptide-1 (GLP1) agonists	• Albiglutide • Liraglutide • Tirzepatide	• Dulaglutide • Lixisenatide	• Exenatide • Semaglutide
Sodium glucose cotransporter 2 (SGLT2) inhibitor	• Canagliflozin • Ertugliflozn	• Dapagliflozin	• Empagliflozin
Sulfonylureas	• Chlorpropamide • Glyburide	• Glimepiride • Tolazamide	• Glipizide • Tolbutamide
Thiazolidinediones	• Pioglitazone	• Rosiglitazone	
Dipeptidyl peptidase-4 (DDP-4) inhibitors	• Alogliptin • Sitagliptin	• Linagliptin	• Saxagliptin

Cervical Cancer Screening (CCS-E)

Quality Base Reimbursement Program (QBRP)
Alternative Payment Method (APM)

Description

The percentage of persons 21–64 years of age who were recommended for routine cervical cancer screening who were screened for cervical cancer using any of the following criteria:

- Persons 21–64 years of age who were recommended for routine cervical cancer screening and had cervical cytology performed within the last 3 years.
- Persons 30–64 years of age who were recommended for routine cervical cancer screening and had cervical high-risk human papillomavirus (hrHPV) testing performed within the last 5 years.
- Persons 30–64 years of age who were recommended for routine cervical cancer screening and had cervical cytology/high-risk human papillomavirus (hrHPV) cotesting within the last 5 years

Why it matters

Cervical cancer is a disease in which cells in the cervix (the lower, narrow end of the uterus) grow out of control. Cervical cancer was one of the most common causes of cancer death for American women. Effective screening and early detection of cervical pre-cancers have led to a significant reduction in this death rate.

Calculation

Numerator divided by denominator

Initial population

Measure item count: Person.
Attribution basis: Enrollment.

- *Benefits:* Medical – Person must have Blue Cross and Blue Shield medical and pharmacy.
- *Continuous enrollment:*

Commercial: The measurement period and the 730 days prior to the measurement period.
Medicaid: The measurement period.

- *Allowable gap:* No more than one gap of ≤45 days each year of continuous enrollment. No gaps on the last day of the measurement period.
- *Ages:* 24–64 years of age as of the last day of the measurement period.

Include persons recommended for routine cervical cancer screening with any of the following criteria:

- Administrative Gender of Female (Administrative Gender code female) at any time in the person's history.
- Sex Assigned at Birth (LOINC code 76689-9) of Female (LOINC code LA3-6) at any time in the person's history.
- Sex Parameter for Clinical Use of Female (Sex Parameter for Clinical Use code female-typical) during the measurement period.

Continuous enrollment

- The person was enrolled with a medical benefit throughout the measurement period and the two years prior to the measurement period.
- No more than one gap in enrollment of up to 45 days during each year of continuous enrollment.
- The person must be enrolled on the last day of the measurement period.

Measurement period

Jan. 1 – Dec. 31

2026 NCQA HEDIS tech spec updates

- Updated the race and ethnicity stratification categories to align with OMB SPD 15 2024.
- Removed the definitions of “participation” and “participation period.”
- Removed the SSoR data elements from the data element tables.
- Added instructions on allowable adjustments to the race and ethnicity stratifications.

Event/Diagnosis

None defined

Supplemental data

No special requirements. NOTE: Remember to code history of hysterectomy as appropriate at least once per calendar year.

Denominator

The initial population minus denominator exclusions.

Numerator

The number of women recommended and screened for cervical cancer and meet the following criteria:

- Women 24–64 years of age as of Dec. 31 of the measurement period who had cervical cytology during the measurement period or the two years prior to the measurement period.
- Women 30–64 years of age as of Dec. 31 of the measurement period who had cervical high-risk human papillomavirus (hrHPV) testing during the measurement period or the four years prior to the measurement period and who were 30 years or older on the date of the test.
- Note: Evidence of hrHPV testing within the last five years also captures patients who had cotesting; therefore, additional methods to identify cotesting are not necessary.

Denominator exclusions

- Persons who use hospice services (Hospice Encounter Value Set; Hospice Intervention Value Set) or elect to use a hospice benefit any time during the measurement period. Organizations that use the Monthly Membership Detail Data File to identify these persons must use only the run date of the file to determine if the person elected to use a hospice benefit during the measurement period.
- Persons with a date of death during the measurement period.
- Hysterectomy with no residual cervix (Hysterectomy with No Residual Cervix Value Set) any time during the person's history through Dec. 31 of the measurement period.
- Cervical agenesis or acquired absence of cervix (Absence of Cervix Diagnosis Value Set) any time during the person’s history through the end of the measurement period. Do not include laboratory claims (with place of service code 81).
- Persons receiving palliative care (Palliative Care Assessment Value Set; Palliative Care Encounter Value Set; Palliative Care Intervention Value Set) any time during the measurement period.
- Persons who had an encounter for palliative care (ICD-10-CM code Z51.5) any time during the measurement period. Do not include laboratory claims (with place of service code 81).
- Persons with Sex Assigned at Birth (LOINC code 76689-9) of Male (LOINC code LA2-8) at any time during the patient’s history.

Tips for patients

- The goal of screening for cervical cancer is to find precancerous cervical cell changes, when treatment can prevent cervical cancer from developing. Sometimes, cancer is found during cervical screening. Cervical cancer found at an early stage is usually easier to treat. By the time symptoms appear, cervical cancer may have begun to spread, making treatment more difficult.
- Cervical cancer screening is often covered by insurance, especially for individuals over the age of 21. Check with your insurance provider to verify coverage and find out which tests are included.
- The HPV test and Pap test: What they check:

    - The HPV test looks for a virus that can change cervical cells.
    - The Pap test checks for early cell changes in the cervix that might turn into cancer.
    - Both tests happen at your provider's office. The doctor or nurse uses a tool to collect a few cells, which are sent to a lab for a closer look.
- When to get checked
    - Ages 21 to 29: Start Pap tests at 21. If everything looks good, you can wait three years for the next test.
    - Ages 30 to 65: You have choices—Pap test only or Pap test with HPV test. If the results are normal for Pap test only, wait three years for the next test. If Pap test with HPV are normal, wait five years for the next test.
    - Ages over 65: You might not need screening if certain conditions are met.
- Getting ready for your Test
    - HPV test: No special preparation needed.
    - Pap test: Avoid intercourse, douching, or using vaginal medicines for two days before the test. Don't worry if you have your period.

Tips for providers

- Offer cervical cancer screening in the office if possible or support scheduling with accessible in-network provider during patient visits and have easily accessible referrals or standing orders.
- Provide cervical cancer screening reminder at the time of appointment scheduling so the patient is aware and prepared for the exam during the visit.
- Offer support to patients that are fearful of the exam and be mindful of barriers related to trauma history.
- Document and code if person has had a hysterectomy with no residual cervix or absence of cervix.
- Help persons schedule their routine cervical cancer screening. Document the date and the specific procedure completed when reviewing the patient's history.
- Submit the applicable codes.

Colorectal Cancer Screening (COL-E)

Quality Base Reimbursement Program (QBRP)
Alternative Payment Method (APM)
Medicare Advantage (MA)

Description
The percentage of persons 45–75 years of age who had appropriate screening for colorectal

Why it matters
Treatment for colorectal cancer in its earliest stage can lead to a 90 percent survival rate after five years. However, more than one third of adults ages 50–75 do not get recommended screenings. Colorectal cancer screening of asymptomatic adults in that age group can catch polyps before they become cancerous or detect colorectal cancer in its early stages, when treatment is most effective.

Calculation
Numerator divided by denominator

Initial population
Measure item count: Person
Attribution basis: Enrollment
- *Benefits*: Medical – Person must have Blue Cross and Blue Shield of Kansas medical and pharmacy.
- *Continuous enrollment*: The measurement period and the year prior to the measurement period.
- *Allowable gap*: No more than one gap of < days during each year of the continuous enrollment period. No gaps on the last day of the measurement period.

Ages: 46-75 years of age as of the last day of the measurement period.
Event: None.

Continuous enrollment
- The person was enrolled with a medical benefit throughout the measurement period and the two years prior to the measurement period.
- No more than one gap in enrollment of up to 45 days during each year of continuous enrollment.
- The person must be enrolled on the last day of the measurement period.

Measurement period
Jan. 1 – Dec. 31

2026 NCQA HEDIS tech spec updates
- Updated the race and ethnicity stratification categories to align with OMB SPD 15 2024.
- Removed the definitions of “participation” and “participation period.”
- Removed the SSoR data elements from the data elements tables.
- Added instructions on allowable adjustments to the race and ethnicity and SES stratifications.

Supplemental data
No special requirements.

Denominator
The initial population minus denominator exclusions.

Numerator
Persons with one or more screenings for colorectal cancer. Any of the following met criteria:

- Fecal occult blood test during the measurement period. For administrative data, assume the required number of samples were returned, regardless of FOBT type.
- Stool DNA (sDNA) with FIT test (sDNA FIT Lab Test Value Set; SNOMEDCT code 708699002) during the measurement period or the 2 years prior to the measurement period.
- Flexible Sigmoidoscopy (Flexible Sigmoidoscopy Value Set; SNOMEDCT code 841000119107) during the measurement period or the 4 years prior to the measurement period.
- CT colonography (CT Colonography Value Set) during the measurement period or the 4 years prior to the measurement period.
- Colonoscopy (Colonoscopy Value Set; SNOMEDCT code 851000119109) during the measurement period or the 9 years prior to the measurement period.

Denominator exclusions

- Persons in hospice or using hospice services anytime during the measurement period.
- Persons with a date of death during the measurement period.
- Persons who had colorectal cancer any time during the person's history through Dec.31 of the measurement period. Do not include laboratory claims (with place of service code 81)
- Persons who had a total colectomy any time during the person's history through Dec.31 of the measurement period.
- Persons 66 years of age and older by the end of the measurement period, with frailty and advanced illness. Persons must meet both frailty and advanced illness criteria to be excluded:
- Persons 66 years of age as of Dec. 31 of the measurement period with criteria of frailty and advanced illness. Person must meet BOTH frailty and advanced illness criteria to be excluded. Frailty: At least two indications and two different dates of service during the measurement period and Advanced Illness: Either of the following during the measurement period or the year prior to the measurement period. Advanced illness on at least two different dates of service (not including laboratory claims place of service 81) or dispensed dementia medication of the measurement period.
- Persons receiving palliative care or palliative encounter (ICD-10- CM Code Z51.50) anytime during the measurement period. Do not include laboratory claims (with place of service code 81).

Tips for patients

- The American Cancer Society recommends that people with an average risk of colorectal cancer start regular screenings at age 45.
- People with high or increased risk of colorectal cancer include:
    - Individuals with family history of colorectal cancer or certain types of polyps.
    - A personal history of colorectal cancer or certain types of polyps.
    - Personal history of inflammatory bowel disease (ulcerative colitis or Crohn's disease).
    - A personal history of radiation to the abdomen (belly) or pelvic area to treat a prior cancer.
- There are different screening methods for persons that cannot tolerate a colonoscopy.

Tips for providers

- For patients who refuse a colonoscopy, discuss options of noninvasive screenings and have FIT kits readily available to give patients during the visit.
- If telehealth, telephone or e-visits are used instead of face-to-face visits, ask the patient if he or she would be willing to complete an in-home FIT-DNA test.
- Educate patients about the importance of early detection:
- Colorectal cancer usually starts as growths in the colon or rectum and does not typically cause noticeable symptoms.
- You can prevent colorectal cancer by removing growths before they turn into cancer.
- Discuss the benefits and risks of different screening options and make a plan that offers the best health outcomes for your patient.

Appropriate Testing for Pharyngitis (CWP)

Quality Base Reimbursement Program (QBRP)
Alternative Payment Method (APM)

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

Why it matters
Pharyngitis, or sore throat, is a leading cause of outpatient care and can be caused by a viral or bacterial infection. Viral pharyngitis does not require antibiotic treatment, but antibiotics continue to be inappropriately prescribed. Proper testing and treatment of pharyngitis prevents the spread of sickness, while reducing unnecessary use of antibiotics. The misuse of antibiotics can have adverse clinical outcomes such as Clostridioides difficile infections and has public health implications including encouragement of antibiotic resistance (when antibiotics can no longer cure bacterial infections). Antibiotic resistance is a major health concern in the United States, with 2.8 million antibiotic-resistant infections and 35,000 deaths occurring annually.

Calculation
Numerator divided by denominator

Initial population
Measure item count: Episode.
Attribution basis: Enrollment.
- *Benefits:* Person must have Blue Cross and Blue Shield of Kansas medical and pharmacy
- *Continuous enrollment*: 30 days prior to the episode date through 3 days after the episode date (34 total days).
- *Allowable gap*: None.

Ages: 3 years of age or older as of the episode date.
Event: Episodes of pharyngitis diagnosis where an antibiotic was dispensed.

Continuous enrollment
30 days prior to the episode date through three days after the episode date (34 total days).

Measurement period
Jan. 1 -Dec. 31

2026 NCQA HEDIS tech spec updates
No changes to this measure

Event/Diagnosis - Episodes of pharyngitis diagnosis where an antibiotic was dispensed.
- Identify all persons who had an outpatient visit, ED visit, telephone visit, e-visit or virtual check-in (Outpatient, ED and Telehealth Value Set) during the intake period, with a diagnosis of pharyngitis (Pharyngitis Value Set).
- Determine all pharyngitis episode dates. For each person identified in step 1, determine all outpatient, telephone or ED visits, e-visits and virtual check-ins with a diagnosis of pharyngitis. Exclude visits that result in an inpatient stay (Inpatient Stay Value Set).

- 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. Remove episode dates if the person did not receive antibiotics on or up to three days after the episode date.
- Test for negative comorbid condition history. Remove episode dates where the person had a claim/encounter with any diagnosis for a comorbid condition (Comorbid Conditions Value Set) during the 365 days prior to or on the episode date (366 days total). Do not include laboratory claims (with place of service code 81).
- Test for negative medication history. Remove episode dates where a new or refill prescription for an antibiotic medication (Table 4: Antibiotic Medications List) was dispensed 30 days prior to the episode date or was active on the episode date.
- Test for negative competing diagnosis. Remove episode dates where the person had a claim/encounter with a competing diagnosis (Competing Diagnosis Value Set) on or three days after the episode date. Do not include laboratory claims (with place of service code 81).
- Calculate continuous enrollment. The person must be continuously enrolled without a gap in coverage from 30 days prior to the episode date through three days after the episode date (34 total days).
- Deduplicate eligible episodes. If a person has more than one eligible episode in a 31-day period, include only the first eligible episode.
- For example, if a person has an eligible episode on Jan.1, include the Jan.1 visit and does not include eligible episodes that occur on or between Jan. 2nd - Jan.31; then, if applicable, include the next eligible episode that occurs on or after Feb1. Identify visits chronologically including only one per 31-day period.

Supplemental data

Supplemental data may be used to identify initial population, denominator, exclusion and numerator events.

Denominator

The initial population minus denominator exclusions.

Numerator

- A Group A streptococcus test in the seven-day period from three days prior to the Episode Date through three days after the Episode Date.
- Index Episode Start Date. The earliest Episode Date during the Intake Period that meets all the following criteria:
- Linked to a dispensed (Table 4: antibiotic prescription) on or during the three days after the Episode Date.
- A 30-day Negative Medication History prior to the Episode Date.
- The person was continuously enrolled without a gap in coverage during the 30 days prior to the Episode Date through three days after the Episode Date.
- This measure is reported as four rates:
    - 3-17 years
    - 18-64 years
    - 65 years and older
    - Total

Denominator exclusions

- Persons in hospice or using hospice services anytime during the measurement period.
- Persons with a date of death during the measurement period.

Tips for patients

- Chest colds typically improve after a week to ten days.
- Speed up recovery by: staying hydrated, getting plenty of sleep, and keeping a humidifier in your bedroom.

Tips for providers

Review the side effects of antibiotics:

- Nausea, upset stomach, diarrhea or loss of appetite.

- Kills helpful bacteria in your body.
- Creates antibiotic-resistant bacteria such as MRSA, a type of flesh-eating bacteria.
- May increase the risk of serious diseases (e.g., autoimmune disorder)
- Avoid cigarette smoke.
- Suggest over-the-counter treatments to help alleviate some symptoms:
    - Cough suppressants (dextromethorphan)
    - Consider adding OTC analgesics (acetaminophen, ibuprofen)
- Additional non-pharmacologic measures specific to symptomatic relief of sore throat would include
    - Sipping cold or warm beverages
    - Eating cold or frozen desserts or ice
    - Gargling with warm salt water
    - Sucking on hard candy

Definitions

Intake period: July 1 of the year (2024) prior to the measurement period to June 30 of the measurement period (2025). The intake period captures eligible episodes of treatment.

Episode date: The date of service for any outpatient, telephone or ED visit, e-visit, or virtual check-in during the intake period with a diagnosis of pharyngitis.

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

- A period of 30 days prior to the episode date when the person had no pharmacy claims for either new or refill prescriptions for a listed antibiotic drug
- No prescriptions dispensed more than 30 days prior to the episode date that are active on the episode date.
- A prescription is considered active if the “days supply” indicated on the date when the person was dispensed the prescription is the number of days or more between that date and the relevant service date. The 30 day look back period for pharmacy data includes the 30 days prior to the intake period.

Exclude negative comorbid condition history: A period of 365 days prior to and including the episode date when the person had no claims/encounters with any diagnosis for a comorbid condition (366 days total). Do not include laboratory claims (claims with place of service 81).

Exclude negative competing diagnosis: The episode date and three days following the episode date when the person had no claims/encounters with a competing diagnosis. Do not include laboratory claims (claims with place of service 81).

Table 4: Antibiotic Medications (CWP)[2]		
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	
Natural penicillin's	• Penicillin G benzathine • Penicillin G potassium	• Penicillin G sodium • Penicillin V potassium
Quinolones	• Ciprofloxacin • Levofloxacin	• Moxifloxacin • Ofloxacin
Second generation cephalosporins	• Cefaclor • Cefprozil	• Cefuroxime
Sulfonamides	• Sulfamethoxazole-trimethoprim	
Tetracyclines	• Doxycycline • Minocycline	• Tetracycline
Third generation cephalosporins	• Cefdinir • Cefixime • Cefpodoxime	• Ceftriaxone

Eye Exam for Patients with Diabetes (EED)

Quality Base Reimbursement Program (QBRP)
Alternative Payment Method (APM)
Medicare Advantage (MA)

Description
The percentage of persons 18–75 years of age with diabetes (types 1 and 2) who had a retinal or dilated eye exam by an eye care professional (optometrist or ophthalmologist).

Why it matters
Diabetes is a chronic condition marked by high blood sugar due to the body's inability to make or use insulin. Left unmanaged, diabetes can lead to serious health conditions, including vision loss and blindness. Diabetes is the leading cause of new cases of blindness among adults 18–64 years of age. Adults with diabetes should receive regular eye exams to help detect and manage visual complications. Regular eye exams are the best way to reduce the risk of blindness and maintain a healthy and productive life.

Calculation
Numerator divided by denominator

Initial population
Measure item count: Person.
Attribution basis: Enrollment.
- *Benefits:* Medical – Person must have Blue Cross and Blue Shield of Kansas medical and pharmacy.
- *Continuous enrollment:* The measurement period.
- *Allowable gap:* No more than one gap of ≤45 days during the measurement period. No gaps on the last day of the measurement period.

Ages: 18–75 years of age as of the last day of the measurement period.

Continuous enrollment
The measurement period.

Measurement period
Jan. 1 – Dec. 31

2026 NCQA HEDIS tech spec updates
- Updated the race and ethnicity stratification categories to align with OMB SPD 15 2024.
- Added instructions on allowable adjustments to the race and ethnicity and SES stratification.

Event/Diagnosis – Identify persons with a diagnosis of diabetes.
Persons with diabetes can be identified by claim/encounter data and/or pharmacy data. The organization must use both methods to identify the initial population, but a person only needs to be identified by one method to be included in the measure. Persons may be identified as having diabetes during the measurement period or the year prior to the measurement period.
- Claim/encounter data – Persons who had at least two diagnoses of diabetes on different dates of service during the measurement period or the year prior to the measurement period (count services that occur over both years). Do not include laboratory claims (with place of service code 81).
- Pharmacy data – Persons who were dispensed insulin or hypoglycemics/antihyperglycemics during the measurement period or the year prior to the measurement period and have at least one diagnosis of diabetes during the measurement period or the year prior to the measurement period. Do not include laboratory claims (with place of service code 81).

Supplemental data
Supplemental data may be used to identify initial population, denominator, exclusion and numerator events.

Denominator
The initial population minus denominator exclusions.

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

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

Any of the following meet criteria:

- Any code in the Retinal Eye Exams Value Set billed by an eye care professional (optometrist or ophthalmologist) during the measurement period.
- Any code in the Retinal Eye Exams Value Set billed by an eye care professional (optometrist or ophthalmologist) during the year prior to the measurement period, with a diagnosis of diabetes without complications (Diabetes Mellitus Without Complications Value Set).
- Any code in the (Eye Exam with Evidence of Retinopathy Value Set) or (Eye Exam Without Evidence of Retinopathy Value Set) billed by any provider type during the measurement period.
- Do not include codes with a modifier (CPT CAT II Modifier Value Set).
- Retinal imaging with interpretation and reporting by a qualified reading center (Retinal Imaging Value Set) billed by any provider type during the measurement period.
- Autonomous eye exam billed by any provider type during the measurement period. Either of the following meets criteria:
- CPT code 92229.
- LOINC code 105914-6 with a result (Autonomous Eye Exam Result or Finding Value Set).
- Any code in the Eye Exam Without Evidence of Retinopathy Value Set billed by any provider type during the year prior to the measurement period. Do not include codes with a modifier (CPT CAT II Modifier Value Set).
- Diabetic retinal screening negative in prior year (CPT-CAT-II code 3072F) billed by any provider type during the measurement period. Do not include codes with a modifier (CPT CAT II Modifier Value Set).
- Any combination that indicates findings from a retinal exam for diabetic retinopathy performed in both the left and right eye by any provider, or a combination that indicates one eye is enucleated and the other was examined:

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

Denominator exclusions

- Exclude persons who meet any of the following criteria:
- Bilateral eye enucleation any time during the person's history through Dec. 31 of the measurement period.
- Unilateral eye enucleation with a bilateral modifier (CPT Modifier code 50).
- Two unilateral eye enucleations with service dates 14 days or more apart. For example, if the service date for the first unilateral eye enucleation was Feb.1 of the measurement period, the service date for the second unilateral eye enucleation must be on or after Feb.15.

- Left unilateral eye enucleation (ICD-10-PCS code 08T1XZZ) and right unilateral eye enucleation (ICD-10-PCS code 08T0XZZ) on the same or different dates of service.
- A unilateral eye enucleation and a left unilateral eye enucleation (ICD-10-PCS code 08T1XZZ) with service dates 14 days or more apart.
- A unilateral eye enucleation and a right unilateral eye enucleation (ICD-10-PCS code 08T0XZZ) with service dates 14 days or more apart.
- Persons who use hospice services or elect to use a hospice benefit any time during the measurement period. Organizations that use the Monthly Personship Detail Data File to identify these persons must use only the run date of the file to determine if the person elected to use a hospice benefit during the measurement period.
- Persons with a date of death during the measurement period.
- Persons receiving palliative care any time during the measurement period. Persons who had an encounter for palliative care (ICD-10- CM Code Z51.50) anytime during the measurement period.
- Do not include laboratory claims (claims with place of service 81).
- Persons 66 years of age as of Dec. 31 of the measurement period with criteria of frailty and advanced illness. Person must meet BOTH frailty and advanced illness criteria to be excluded. Frailty: At least two indications and two different dates of service during the measurement period and Advanced Illness: Either of the following during the measurement period or the year prior to the measurement period. Advanced illness on at least two different dates of service (not including laboratory claims place of service 81) or dispensed dementia medication of the measurement period.
- Bilateral absence of eyes (SNOMED CT code 15665641000119103) any time during the person's history through Dec.31 of the measurement period.
- 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.

Tips for patients

- Diabetes can cause damage to the blood vessels in the eyes, leading to diabetic retinopathy. Early detection through regular eye exams can prevent vision loss and other complications.
- Diabetic retinopathy is one of the leading causes of blindness in adults, but it is treatable if detected early. Eye exams help to monitor any changes and guide appropriate treatment to preserve vision.
- The American Diabetes Association recommends that all people with diabetes have a comprehensive eye exam at least once a year, even if they don't have symptoms. This is critical for detecting diabetic retinopathy and other eye conditions early.
- Uncontrolled blood sugar levels can increase your risk for diabetic retinopathy and other eye conditions. Keeping your blood sugar within the target range is crucial to prevent or slow the progression of eye problems.
- If you experience symptoms such as blurry vision, floaters, or dark spots, report them to your health care provider immediately. These could be signs of diabetic retinopathy or other diabetic eye diseases. Also look for eye pain, redness, or sudden changes in vision. These should be addressed promptly, as they may indicate serious complications.

Tips for providers

- Refer patients to an optometrist or ophthalmologist for a dilated retinal eye exam annually and explain why this is different than a screening for glasses or contacts.
- Educate patients about the importance of routine screening and medication compliance.
- Review diabetic services needed at each office visit
- Hypertensive retinopathy is handled the same as diabetic retinopathy when reporting this measure.
- Routine eye exams for glasses, glaucoma or cataracts do not count. Must be a retinal/dilated exam.

Emergency Department Utilization (EDU)

Alternative Payment Method (APM)

Description
Assesses emergency department (ED) utilization among health plan persons (18 and older) through an observed-to-expected ratio. Plans report observed rates of ED use and a predicted rate of ED use based on the health of the person population and factors.

Why it matters
ED visits are a high-intensity service and a cost burden on the health care system, as well as on patients. Some ED events may be attributed to preventable or treatable conditions. A high rate of ED utilization may indicate poor care management, inadequate access to care or poor patient choices, resulting in ED visits that could be prevented.[1,2] Plans can ensure that persons receive appropriate, coordinated primary care to address preventable ED visits.

Observed events: Count all ED visits during the measurement period for non-outlier persons, excluding them if they result in an inpatient stay/observation or have a principal diagnosis of mental health or chemical dependency, psychiatry encounter, or electroconvulsive therapy.
Expected events: For each of those non-outlier persons in the initial population, identify the HCC category, age and gender to which they belong. With this information there are two calculations made using risk weights associated with the HCC and age-gender categories: Predicted Probability of a Visit (PPV) and Predicted Unconditional Count of Visits (PUCV). NCQA® defines the risk weights. The final Expected Events calculation is derived from multiplying these two numbers together. An observed/expected (O/E) ratio also will be calculated.

Observed visits per 1,000 nonoutlier persons: The number of observed ED visits divided by the number of non-outlier persons in the initial population, multiplied by 1,000 for each age and gender group and totals. Calculated by IDSS as the Observed Rate.
Expected visits per 1,000 nonoutlier persons: The number of expected ED visits divided by the number of non-outlier persons in the initial population, multiplied by 1,000 for each age and gender group and totals. Calculated by IDSS as the Expected Rate.
O/E Ratio: The number of observed events among non-outlier persons divided by the number of expected events among non-outlier persons for each age and gender group and totals. Calculated by IDSS as the OE.

Initial population
Measure item count: Person.
Attribution basis: Enrollment.

- *Benefits:* Medical – Persons must have Blue Cross and Blue Shield medical and pharmacy.
- *Continuous enrollment:* The measurement period and the year prior to the measurement period.
- *Allowable gap:* No more than one gap of ≤45 days during each year of continuous enrollment. No gaps on the last day of the measurement period.
- *Ages:* 18 years of age and older as of the last day of the measurement period.

Gender/sex criteria:
Administrative Gender of Female (AdministrativeGender code female).
Administrative Gender of Male (AdministrativeGender code male).

Continuous enrollment
The measurement period and the year prior to the measurement period.
Measurement Period
Jan. 1 – Dec. 31

2026 NCQA HEDIS tech spec updates

- Integrated the Risk Adjustment General Guidelines into the *Guidance* section.
- Removed the definition of "classification period" and put the time frame in the r*isk adjustment comorbidity category determination* section.
- Added administrative gender codes to the initial population.

Event/Diagnosis – Episodes for persons in hospice or using hospice services.

- An acute inpatient discharge with a principal diagnosis of mental illness or intentional self-harm on the discharge claim on or between Jan. 1 and Dec. 31 of the measurement period.
- To identify acute inpatient discharges, identify all acute and nonacute inpatient stays, exclude nonacute inpatient stays, then identify the discharge date for the stay.
- The denominator for this measure is based on discharges, not persons. If persons have more than one discharge, include all discharges on or between Jan. 1 and Dec. 31 of the
- measurement period.

Acute readmission or direct transfer

- Identify readmissions and direct transfers to an acute inpatient care setting during the 30-day follow-up period. Identify all acute and nonacute inpatient stays, exclude nonacute inpatient stays, identify the admission date for the stay, then identify the discharge date for the stay.
- Exclude both the initial discharge and the readmission/direct transfer discharge if the last discharge occurs after Dec. 1 of the measurement period.
- If the readmission/direct transfer to the acute inpatient care setting was for a principal diagnosis of mental health disorder or intentional self-harm, count only the last discharge.
- If the readmission/direct transfer to the acute inpatient care setting was for any other principal diagnosis, exclude both the original and the readmission/direct transfer discharge.

Nonacute readmission or direct transfer

- Exclude discharges followed by readmission or direct transfer to a nonacute inpatient care setting within the 30-day follow-up period, regardless of the principal diagnosis for readmission. These discharges are excluded from the measure because rehospitalization or direct transfer may prevent an outpatient follow-up visit from taking place.
- To identify readmissions and direct transfers to a nonacute inpatient care setting, identify all acute and nonacute inpatient stays, confirm the stay was for nonacute care based on the presence of a nonacute code on the claim, then identify the admission date for the stay.

Supplemental data

Supplemental data may not be used to identify initial population, denominator and numerator events.

Nonoutlier:

- Medicare persons 18–64 years of age with five or fewer ED visits during the measurement period.
- Medicare persons 65 years of age and older with three or fewer ED visits during the measurement period.
- Commercial persons 18 years of age and older with three or fewer ED visits during the measurement period.

Outlier:

- Medicare persons 18–64 years of age with six or more ED visits during the measurement period.
- Medicare persons 65 years of age and older with four or more ED visits during the measurement period.
- Commercial persons 18 years of age and older with four or more ED visits during the measurement period.

Tips for patients

- Preventive care is a core aspect of many HEDIS measures, including screenings, vaccinations, and health education. By understanding the importance of regular screenings (like mammograms, colorectal cancer screenings, and immunizations), you can take proactive steps to protect your health.
- Enroll in disease management programs: If you have a chronic condition (e.g., diabetes, hypertension), many health plans offer disease management programs that provide education and support. These programs can help you better understand your condition, improve your treatment adherence, and manage symptoms effectively.
- Take medications as prescribed: Make sure you understand how to take your medications, when to take them, and the potential side effects. If you have trouble with medications (e.g., affordability, side effects), discuss options with your provider.

- Ensure that you're up to date on vaccinations, such as the flu shot, pneumonia vaccine, and others based on your age and health status.
- Don't hesitate to speak up if you have concerns, if you don't understand something, or if you need more information. Being an active participant in your health care helps ensure you receive the best care.

Tips for providers

- Discuss the discharge summary with patients and ask if they understand the instructions and filled the new prescriptions.
- Complete a thorough medication reconciliation and ask patients and caregivers to recite their new medication regimen back to you.
- Develop an action plan for chronic conditions. The plan should include what symptoms would trigger the patient to:
    - Start as needed (PRN) medications.
    - Call their doctor during after-office hours.
    - Go to the emergency room.
- Have patients and caregivers repeat the care plan back to you to demonstrate understanding.
- Provide a written home management plan or after-visit summary the patient or caregiver can use to make notes during the visit and reference for their plan of care.
- Ask about barriers or issues that might have contributed to patients' hospitalization and discuss how to prevent them in the future.

Definition

PPV: Predicted probability of a visit. The predicted probability of a person having an ED visit in the measurement period.

PUCV: Predicted unconditional count of visits. The unconditional count of ED visits for persons during the measurement period.

Follow-Up Emergency Department Visit for Substances Use (FUA)

Potential new Quality Base Reimbursement Program (QBRP) Measure

Description
Assesses emergency department (ED) visits for persons 13 years of age and older with a principal diagnosis of substance use disorder (SUD) -- or any diagnosis of drug overdose -- who had a follow up visit for SUD.

- Rate 1: ED visits for which the person received follow-up within 30 days of the ED visit (31 total days).
- Rate 2: ED visits for which the person received follow-up within 7 days of the ED visit (8 total days).

Why it Matters
In 2022, 48.7 million Americans over 12 years of age (about 17.3% of the population) were classified as having a substance use disorder (SUD). Between 2018 and 2021, the use of ED services for substance use increased 39%, and the rate of ED visits related to substance use went up from 74.4 to 103.8 visits per 10,000 individuals. The ED plays a crucial role in helping individuals with substance use by providing immediate care and timely diagnosis and connecting individuals to further care. This measure focuses on making sure that people leaving the ED after a high-risk substance use event get coordinated care, because they might be at a higher risk of losing touch with the health care system.

Calculation
Numerator divided by denominator

Initial population
Measure item count: Episode.
Attribution basis: Enrollment.

- *Benefits:* Medical – Persons must have Blue Cross and Blue Shield medical and pharmacy and chemical dependency.
  Note: *A withdrawal management/detoxification-only chemical dependency benefit does not meet these criteria.*

Continuous enrollment: The date of the ED visit through 30 days after the ED visit (31 total days).

- *Allowable gap:* None.

Ages: 13 years of age or older as of the ED visit.

Continuous enrollment
The date of the Emergency Department visit through 30 days after the visit (31 total days).

Measurement period
Jan. 1 – Dec. 31

2026 NCQA HEDIS tech spec updates

- Updated the race and ethnicity stratification categories to align with OMB SPD 15 2024.
- Added instructions on allowable adjustments to the race and ethnicity stratification.

Event/Diagnosis – Emergency department visit for substance use.

- An ED visit (ED Value Set) with a principal diagnosis of SUD (AOD Abuse and Dependence Value Set) or any diagnosis of drug overdose (Unintentional Drug Overdose Value Set) on or between Jan. 1 and Dec. 31 of the measurement period, where the person was 13 years or older on the date of the visit.

- The denominator for this measure is based on ED visits, not on persons. If a person has more than one ED visit, identify all eligible ED visits between Jan. 1st and Dec. 31st of the measurement period and do not include more than one visit per 31-day period, as described below.
- Multiple Visits in a 31-day period: Only include the first eligible emergency department visit.
- ED visits followed by inpatient admission:
    - Exclude ED visits that result in an inpatient stay.
    - Exclude ED visits followed by an admission to an acute or nonacute inpatient care setting on the date of the ED visit or within the 30 days after the ED visit, regardless of the principal diagnosis for the admission.
- To identify admissions to an acute or nonacute inpatient care setting:
    - Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
    - Identify the admission date for the stay.
- ED visits followed by residential treatment: Exclude ED visits followed by residential treatment on the date of the ED visit or within the 30 days after the ED visit.
- Any of the following meets the criteria for residential treatment:
    - (Residential Behavioral Health Treatment Value Set).
    - Psychiatric Residential Treatment Center (place of service code 56).
    - Residential Substance Abuse Treatment Facility (place of service code 55).
    - (Residential Program Detoxification Value Set).
    - These events are excluded from the measure because admission to an acute or nonacute inpatient setting may prevent an outpatient follow-up visit from taking place.

Supplemental data
Supplemental data may be used to identify initial population, denominator, exclusion and numerator events.

Denominator
The initial population minus denominator exclusions.

Numerator
- Rate 1: 30-day follow-up: A follow-up visit or a pharmacotherapy dispensing event within 30 days after the ED visit (31 total days). Include visits and pharmacotherapy events that occur on the date of the ED visit.
- Rate 2: 7-day follow-up: A follow-up visit or a pharmacotherapy dispensing event within 7 days after the ED visit (8 total days). Include visits and pharmacotherapy events that occur on the date of the ED visit.

Denominator exclusions
Exclude persons who meet either of the following criteria:
- Persons who use hospice services (Hospice Encounter Value Set; Hospice Intervention Value Set) or elect to use a hospice benefit any time during the measurement period. Organizations that use the Monthly Membership Detail Data File to identify these persons must use only the run date of the file to determine if the person elected to use a hospice benefit during the measurement period.
- Persons with a date of death any time during the measurement period.

Tips for patients
- Timely follow-up after hospitalization can reduce the duration of disability and, for certain conditions, the likelihood of rehospitalization. It is important to provide regular follow-up therapy to patients after they have been hospitalized for mental illness. An outpatient visit with a mental health practitioner is necessary to ensure that the patient's transition to the home and work environment is supported and that gains made during hospitalization are not lost. A follow-up visit also helps health care providers detect early post-hospitalization reactions or medication problems and demonstrates continuing care.

- Hospitalization for a mental illness stabilizes the patient. This is a crucial element of care because it quickly transitions a patient from an unhealthy, potentially dangerous state to one that is more manageable. It takes away much of the risk that the individual will harm himself or someone else.
- While this crisis stabilization is important, it's only the beginning of care. A follow-up after hospitalization for mental illness and ongoing treatment is essential for several reasons:
    - Follow-up care helps patients maintain stable functioning
    - Gains made during inpatient care are more likely to be kept with follow-up treatment
    - Ongoing treatments and follow-up care reduce and delay hospitalizations in the future
    - Failure to seek follow up care can worsen psychiatric symptoms
    - Not receiving ongoing care can also increase the risk of related negative outcomes, like substance abuse, homelessness, violence, and suicide.

Tips for providers

- Schedule follow up appointments prior to discharge and include the date and time on discharge instructions.
- Offer virtual, telehealth, and phone visits.
- Reach out proactively to assist in (re)scheduling appointments within the required timeframes.
- Reach out within 24 hours if the patient does not keep scheduled appointment to schedule another appointment.
- Partner with the health plan to address social determinants, health equity, and quality of care.
- Maintain appointment availability in your practice for patients and schedule follow-up appointments before the patient leaves the office.
- Discuss the benefits of seeing a primary or specialty provider.
- Discuss appropriate ED utilization.
- Offer mutual help options like case management, peer recovery support, harm reduction, 12-step fellowships (AA, NA, etc.), or other community support groups.

Follow-Up after Hospitalization for Mental Illness (FUH)

Quality Base Reimbursement Program (QBRP)

Description
The percentage of discharges for persons 6 years of age and older 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:

- Rate 1: The percentage of discharges for which the person received follow-up within 30 days after discharge.
- Rate 2: The percentage of discharges for which the person received follow-up within 7 days after discharge.

Why it matters
In 2019, nearly one in five adults aged 18 and older in the U.S. had a diagnosed mental health disorder. Despite this, individuals hospitalized for mental health disorders often do not receive adequate follow-up care. Providing follow-up care to patients after psychiatric hospitalization can improve patient outcomes, decrease the likelihood of re-hospitalization and the overall cost of outpatient care.

Calculation
Numerator divided by denominator

Initial population
Measure item count: Episode.
Attribution basis: Enrollment.

- Benefits: Medical – Person must have Blue Cross and Blue Shield of Kansas medical, pharmacy and mental health (inpatient and outpatient).
- Continuous enrollment: Date of discharge through 30 days after discharge.
- Allowable gap: None.

Ages: 6 years of age and older as of the date of discharge.

Continuous enrollment
Date of discharge through 30 days after discharge.

Measurement period
Jan. 1 -Dec. 31

2026 NCQA HEDIS tech spec updates

- Updated the race and ethnicity stratification categories to align with OMB SPD 15 2024.
- Added instructions on allowable adjustments to the race and ethnicity stratification.

Event/Diagnosis – Hospitalization for mental illness

- An acute inpatient discharge with a principal diagnosis of mental illness or intentional self-harm on the discharge claim on or between Jan. 1 and Dec. 31 of the measurement period.
- To identify acute inpatient discharges, identify all acute and nonacute inpatient stays, exclude nonacute inpatient stays, then identify the discharge date for the stay.
- The denominator for this measure is based on discharges, not persons. If persons have more than one discharge, include all discharges on or between Jan. 1 and Dec. 31 of the measurement period.

Acute readmission or direct transfer

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

- Identify all acute and nonacute inpatient stays.
- Exclude nonacute inpatient stays.
- Identify the admission date for the stay (the admission date must occur during the 30-day follow-up period).
- Identify the discharge date for the stay.
- Exclude both the initial discharge and the readmission/direct transfer discharge if the last discharge occurs after Dec.1 of the measurement period.
- If the readmission/direct transfer to the acute inpatient care setting was for a principal diagnosis of mental health disorder, or any diagnosis of intentional self-harm (Mental Health Diagnosis Value Set; Intentional Self Harm Value Set), count only the last discharge (Use only the discharge claim).
- If the readmission/direct transfer to the acute inpatient care setting was for any other principal diagnosis -- and intentional self-harm was not on the claim in any diagnosis position -- exclude both the original and the readmission/direct transfer discharge (Use only the discharge claim).

Nonacute readmission or direct transfer

Exclude discharges followed by readmission or direct transfer to a nonacute inpatient care setting -- (except for psychiatric residential treatment) --within the 30-day follow-up period, regardless of the diagnosis for the readmission. To identify readmissions and direct transfers to a nonacute inpatient care setting:

- Identify all acute and nonacute inpatient stays except for residential psychiatric treatment (Inpatient Stay Except Psychiatric Residential Value Set).
- Confirm the stay was for nonacute care based on the presence of a nonacute code (Nonacute Inpatient Stay Value Set) on the claim.
- Identify the admission date for the stay.

These discharges are excluded from the measure because rehospitalization or direct transfer may prevent an outpatient follow-up visit from taking place.

Supplemental data

Supplemental data may be used to identify initial population, denominator, exclusion and numerator events.

Denominator

The initial population minus denominator exclusions.

Numerator

Persons with:

- Rate 1: 30-day follow-up: follow-up visits with a mental health provider within 30 days after discharge. Do not include visits that occur on the date of discharge.
- Rate 2: 7-day follow-up: follow-up visits with a mental health provider within 7 days after discharge. Do not include visits that occur on the date of discharge.

Denominator exclusions

- Persons in hospice or using hospice services anytime during the measurement period.
- Persons with a date of death during the measurement period.

Tips for patients

- Timely follow-up after hospitalization can reduce the duration of disability and, for certain conditions, the likelihood of rehospitalization. It is important to provide regular follow-up therapy to patients after they have been hospitalized for mental illness. An outpatient visit with a mental health practitioner is necessary to ensure that the patient's transition to the home and work environment is supported and that gains made during hospitalization are not lost. A follow-up visit also helps health care providers detect early post-hospitalization reactions or medication problems and demonstrates continuing care.
- Hospitalization for a mental illness stabilizes the patient. This is a crucial element of care because it quickly transitions a patient from an unhealthy, potentially dangerous state to one that is more manageable. It takes away much of the risk that the individual will harm himself or someone else.
- While this crisis stabilization is important, it's only the beginning of care. A follow-up after hospitalization for mental illness and ongoing treatment is essential for several reasons:
    - Follow-up care helps patients maintain stable functioning
    - Gains made during inpatient care are more likely to be kept with follow-up treatment
    - Ongoing treatments and follow-up care reduce and delay hospitalizations in the future
    - Failure to seek a follow up can worsen psychiatric symptoms
    - Not receiving ongoing care can also increase the risk of related negative outcomes, like substance abuse, homelessness, violence, and suicide.

Tips for providers

- Schedule follow up appointments prior to discharge and include the date and time on discharge instructions.
- Offer virtual, telehealth, and phone visits.
- Reach out proactively to assist in (re)scheduling appointments within the required timeframes.
- Reach out proactively within 24 hours if the patient does not keep scheduled appointment to schedule another appointment.
- Partner with the health plan to address social determinants, health equity, and quality care.
- Maintain appointment availability in your practice for patients and schedule follow-up appointments before the patient leaves the office.
- Discuss the benefits of seeing a primary or specialty provider.
- Discuss appropriate ED utilization.
- Offer mutual help options like case management, peer recovery support, harm reduction, 12-step fellowships (AA, NA, etc.), or other community support groups.

Follow-Up after Emergency Department Visit for Mental Illness (FUM)

Possible future measure for Quality-Based Reimbursement Method

Description
The percentage of emergency department (ED) visits for persons 6 years of age and older with a principal diagnosis of mental illness or intentional self-harm, who had a follow-up visit for mental illness. Two rates are reported:

- Rate 1: The percentage of ED visits for which the person received follow-up within 30 days of the ED visit (31 total days).
- Rate 2: The percentage of ED visits for which the person received follow-up within 7 days of the ED visit (8 total days).

Why it matters
Mental illness can affect people of all ages. In the United States, 18% of adults and 13%–20% of children under 18 years of age experience mental illness. Research suggests that follow-up care for people with mental illness is linked to fewer repeat ED visits, improved physical and mental function and increased compliance with follow-up instructions.

Calculation
Numerator divided by denominator

Initial population
Measure item count: Episode.
Attribution basis: Enrollment.

- Benefits: Medical – Person must have Blue Cross and Blue Shield medical, pharmacy and mental health.
- Continuous enrollment: Date of the ED visit through 30 days after the ED visit (31 total days).
- Allowable gap: None.

Ages: 6 years of age and older as of the ED visit.

Continuous enrollment
Date of the ED visit through 30 days after the ED visit (31 total days).

Measurement period
Jan. 1 – Dec. 31

2026 NCQA HEDIS tech spec updates

- Updated the race and ethnicity stratification categories to align with OMB SPD 15 2024.
- Added instructions on allowable adjustments to the race and ethnicity stratification.

Event/Diagnosis – Emergency department visit for mental illness.

- An ED visit with a principal diagnosis of mental illness or intentional self-harm on or between Jan. 1 and Dec. 1 of the measurement period where the person was 6 years or older on the date of the visit.
- The denominator for this measure is based on ED visits, not on persons.
- If a person has more than one ED visit, identify all eligible ED visits between Jan. 1 and Dec. 31 of the measurement period and do not include more than one visit per 31-day period as described below.

- If a person has more than one ED visit in a 31-day period, include only the first eligible ED visit. For example, if a person has an ED visit on Jan. 1, include the Jan. 1 visit and do not include ED visits that occur on or between Jan. 2 and Jan. 31, then--if applicable--include the next ED visit that occurs on or after February 1. Identify visits chronologically, including only one per 31-day period.

Supplemental data
Supplemental data may be used to identify initial population, denominator, exclusion and numerator events.

Denominator
The initial population minus denominator exclusions.

Numerator
- Rate 1: A follow-up visit with any practitioner, with a principal diagnosis of a mental health disorder or with a principal diagnosis of intentional self-harm and any diagnosis of a mental health disorder within 30 days after the ED visit (31 total days). Include visits that occur on the date of the ED visit.
- Rate 2: A follow-up visit with any practitioner, with a principal diagnosis of a mental health disorder or with a principal diagnosis of intentional self-harm and any diagnosis of a mental health disorder within 7 days after the ED visit (8 total days). Include visits that occur on the date of the ED visit.
- Note: Events that meet both initial population and numerator criteria should not be included in the numerator.

Denominator exclusions
- Exclude ED visits that result in an inpatient stay and ED visits followed by an admission to an acute or nonacute inpatient care setting on the date of the ED visit or within the 30 days after the ED visit, regardless of the principal diagnosis for the admission.
- To identify admissions to an acute or nonacute inpatient care setting:
    - Identify all acute and nonacute inpatient stays.
    - Identify the admission date for the stay.
- These events are excluded from the measure because admission to an acute or nonacute inpatient setting may prevent an outpatient follow-up visit from taking place.
- Persons in hospice or using hospice services anytime during the measurement period.
- Persons with a date of death during the measurement period.

Tips for patients
- Timely follow-up after hospitalization can reduce the duration of disability and, for certain conditions, the likelihood of rehospitalization. It is important to provide regular follow-up therapy to patients after they have been hospitalized for mental illness. An outpatient visit with a mental health practitioner is necessary to ensure that the patient's transition to the home and work environment is supported and that gains made during hospitalization are not lost. A follow-up visit also helps health care providers detect early post-hospitalization reactions or medication problems and demonstrates continuing care.
    - Hospitalization for a mental illness stabilizes the patient. This is a crucial element of care because it quickly transitions a patient from an unhealthy, potentially dangerous state to one that is more manageable. It takes away much of the risk that the individual will harm himself or someone else.
- While this crisis stabilization is important, it's only the beginning of care. A follow-up after hospitalization for mental illness and ongoing treatment is essential for several reasons:
- Follow-up care helps patients maintain stable functioning
- Gains made during inpatient care are more likely to be kept with follow-up treatment
- Ongoing treatments and follow-up care reduce and delay hospitalizations in the future
- Failure to seek a follow up can worsen psychiatric symptoms
- Not receiving ongoing care can also increase the risk of related negative outcomes, like substance use, homelessness, violence, and suicide.

Tips for providers

- Schedule follow up appointments prior to discharge and include the date and time on discharge instructions.
- Offer virtual, telehealth, and phone visits.
- Reach out proactively to assist in (re)scheduling appointments within the required timeframes.
- Reach out proactively within 24 hours if the patient does not keep scheduled appointment to schedule another appointment.
- Partner with the health plan to address social determinants, health equity, and quality care.
- Maintain appointment availability in your practice for patients and schedule follow-up appointments before the patient leaves the office.
- Discuss the benefits of seeing a primary or specialty provider.
- Discuss appropriate ED utilization.
- Offer mutual help options like case management, peer recovery support, harm reduction, 12-step fellowships (AA, NA, etc.), or other community support groups.

Definitions

Intake period: July 1 of the year prior to the measurement period to June 30 of the measurement period. The intake period captures eligible episodes of treatment. (Continuous enrollment --without a gap in coverage - 30 days prior to the episode date through three days after the episode date).

Episode date:

- The date of service for an eligible encounter during the intake period with a diagnosis of fracture.
- For an outpatient 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.

Use of Imaging Studies for Low Back Pain (LBP)

Quality Base Reimbursement Program (QBRP)
Alternative Payment Method (APM)

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

Why it matters
About 2.63 million ER visits in the U.S. each year are for low back pain-related disorders. Most Americans 75%–85% will have low back pain at some time in their lives. In any 3-month period, about 25% of Americans will face at least one day of back pain. Evidence shows that when there is no "red flag" (e.g., a broken bone, a serious disease), routine imaging (X-ray, MRI, CT scan) for low back pain does not always improve outcomes and could expose an individual to unneeded harms like radiation and unnecessary treatment. It is critical to reduce imaging when there are no red flags so treatments that are not effective, and that may result in extra costs, are kept to a minimum.

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

Initial population
Measure item count: Person.
Attribution basis: Enrollment.
- Benefits: Medical – Person must have Blue Cross and Blue Shield medical and pharmacy.
- Continuous enrollment: 180 days prior to the Index Episode Start Date (IESD) through 28 days after the IESD.
- Allowable gap: None.

Ages: 18–75 years of age as of the last day of measurement period.

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

Measurement Period
Jan.1 – Dec.31 of the measurement period. The intake period is used to identify the first eligible encounter with a principal diagnosis of low back pain.

2026 NCQA HEDIS tech spec updates
No changes to this measure.

Event/Diagnosis – Low back pain diagnosis.
- Identify persons with a principal diagnosis of uncomplicated low back pain (Uncomplicated Low Back Pain Value Set) during the intake period. Do not include inpatient stays (Inpatient Stay Value Set) or visits that result in an inpatient stay (Inpatient Stay Value Set). Do not include laboratory claims (with place of service code 81).
- Determine the IESD. For each person identified in step 1, determine the earliest episode of low back pain. If the person had more than one encounter, include only the first encounter.
- Test for negative diagnosis history. Remove persons with a diagnosis of uncomplicated low back pain (Uncomplicated Low Back Pain Value Set) during the 180 days prior to the IESD. Do not include laboratory claims (with place of service code 81).
- Calculate continuous enrollment. Persons must be continuously enrolled for 180 days prior to the IESD through 28 days after the IESD.

Supplemental data
Supplemental data may be used to identify initial population, denominator, exclusion and numerator events.

Denominator
The initial population minus denominator exclusions. Determine the earliest episode of low back pain. If the person had more than one encounter, include only the first encounter.

Numerator
An imaging study with a diagnosis of uncomplicated low back pain on the IESD or in the 28 days following the IESD.

Denominator exclusions
- Remove persons with a diagnosis of uncomplicated low back pain in a period of 180 days (six months) prior to the IESD. Do not include visits that result in an inpatient stay.
- Exclude any person who had a diagnosis for which imaging is clinically appropriate,- which includes any of the following met criteria:
- Cancer any time during the person's history through 28 days after the IESD. Any of the following criteria met:
    - Malignant Neoplasms
    - Other Neoplasms
    - History of Malignant Neoplasm
    - Other Malignant Neoplasm of Skin
- Trauma any time during the three months (90 days) prior to the IESD through 28 days after the IESD. Do not include laboratory claims (with place of service code 81).
- IV drug abuse any time during the 12 months (one year) prior to the IESD through 28 days after the IESD.
- Neurologic impairment any time during the 12 months (one year) prior to the IESD through 28 days after the IESD.
- HIV any time during the person's history through 28 days after the IESD.
- Spinal infection any time during the 12 months (one year) prior to the IESD through 28 days after the IESD.
- Major organ transplant or history of major organ transplant at any time in the person's history through 28 days after the IESD.
- Prolonged use of corticosteroids. 90 consecutive days of corticosteroid treatment any time during the 366-day period that begins 365 days prior to the IESD and ends on the IESD.
- Osteoporosis therapy or a dispensed prescription to treat osteoporosis any time during the person's history through 28 days after the IESD.
- Fragility fractures any time during the three months (90 days) prior to the IESD through 28 days after the IESD.
- Lumbar surgery any time during the person's history through 28 days after the IESD.
- Spondylopathy any time during the person's history through 28 days after the IESD.
- Persons receiving palliative care anytime during the measurement period.
- Persons had an encounter for palliative care (ICD-10- CM Code Z51.50) anytime during the measurement period. Do not include laboratory claims (claims with place of service 81).
- Persons in hospice or using hospice services anytime during the measurement period.
- Persons with a date of death during the measurement period.

Tips for patients (FEP BCBSA Lower Back Pain Remedies Quick Reference Guide)[12]
When to see a doctor. Talk to your doctor if you have back pain with any of the following symptoms:
- Weight loss that you cannot explain
- Fever over 102 degrees F
- Loss of control of your bowel or bladder
- A history of cancer
- Loss of feeling or strength and numbness or tingling sensation in your legs
- Problems with your reflexes

Tips for providers
Most back pain can be treated at home.

- Ice and heat: Ice for 20 minutes at a time, several times a day. After 48 hours, switch to the same interval with a heating pad.
- Take the recommended amount of an over-the-counter anti-inflammatory medicine, such as ibuprofen or naproxen.
- Physical therapy or a visit to a chiropractor can help relieve stiff muscles and treat lower back pain.
- Swap your shoes: Back pain often starts from the ground up, so make sure your shoes are the right fit.
- Get a new mattress if yours is eight years or older. Sagging springs could cause lower back pain.
- A healthy diet that includes nutrients like calcium, vitamin D, magnesium and iron can have a major impact on preventing back problems and improving recovery

Definitions

Intake period:
Jan. 1 – Dec. 31 of the measurement period. The intake period is used to identify the first eligible encounter with a principal diagnosis of low back pain.

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

Negative diagnosis history:
A period of 180 days prior to the IESD when the person had no claims/encounters with any diagnosis of low back pain.

Statin Therapy for Patients with Cardiovascular Disease (SPC-E)

Quality Base Reimbursement Program (QBRP)
Alternative Payment Method (APM)
Medicare Advantage (MA)

Description

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

- Rate 1: Received Statin therapy. Persons who were dispensed at least one high-intensity or moderate-intensity statin medication (Table 5) during the measurement period.
- Rate 2: Statin adherence 80%. Persons who remained on a high-intensity or moderate-intensity statin medication (Table 5) for at least 80% of the treatment period.

Why it Matters:

- Cardiovascular disease is the leading cause of death in the United States. It is estimated that 92.1 million American adults have one or more types of cardiovascular disease (Benjamin et al., 2017). People with diabetes also have elevated cardiovascular risk, thought to be due in part to elevations in unhealthy cholesterol levels. Having unhealthy cholesterol levels places people at significant risk for developing atherosclerotic cardiovascular disease (ASCVD).
- Statins are a class of drugs that lower blood cholesterol. American College of Cardiology and American Heart Association (ACC/AHA) guidelines state that statins of moderate or high intensity are recommended for adults with established clinical ASCVD. The American Diabetes Association and ACC/AHA guidelines also recommend statins for primary prevention of cardiovascular disease in patients with diabetes, based on age and other risk factors. Guidelines also state that adherence to statins will aid in ASCVD risk reduction in both populations.

Calculation:

- 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 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 Dec.31 of the measurement period.
- 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.

Initial population

Measure item count: Person.
Attribution basis: Enrollment.

- Benefits: Medical – Person must have Blue Cross and Blue Shield medical and pharmacy.
- Continuous enrollment: The measurement period and the year prior to the measurement period.
- Allowable gap: No more than one gap of ≤45 days during each year of continuous enrollment. No gaps on the last day of the measurement period.

Ages: 21–75 years of age as of the last day of the measurement period.

Continuous enrollment

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

Measurement period

Jan. 1 – Dec. 31

2026 NCQA HEDIS tech spec updates

- This is the first year the measure is reported using ECDS.
- Removed the Administrative Data Collection Method.
- Removed sex-specific age bands.
- Removed the requirement to use the same data source for rate 1 and rate 2.
- Updated the initial population criteria to identify persons with ASCVD diagnosis.
- Expanded ASCVD diagnosis criteria in the initial population to allow diagnosis in the measurement period or the year prior to the measurement period.
- Removed denominator exclusion for persons enrolled in an I-SNP or LTI.

Event/Diagnosis – Persons with clinical atherosclerotic cardiovascular disease

Eligible persons are identified by event or diagnosis. The organization must use BOTH methods to identify the initial population but one method to be included in the measure. Events include:

- Discharged from an inpatient setting with a myocardial infarction. (identify acute and nonacute inpatients stays and discharge dates).
- Persons that have had a CABG, PCI, or other revascularization procedure.
- Persons who have at least one encounter (outpatient visit, telephone visit, e-visit, virtual check-in, or acute inpatient encounter) with a diagnosis of IVD during both the measurement period and the year prior to it.
- At least one acute inpatient discharge with an IVD diagnosis is required on the discharge claim. Identify all acute and nonacute inpatient stays; exclude nonacute inpatient stays and identify the discharge dates for the stay.

Supplemental data

Supplemental data may be used to identify initial population, denominator, exclusion and numerator events.

Denominator

Denominator 1: Received statin therapy. The Initial population minus denominator exclusions.
Denominator 2: Statin adherence 80%. Persons who meet numerator 1 criteria.

Numerator

Numerator 1: Received statin therapy. The number of persons who had at least one dispensing event for a high-intensity or moderate-intensity statin medication during the measurement period.
Numerator 2: Statin adherence 80%. PDC of at least 80% during the treatment period.

Denominator exclusions

- Exclude persons from the initial population with a diagnosis of pregnancy, dispensed at least one prescription for clomiphene, ESRD, Cirrhosis, Myalgia, Myositis, Myopathy and Rhabdomyolysis as well as those persons undergoing dialysis or in vitro fertilization.
- Persons with a date of death during the measurement period.
- Persons receiving palliative care or have had an encounter for palliative care (ICD-10- CM Code Z51.50) anytime during the measurement period. Do not include laboratory claims (claims with place of service 81).
- Persons in hospice or using hospice services anytime during the measurement period.
- Persons 66 years of age as of Dec. 31 of the measurement period with criteria of frailty and advanced illness. Person must meet BOTH frailty and advanced illness criteria to be excluded. Frailty: At least two indications and two different dates of service during the measurement period and advanced illness: Either of the following during the measurement period or the year prior to the measurement period. Advanced illness on at least two different dates of service (not including laboratory claims place of service 81) or dispensed dementia medication of the measurement period.

Tips for patients

- Statins are prescribed to help reduce the risk of cardiovascular events, like heart attacks or strokes. For patients with cardiovascular disease, statins can help stabilize plaque in the arteries and prevent it from causing blockages.
- Statins lower LDL (bad) cholesterol, which can build up in arteries and cause plaque formation, leading to atherosclerosis (narrowing of the arteries). By taking statins, you can help prevent these issues and reduce the risk of further heart complications.
- If you have certain conditions like high blood pressure, diabetes, high cholesterol, or a history of heart disease, you may be at an increased risk for cardiovascular disease and would likely benefit from statin therapy. Discuss your cardiovascular risk profile with your health care provider.
- High blood pressure can strain your heart and blood vessels, contributing to cardiovascular disease. Keep your blood pressure under control through lifestyle changes and medications as prescribed by your doctor.
- If you experience side effects, don't stop taking your statin medication without talking to your health care provider. They can suggest alternatives or adjust your dosage to minimize side effects **Tips for providers**
- Prescribe high-intensity or moderate-intensity statin medication to patients diagnosed with ASCVD when clinically appropriate.
- Once patients demonstrate they can tolerate statin therapy, utilize 90-day prescription fills to encourage medication adherence.
- Instruct patients to fill prescriptions using their pharmacy benefit. Claims filled through pharmacy discount programs, cash claims and medication samples would not count. Gap closure is dependent on pharmacy claims.
- Educate patients on the importance of statin medication adherence.
- Remind patients to contact their provider if they think they are experiencing adverse effects. If the patient experiences any of the excluded symptoms or conditions, submit an office visit claim with the appropriate ICD-10.

Definitions

Index prescription start date (IPSD): The earliest prescription dispensing date for any statin medication of at least moderate intensity during the measurement period.

Treatment period: The time beginning the IPSD through the last day of the measurement period.

Proportion of days covered (PDC): The number of days the person is covered by at least one statin medication prescription of appropriate intensity, divided by the number of days in the treatment period.

Table 5: High- and Moderate-Intensity Statin Medications[2]		
Description		**Prescription**
High-intensity statin therapy	• Atorvastatin 40-80 mg • Amlodipine-atorvastatin 40-80 mg • Ezetimibe-simvastatin 80 mg	• Rosuvastatin 20-40 mg • Simvastatin 80 mg
Moderate-intensity statin therapy	• Atorvastatin 10-20 mg • Amlodipine-atorvastatin 10-20 mg • Rosuvastatin 5-10 mg • Simvastatin 20-40 mg • Ezetimibe-simvastatin 20-40 mg	• Pravastatin 40-80 mg • Lovastatin 40-60 mg • Fluvastatin 40-80 mg • Pitavastatin 1–4 mg

Statin Therapy for Patients with Diabetes (SPD-E)

Quality Base Reimbursement Program (QBRP)
Alternative Payment Method (APM)

Description

The percentage of persons 40-75 years of age during the measurement period with diabetes who do not have atherosclerotic cardiovascular disease (ASCVD) met the following criteria.

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

Why it matters

- Cardiovascular disease is the leading cause of death in the United States. It is estimated that 92.1 million American adults have one or more types of cardiovascular disease (Benjamin et al., 2017). People with diabetes also have elevated cardiovascular risk, thought to be due in part to elevations in unhealthy cholesterol levels. Having unhealthy cholesterol levels places people at significant risk for developing atherosclerotic cardiovascular disease (ASCVD.
- Statins are a class of drugs that lower blood cholesterol. American College of Cardiology and American Heart Association (ACC/AHA) guidelines state that statins of moderate or high intensity are recommended for adults with established clinical ASCVD. The American Diabetes Association and ACC/AHA guidelines also recommend statins for primary prevention of cardiovascular disease in patients with diabetes, based on age and other risk factors. Guidelines also state that adherence to statins will aid in ASCVD risk reduction in both populations.

Calculation

- 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, three prescriptions for the same medication are dispensed on the same day, each with a 30-days supply. Sum the days supply for a total of 90 days covered by a statin. Subtract any days supply that extends beyond Dec. 31 of the measurement period.
- 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 (Table 6: Amlodipine Atorvastatin High Intensity Medications List) and a dispensing event from (Table 6: Amlodipine Atorvastatin High Intensity Medications List) are dispensing events for different medications.

Initial population

Measure item count: Person.
Attribution basis: Enrollment.

- *Benefits:* Medical - Person must have Blue Cross and Blue Shield medical and pharmacy.
- *Continuous enrollment:* The measurement period and the year prior to the measurement period.
- *Allowable gap:* No more than one gap of ≤45 days during each year of continuous enrollment. No gaps on the last day of the measurement period.

Ages: 40–75 years of age as of last day of the measurement period.

Continuous enrollment

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

Measurement period

Jan. 1 – Dec. 31

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2026 NCQA HEDIS tech spec updates

- This is the first year this measure is reported using ECDS.
- Removed the Administrative Data Collection Method.
- Removed the requirement to use the same data source for rate 1 and rate 2.
- Updated the ASCVD diagnosis criteria in the denominator exclusions to allow diagnoses to occur in the measurement period or the year prior to the measurement period.
- Removed denominator exclusion for persons enrolled in an I-SNP or living long-term in an institution.
- Updated the denominator exclusion to remove persons with an ASCVD diagnosis.

Event/Diagnosis – Identify persons with a diagnosis of diabetes.

Persons with diabetes can be identified by claim/encounter data and/or pharmacy data. The organization must use both methods to identify the initial population, but a person only needs to be identified by one method to be included in the measure. Persons may be identified as having diabetes during the measurement period or the year prior to the measurement period.

- Claim/encounter data – Persons who had at least two diagnoses of diabetes on different dates of service during the measurement period or the year prior to the measurement period. Count services that occur over both years.
- Pharmacy data – Persons who were dispensed insulin or hypoglycemics/antihyperglycemics during the measurement period or the year prior to the measurement period and have at least one diagnosis of diabetes during the measurement period or the year prior to the measurement period.

Supplemental data

Supplemental data may be used to identify initial population, denominator, exclusion and numerator events.

Denominator

Denominator 1: Received statin therapy. Initial population minus denominator exclusions.
Denominator 2: Statin adherence 80%. Persons who meet numerator 1 criteria.

Numerator

Numerator 1: Received statin therapy. The number of persons who had at least one dispensing event for a high-intensity, moderate intensity, or low-intensity statin medication during the measurement period.
Numerator 2: Statin adherence 80%. PDC of at least 80% during treatment period.

Denominator exclusions

- Persons with at least one of following: Myocardial Infarction on a discharge claim; CABG, PCI, or any other revascularization procedure in any other setting.
- Persons who had at least one encounter with a diagnosis of IVD during both the measurement period and the previous measurement period - exclude nonacute inpatient stays.
- Persons with a diagnosis of pregnancy, IVF, a prescription for clomiphene, ESRD, dialysis, cirrhosis, myalgia, myositis, myopathy, or rhabdomyolysis during the measurement period.
- Persons receiving palliative care or have had an encounter for palliative care (ICD-10- CM Code Z51.50) anytime during the measurement period. Do not include laboratory claims (claims with place of service 81).
- Persons in hospice or using hospice services anytime during the measurement period.
- Persons with a date of death during the measurement period.
- Persons 66 years of age as of Dec. 31 of the measurement period with criteria of frailty and advanced illness. Person must meet BOTH frailty and advanced illness criteria to be excluded. Frailty: At least two indications and two different dates of service during the measurement period and advanced illness: Either of the following during the measurement period or the year prior to the measurement period. Advanced illness on at least two different dates of service (not including laboratory claims-place of service 81) or dispensed dementia medication of the measurement period

Tips for patients

- People with diabetes are at higher risk for cardiovascular disease (CVD) because high blood sugar can damage blood vessels and lead to plaque buildup in the arteries. Statins are prescribed to lower cholesterol levels and reduce this risk.
- Statins help prevent heart attacks, strokes, and other cardiovascular complications by lowering LDL (bad) cholesterol. Even if you don't have visible heart disease, statins can help protect your cardiovascular health if you have diabetes.
- Adhere to the treatment plan. Statins are most effective when taken regularly and skipping doses or stopping medication without consulting your doctor can undermine your treatment. Always check with your health care provider if you need to adjust your dosage or if you have any concerns.
- Keeping your blood glucose (blood sugar) levels in a healthy range is critical for reducing your cardiovascular risk. Proper blood sugar management can help prevent damage to your blood vessels and reduce your need for additional medications.
- Focus on a diet rich in fruits, vegetables, whole grains, lean proteins, and healthy fats. Avoid foods high in saturated fats and cholesterol, which can contribute to plaque buildup in your arteries. Physical activity can help lower cholesterol, reduce blood sugar levels, and improve your overall heart health. Aim for at least 150 minutes of moderate exercise per week. Smoking and excessive alcohol consumption can worsen cardiovascular disease and undermine your health. If you smoke, seek support to quit, and drink alcohol only in moderation.

Tips for providers

- Educate patients on the importance of taking their medications regularly and as prescribed. Once patients demonstrate they tolerate statin therapy, utilize 90-day prescription fills to encourage medication adherence
- Educate patients on the importance of statin medications for diabetic patients over the age of 40, regardless of LDL levels.
- Remind patients to contact you if they think they are experiencing adverse effects, such as myalgia, to statins. Consider trying a different statin that is more hydrophilic or reducing the dose or frequency.

Definitions

Index prescription start date (IPSD):
The earlies prescription dispensing date for any statin medication of any intensity during the measurement period.

Treatment period:
The time beginning the IPSD through the last day of the measurement period.

Proportion of days covered (PDC):
The number of days the person is covered by at least one statin medication prescription of appropriate intensity, divided by the number of days in the treatment period.

Table 6: Statin Medications[2]		
Description	**Prescription**	
High-intensity statin therapy	• Atorvastatin 40-80 mg • Amlodipine-atorvastatin 40-80 mg • Ezetimibe-simvastatin 80 mg	• Rosuvastatin 20-40 mg • Simvastatin 80 mg
Moderate-intensity statin therapy	• Atorvastatin 10-20 mg • Amlodipine-atorvastatin 10-20 mg • Rosuvastatin 5-10 mg • Simvastatin 20-40 mg • Ezetimibe-simvastatin 20-40 mg	• Pravastatin 40-80 mg • Lovastatin 40-60 mg • Fluvastatin 40-80 mg • Pitavastatin 1–4 mg
Low-intensity statin therapy	• Simvastatin 5-10 mg • Ezetimibe-simvastatin 10 mg • Pravastatin 10–20 mg	• Lovastatin 10-20 mg • Fluvastatin 20 mg

Appropriate Treatment for Upper Respiratory Infections (URI)

Quality Base Reimbursement Program (QBRP)
Alternative Payment Method (APM)

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

Why it Matters
Most URIs, also known as the common cold, are caused by viruses that require no antibiotic treatment. Too often antibiotics are prescribed inappropriately. The misuse of antibiotics can have adverse clinical outcomes such as Clostridioides difficile infections and has public health implications including encouragement of antibiotic resistance (when antibiotics can no longer cure bacterial infections). Antibiotic resistance is a major health concern in the United States, with 2.8 million antibiotic-resistant infections and 35,000 deaths occurring annually.

Recent efforts to use antibiotics judiciously has resulted in fewer inappropriately prescribed antibiotics- however, the problem remains. Increased education and awareness of appropriate treatment for URIs can reduce the danger of antibiotic-resistant bacteria.

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

Initial population
Measure item count: Episode.
Attribution basis: Enrollment.
- Benefits: Medical - Person must have Blue Cross and Blue Shield medical and pharmacy.
- Continuous enrollment: 30 days prior to the episode date through 3 days after the episode date (34 total days).
- Allowable gap: None.

Ages: 3 months of age or older as of the episode date.

Continuous enrollment
30 days prior to the episode date through three days after the episode date (34 total days).

Measurement Period
Jan. 1 – Dec. 31

2026 NCQA HEDIS Tech Spec Updates
No changes to this measure.

Event/Diagnosis- Episodes of upper respiratory infection diagnosis.
- Identify all persons who had an outpatient visit, a telephone visit, an online assessment, or an ED visit during the intake period, with a diagnosis of URI. Exclude outpatient, ED or observation visits that result in an inpatient stay.
- Determine all URI episode dates. For each person identified in step 1, determine all outpatient, telephone, online assessments, or ED visits with a URI diagnosis. Exclude visits that result in an inpatient stay (Inpatient Stay Value Set).

- Test for negative comorbid condition history. Remove episode dates where the person had a claim/encounter with any diagnosis for a comorbid condition (Comorbid Conditions Value Set) during the 365 days prior to or on the episode date. Do not include laboratory claims (with place of service code 81).
- Test for negative medication history. Remove episode dates where a new or refill prescription for an (Table 7: Antibiotic Medication list) was filled 30 days prior to the episode date or was active on the episode date.
- Test for negative competing diagnosis. Exclude episode dates where the person had a claim/encounter with a competing diagnosis (Pharyngitis Value Set), (Competing Diagnosis Value Set) or three days after the episode date.
- Calculate continuous enrollment. The person must be continuously enrolled without a gap in coverage from 30 days prior to the episode date through three days after the episode date (34 total days).
- Deduplicate eligible episodes. If a person has more than one eligible episode in a 31-day period, include only the first eligible episode. For example, if a person has an eligible episode on Jan. 1, include the Jan. 1 visit and do not include eligible episodes that occur on or between Jan. 2 and Jan.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.

Supplemental data
Although denied claims are not included when assessing the numerator, all claims must be included when identifying the initial population.
Supplemental data may not be used for this measure, except for denominator exclusions.

Denominator
The initial population minus denominator exclusions.

Numerator
Dispensed prescription for an antibiotic medication from the (AAB Antibiotic Medications list**)** on or up to three days after the episode date.

Denominator exclusions
- Persons in hospice or using hospice services anytime during the measurement period.
- Persons with a date of death during the measurement period.

Tips for patients
- Chest colds typically improve after a week to ten days.
- Speed up recovery by: staying hydrated, getting plenty of sleep, and keeping a humidifier in your bedroom.

Tips for providers
Review the side effects of antibiotics:
- Nausea, upset stomach, diarrhea or loss of appetite.
- Kills helpful bacteria in your body.
- Creates antibiotic-resistant bacteria such as MRSA, a type of flesh-eating bacteria.
- May increase the risk of serious diseases (e.g., autoimmune disorder)
- Avoid cigarette smoke
- Suggest over-the-counter treatments to help alleviate some symptoms:
    - Pain relievers (acetaminophen, ibuprofen)
    - Nasal saline sprays

Definitions

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

Episode date:

- The date of service for an eligible encounter during the intake period with a diagnosis of fracture.
- For an outpatient 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.

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

- A period of 30 days prior to the episode date when the person had no pharmacy claims for either new or refill prescriptions for a listed antibiotic drug.
- No prescriptions dispensed more than 30 days prior to the episode date that are active on the episode date.
- A prescription is considered active if the ‘‘day supply” indicated on the date when the person was dispensed the prescription is the number of days or more between that date and the relevant service date. The 30-day look-back period for pharmacy data includes the 30 days prior to the intake period.

Exclude negative comorbid condition history: A period of 365 days prior to including the episode date when the person had no claims or encounters with any diagnosis for a comorbid condition (366 days total).

Exclude negative competing diagnosis: The episode date and three days following the episode date when the person had no claims or encounters with a competing diagnosis.

Table 7: Antibiotic Medications (URI)[2]			
Description	**Prescription**		
Aminoglycosides	• Amikacin • Gentamicin	• Streptomycin	• Tobramycin
Aminopenicillins	• Amoxicillin	• Ampicillin	
Beta-lactamase inhibitors	• Amoxicillin-clavulanate	• Ampicillin-sulbactam	• Piperacillin-tazobactam
First-generation cephalosporins	• Cefadroxil	• Cefazolin	• Cephalexin
Fourth generation cephalosporins	• Cefepime		
Lincomycin derivatives	• Clindamycin	• Lincomycin	
Macrolides	• Azithromycin	• Clarithromycin	• Erythromycin
Miscellaneous antibiotics	• Aztreonam • Chloramphenicol • Dalfopristin-quinupristin	• Daptomycin • Linezolid	• Metronidazole • Vancomycin
Natural penicillin's	• Penicillin G benzathine-procaine • Penicillin G potassium	• Penicillin G procaine • Penicillin G sodium	• Penicillin V potassium • Penicillin G benzathine
Penicillinase resistant penicillin's	• 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 • Ceftriaxone	• Cefpodoxime • Cefixime	• Cefpodoxime • Ceftazidime
Urinary anti-infectives	• Fosfomycin • Nitrofurantoin	• Nitrofurantoin macrocrystals-monohydrate	• Trimethoprim

Child and Adolescent Well-care Visits (WCV)

Quality Base Reimbursement Program (QBRP)
Alternative Payment Method (APM)

Description
The percentage of persons 3–21 years of age who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement period.
Note**:** This measure has the same structure as measures in the Effectiveness of Care domain. The organization must follow the Guidelines for Effectiveness of Care Measures when calculating this measure.

Why it matters
Assessing physical, emotional and social development is important at every stage of life, particularly with children and adolescents. Well-care visits provide an opportunity for providers to influence health and development, and they are a critical opportunity for screening and counseling.

Calculation
Numerator divided by denominator

Initial population
Measure item count: Person.
Attribution basis: Enrollment.
- Benefits: Medical - Person must have Blue Cross and Blue Shield medical and pharmacy.
- Continuous enrollment: The measurement period.
- Allowable gap: No more than one gap of ≤45 days during the measurement period. No gaps on the last day of the measurement period.

Ages: 3–21 years of age as of the last day of the measurement period.
Event: None.

Continuous enrollment
Jan. 1 – Dec. 31

Measurement Period
Jan. 1 – Dec. 31

2026 NCQA HEDIS tech spec updates
- Updated the race and ethnicity stratification categories to align with OMB SPD 15 2024.
- Added instructions on allowable adjustments to the race and ethnicity stratifications.

Event/Diagnosis
None

Supplemental data
Supplemental data may be used to identify initial population, denominator, exclusion and numerator events.

Denominator
The initial population minus denominator exclusions.

Numerator
One or more well care visits during the measurement period. Either of the following met criteria:
- A well-care visit (Well Care Visit Value Set).
- An encounter for well-care (Encounter for Well Care Value Set). Do not include laboratory claims (with place of service code 81).
- Do not include telehealth visits (billed with a code that indicates telehealth: Telehealth POS Value Set; Online Assessments Value Set; Telephone Visits Value Set).
- The well-care visit must occur with a PCP or an OB/GYN practitioner, but the practitioner does not have to be the practitioner assigned to the person.

Denominator exclusions
- Persons in hospice or using hospice services anytime during the measurement period.
- Persons with a date of death during the measurement period.

Tips for patients
- A well-child or well-care visit is a chance to get regular updates about your child's health and development. Your health care team will take measurements, conduct a head-to-toe examination, update immunizations, and offer you a chance to talk, ask questions or address concerns. Your well visit includes four specific activities: Determining whether your child has any health concerns; offering ways to keep your child from developing health concerns; providing support for your child's overall health and well-being; and talking through health information and offering advice. Your health care professional offers you tools to support your child's development.
- The well-care visit has a special meaning for teenagers/young adults. It is a chance for these individuals to build responsibility for their own health and wellness. By ensuring teens follow the same steps and regularly attend these yearly visits, you set the stage for their independence. Typically, teens can expect to have one-on-one time with their health care professionals. Teens need to prepare for visits so that they can engage in conversations with their health care team and then follow up on tasks to promote their overall well-being. As teens practice these skills, they learn how to promote their own lifelong health. You should continue to support them by encouraging healthy habits at home such as eating nutritious food, getting a good night's sleep, and paying attention to their emotional well-being.

Tips for providers
- Remind caregivers of appointments by texts or phone calls.
- Educate the caregiver about the importance of preventive care visits.
- When a child is in your office for sports physical or a back-to-school, use that opportunity to conduct a well-child visit when appropriate.
- Screening and counseling for obesity should occur at these visits by calculating a child's body mass index (BMI) percentile for gender and age or plotting the value on a growth curve.
- Discuss physical activity and nutrition at every visit.
- While a patient is in your office for a well-child visit, administer required vaccinations and testing.
- When a child is in your office for a sick visit, schedule a well care visit if appropriate.
- Schedule next appointment at close of visit and offer flexible appointment availability including evening, weekends, and family appointments.

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

Quality Base Reimbursement Program (QBRP)
Alternative Payment Method (APM)

Description

The percentage of persons who had the following number of well-child visits with a PCP during the last 15 months. The following rates are reported:

- Rate 1: Well-child Visits in the First 15 Months. Children who turned 15 months during the measurement period: Six or more well-child visits.
- Rate 2: Well-child Visits for Age 15 Months-30 Months. Children who turned 30 months old during the measurement period: Two or more well-child visits.

Why it matters

Assessing physical, emotional and social development is important at every stage of life, particularly with children and adolescents. Well-care visits provide an opportunity for providers to influence health and development, and they are a critical opportunity for screening and counseling.

Calculation

Numerator divided by denominator

Initial population

Measure item count: Person.
Attribution basis: Enrollment.

- Benefits: Medical - Person must have Blue Cross and Blue Shield medical and pharmacy.
- Continuous *enrollment:*

Initial population 1: 31 days through 15 months of age. Calculate 31 days of age by adding 31 days to the date of birth.
Initial population 2: 15 months plus 1 day through 30 months of age. Calculate the 15-month birthday plus 1 day as the first birthday plus 91 days.

- Allowable gap:

Initial population 1: No more than one gap of ≤45 days during the continuous enrollment period. No gaps on the 15-month birthday.
Initial population 2: No more than one gap of ≤45 days during the continuous enrollment period. No gaps on the 30-month birthday.
Ages:

- Initial population 1: Persons who turn 15 months old during the measurement period. Calculate the 15-month birthday as the first birthday plus 90 days.
- Initial population 2: Persons who turn 30 months old during the measurement period. Calculate the 30-month birthday as the second birthday plus 180 days.

Event: None.

Measurement Period

Jan. 1 – Dec. 31

2026 NCQA HEDIS Tech Spec Updates

- Updated the race and ethnicity stratification categories to align with OMB SPD 15 2024.
- Added instructions on allowable adjustments to the race and ethnicity stratifications.

Event/Diagnosis

No specific event or diagnosis

Supplemental Data
Supplemental data may be used to identify initial population, denominator, exclusion and numerator events.

Denominator
Rate 1: Well-child visits in the first 15 months.
The initial population minus denominator exclusions.
Rate 2: Well-child visits in the for 15 months – 30 months.
The initial population minus denominator exclusions.

Numerator
Rate 1: First 15 Months
- Six or more well-child visits on different dates of service on or before the 15-month birthday. Either of the following criteria met:
- A well-care visit (Well Care Visit Value Set).
- An encounter for well-care (Encounter for Well Care Value Set). Do not include laboratory claims (with place of service code 81).
- Do not include telehealth visits (visits billed with a code that indicates telehealth: Telehealth POS Value Set; Online Assessments Value Set; Telephone Visits Value Set).
- The well-child visit must occur with a PCP, but the PCP does not have to be the practitioner assigned to the child.

Rate 2: 15 Months – 30 Months
- Two or more well-child visits on different dates of service between the child's 15-month birthday plus one day and the 30-month birthday. Either of the following criteria met:
- A well-care visit (Well Care Visit Value Set).
- An encounter for well-care (Encounter for Well Care Value Set). Do not include laboratory claims (with place of service code 81).
- Do not include telehealth visits (billed with a code that indicates telehealth: Telehealth POS Value Set; Online Assessments Value Set; Telephone Visits Value Set).
- The well-child visit must occur with a PCP, but the PCP does not have to be the practitioner assigned to the child.

Denominator exclusions
- Persons in hospice or using hospice services anytime during the measurement period.
- Persons with a date of death during the measurement period.

Tips for patients
A well-child or well-care visit is a chance to get regular updates about your child's health and development. Your health care team will take measurements, conduct a head-to-toe examination, update immunizations and offer you a chance to ask questions and share concerns. Your well visit includes four specific activities: Determining whether your child has any health concerns; offering ways to keep your child from developing health concerns; providing support for your child's overall health and well-being and talking through health information and offering advice. Your health care professional offers tools and information that you can use to support your child's development.

Tips for providers
All events must be at least 14 days apart to avoid double counting events when only assessing administrative data or when combining administrative and medical record data.
Remind caregivers of appointments by texts or phone calls.
Educate the caregiver about the importance of preventive care visits.
When a child is in your office for a sports physical or back-to-school visit, conduct a well-child visit when appropriate.
Screening and counseling for obesity should occur at these visits by calculating a child's body mass index (BMI) percentile for gender and age or plotting the value on a growth curve.
Discuss physical activity and nutrition at every visit.
While a patient is in your office for a well-child visit, administer required vaccinations and testing.
When a child is in your office for a sick visit, schedule a well-care visit if appropriate.
- Schedule next appointment at close of visit and offer flexible appointment availability including evening, weekends, and family appointments.

Appendix A: Definitions

Anchor Date - The specific date the person is required to be enrolled to be eligible for the measure.

Continuous enrollment - A period during the measurement timeline, where a person must be enrolled to be counted towards the measure.

Denominator - Eligible persons of the population

Electronic clinical data systems (ECDS) - The network of data containing a plan'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 so that automated quality measurement queries can be consistently and reliably executed.

Episode date - The date of service for any outpatient or ED visit during the intake period.

HEDIS (Health Care Effectiveness Data and Information Set) - Tool used by more than 90% of America's health plans to measure performance on important dimensions of care and service.

Index episode start date (IESD) - The earliest date of service for an eligible encounter during the intake period.

Intake period - The time-period --typically the measurement period --used to identify the first eligible encounter.

Interactive data submission system (**IDSS**) - Each HEDIS season, a compilation of IDSS file updates is posted for health plans submitting HEDIS data to NCQA. These files are referenced by health plans and HEDIS certified vendors and auditors to utilize during the IDSS process.

Numerator - Persons who met the criteria of a measure.

Measurement period - The 12-month time frame of data used to support the calculation of the bi-annual QBRP performance scores.
For Blue Cross and Blue Shield of Kansas QBRP HEDIS based performance scores as follows:

- The Jan.1 thru Dec.31 measurement period is used to support the July 1 thru Dec. 31 QBRP scores of the following bi-annual QBRP cycle.
- The July 1 thru June 30 measurement period is used to support the Jan. 1 thru June 30 QBRP scores of the following bi-annual QBRP cycle.

Primary care physician (PCP) - A physician or non-physician (e.g., nurse practitioner, physician assistant) who offers primary care medical services.

- LPNs and RNs are not considered PCPs

Supplemental data-Additional clinical information about a person received by a health plan.

Appendix B: Changes

Version	Description	Effective Date
2018.v1	Initial release	March-17
2018.v2	Updated with new coding value sets and formatting changes.	June-17
2019.v1	Updated to include 2019 QBRP measures including code sets. Added negative conditions to CWP, AAB, LBP.	July-18
2019.v2	General updates to Title Page, AWC, CWP, CDC, CCS, LBP, and Appendix A.	Oct.-18
2020.v1	Updated with new coding value sets and addition of new measures. Added CPT II and ICD-10 'history of' codes where applicable. Removed LOINC code sets.	Jan.-19
2020.v2	Updated with addition of new measures CDC-EYE, CDC-NEPH, SPC, and SPD.	Aug.-19
2020.v3	Updated with specification changes for HEDIS 2020 and coding set updates. Changes include: CWP- Expanded age range from 3-18 years of age to 3 years of age and older. URI- Expanded age range from 3 months-18 years of age (children) to 3 months of age and older. AAB- Expanded age range from 18-64 years of age (adults) to persons 3 months of age and older CCS- Updated screening methods to include primary high-risk human papillomavirus testing. Updated measure set to remove AWC, CDC-NEPH, W15, W34, SPC-80%, SPD-80% and replaced with W30 (2 rates), WCV, SPD-Received Statin Therapy, SPC- Received Statin Therapy.	Aug.-20
2022.v1	Updated value code sets. Added Appendix C: Potential Future Changes added Appendix D: Supplemental Code Sets changed Appendix B 'dates' to 'effective date'	Jan.-22
2023.v1	Updated with specification changes for HEDIS 2023 and coding set updates. The following changes were made. CDC- Split into two measures. EED -Eye Exam for Patients with Diabetes added HBD -Hemoglobin A1c for Patients with Diabetes Updated value code sets and Medication list. Updated Appendix C: Supplemental Code Sets (added additional codes) Added Appendix E: Stratification by Race and Ethnicity	Aug.-22
2024.v1	Updated with specification changes for HEDIS 2024 and coding set Removed HBD-Hemoglobin A1c for Patients with Diabetes Moved FUH out of future measures and into the current measures. Changed COL to COL-E. Updated value code sets. Updated Appendix E: Stratification by Race and Ethnicity added HEDIS copyright notice and disclaimer	Jan.-24

2025.v1	Removed AMM measures. Measure has been retired. Changed CCS to CCS-E Updated Appendix E; Stratification by Race and Ethnicity Added Why it Matters to each measure Added Tips for Patients and Providers Added Continuous Enrollment and Measurement Period Added NCQA HEDIS Tech Spec Updates Added impact of supplemental data on measures. Initial population updated for each measure Changed the denominator to read “initial population minus denominator exclusions”. Removed metformin repaglinide from Diabetes Medication Removed AMR measure. Measure has been retired. Changed BPD to BPD-E. Changed SPC to SPC-E Changed SPD to SPD-E Updated terminology: replaced “measurement year” with “measurement period” “members” with “persons” “eligible population” with “initial population” “required exclusions” with “denominator exclusions”.	Jan.-25
2026.v1		Jan-26

Appendix C: Supplemental Code Sets: Z Codes and Other ICD-10CM Z-Codes for HEDIS	
Quality Base Reimbursement Program (QBRP)	
• Blue Cross and Blue Shield of Kansas is promoting the use of ICD-10 Z code sets. • Blue Cross and Blue Shield of Kansas can better identify social determinants of health, history of mastectomy, hysterectomy and colectomy, and lab result codes, which will ultimately result in the reduction of medical record requests. • Persons with potential health hazards related to socioeconomic and psychosocial circumstances (Z55-Z65)	
Social Determinant	*This list should not be considered comprehensive of all available codes. The codes listed are those commonly used codes.* ICD-10-CM Code/Description
Problems related to education and literacy (Z55)	Z55.0 Illiteracy and low-level literacy Z55.1 Schooling unavailable and unattainable Z55.2 Failed school examinations Z55.3 Underachievement in school Z55.4 Educational maladjustment and discord with teachers and classmates Z55.8 Other problems related to education and literacy Z55.9 Problems related to education and literacy, unspecified
Problems related to employment and unemployment (Z56)	Z56.0 Unemployment, unspecified Z56.1 Change of Job Z56.2 Threat of job loss Z56.3 Stressful work schedule Z56.4 Discord with boss and workmates Z56.5 Uncongenial work environment Z56.6 Other physical and mental strain related to work Z56.81 Sexual harassment on the job Z56.82 Military deployment status Z56.89 Other problems related to employment Z56.9 Unspecified problems related to employment

Occupational exposure to risk factors (Z57)	Z57.0 Occupational exposure to noise Z57.1 Occupational exposure to radiation Z57.2 Occupational exposure to dust Z57.31 Occupational exposure to environmental tobacco smoke Z57.39 Occupational exposure to other air contaminants Z57.4 Occupational exposure toxic agents in agriculture Z57.5 Occupational exposure to toxic agents in other industries Z57.6 Occupational exposure to extreme temperature Z57.7 Occupational exposure to vibration Z57.8 Occupational exposure to other risk factors Z57.9 Occupational exposure to unspecified risk factor
Problems related to housing and economic circumstances (Z59)	Z59.0 Homelessness Z59.1 Inadequate housing Z59.2 Discord with neighbors, lodgers, and landlord Z59.3 Problems related to living in residential institution Z59.4 Lack of adequate food and safe drinking water Z59.5 Extreme poverty Z59.6 Low income Z59.7 Insufficient social insurance and welfare support Z59.8 Other problems related to housing and economic circumstances Z59.9 Problem related to housing and economic circumstances, unspecified
Problems related to social environment (Z60)	Z60.0 Problems of adjustment to life-cycle transitions Z60.2 Problems related to living alone Z60.3 Acculturation difficulty Z60.4 Social exclusion and rejection Z60.5 Target of (perceived) adverse discrimination and persecution Z60.8 Other problems related to social environment Z60.9 Problems related to social environment, unspecified

Problems related to upbringing (Z62)	Z62.0 Inadequate parental supervision and control Z62.1 Parental overprotection Z62.21 Child in welfare custody Z62.22 Institutional upbringing Z62.29 Other upbring away from parents Z62.3 Hostility towards and scapegoating of child Z62.6 Inappropriate (excessive) parental pressure Z62.810 Personal history of physical and sexual abuse in childhood Z62.811 Personal history of psychological abuse in childhood Z62.812 Personal history of neglect in childhood Z62.813 Personal history of forced labor or sexual exploitation in childhood Z62.819 Personal history of unspecified abuse in childhood Z62.820 Parent-biological child conflict Z62.821 Parent-adopted child conflict Z62.822 Parent-foster child conflict Z62.890 Parent-child estrangement NEC Z62.891 Sibling rivalry Z62.898 Other specified problems related to upbringing
Other problems related to primary support group, including family circumstances (Z63)	Z63.0 Problems in relationship with spouse or partner Z63.1 Problems in relationship with in-laws Z63.31 Absence of family person due to military deployment Z63.32 Other absence of family person Z63.4 Disappearance and death of family person Z63.5 Disruption of family by separation and divorce Z63.6 Dependent relative needing care at home Z63.71 Stress on family due to return of family person from military deployment Z63.72 Alcoholism and drug addiction in family Z63.79 Other stressful life events affecting family and household Z63.8 Other specified problems related to primary support group Z63.9 Problem related to primary support group, unspecified
Problems related to certain psychosocial circumstances (Z64)	Z64.0 Problems related to unwanted pregnancy Z64.1 Problems related to multiparity Z64.4 Discord with counselor

Problems related to other psychosocial circumstances (Z65)	Z65.0 Conviction in civil and criminal proceedings without imprisonment Z65.1 Imprisonment and other incarceration Z65.2 Problems related to release from prison Z65.3 Problems related to other legal circumstances Z65.4 Victim of crime and terrorism Z65.5 Exposure to disaster, war, and other hostilities Z65.8 Other specified problems related to psychosocial circumstances Z65.9 Problem related to unspecified psychosocial circumstances
Problems related to medical facilities and other health care (Z75)	Z75.0 Medical services not available at home Z75.1 Person awaiting admission to adequate facility elsewhere Z75.2 Other waiting period for investigation and treatment Z75.3 Unavailability and inaccessibility of health care facilities Z75.4 Unavailability and inaccessibility of other helping agencies Z75.5 Holiday relief care Z75.8 Other problems related to medical facilities and other health care Z75.9 Unspecified problem related to medical facilities and other health care

Other ICD-10CM Z-Codes for HEDIS	
Quality Based Reimbursement Method (QBRP)	
• Blue Cross and Blue Shield of Kansas is promoting the use of ICD-10 Z codes sets. • Blue Cross and Blue Shield of Kansas can better identify history of mastectomy, hysterectomy and colectomy and lab result codes, which will ultimately result in the reduction of medical record requests.	
History of mastectomy	Z90.13 Acquired absence of bilateral breasts and nipples
History of hysterectomy	Z90.710 Acquired absence of both cervix and uterus Z90.712 Acquired absence of cervix with remaining uterus
Pregnancy diagnosis	Z03.71 Encounter for suspected problem with amniotic cavity and membrane ruled out Z03.72 Encounter for suspected placental problem ruled out Z03.73 Encounter for suspected fetal anomaly ruled out Z03.74 Encounter for suspected problem with fetal growth ruled out Z03.75 Encounter for suspected cervical shortening ruled out Z03.79 Encounter for other suspected maternal and fetal conditions ruled out Z32.01 Encounter for pregnancy test, result positive Z34.00 Encounter for supervision of normal first pregnancy, unspecified trimester Z34.01 Encounter for supervision of normal first pregnancy, first Trimester Z34.02 Encounter for supervision of normal first pregnancy, second trimester Z34.03 Encounter for supervision of normal first pregnancy, third trimester Z34.80 Encounter for supervision of other normal pregnancy, unspecified trimester Z34.81 Encounter for supervision of other normal pregnancy, first trimester Z34.82 Encounter for supervision of other normal pregnancy, second trimester Z34.83 Encounter for supervision of other normal pregnancy, third trimester Z34.90 Encounter for supervision of normal pregnancy, unspecified, unspecified trimester Z34.91 Encounter for supervision of normal pregnancy, unspecified, first trimester Z34.92 Encounter for supervision of normal pregnancy, unspecified, second trimester Z34.93 Encounter for supervision of normal pregnancy, unspecified, third trimester Z36 Encounter for antenatal screening of mother
Postpartum care	Z39.2 Encounter for routine place of postpartum follow-up Z39.1 Encounter for care and examination of lactating mother

Appendix D: CPTII Codes

Quality Based Reimbursement Payment (QBRP)

- Blue Cross and Blue Shield of Kansas is promoting the use of CPT Category II code sets.
- Blue Cross and Blue Shield of Kansas can better identify history of mastectomy, hysterectomy and colectomy, and lab result codes which will ultimately result in the reduction of medical record requests

Measure	CPT-II Code	Description
PPC	0500F	Initial prenatal care visit (report at first prenatal encounter with health care professional providing obstetrical care. Report also date of visit and, in a separate field, the date of the last menstrual period [LMP]) (Prenatal)
	0501F	Prenatal flow sheet documented in medical record by first prenatal visit (documentation includes at minimum blood pressure, weight, urine protein, uterine size, fetal heart tones, and estimated date of delivery). Report also: date of visit and, in a separate field, the date of the last menstrual period [LMP] (Note: If reporting 0501F Prenatal flow sheet, it is not necessary to report 0500F Initial prenatal care visit) (Prenatal)
	0502F	Subsequent prenatal care visit (Prenatal) [Excludes: patients who are seen for a condition unrelated to pregnancy or prenatal care (eg, an upper respiratory infection; patients seen for consultation only, not for continuing care)]
	0503F	Postpartum care visit (Prenatal)
EED	2022F	Dilated retinal eye exam with interpretation by an ophthalmologist or optometrist documented and reviewed; with evidence of retinopathy (DM)
	2023F	Dilated retinal eye exam with interpretation by an ophthalmologist or optometrist documented and reviewed; without evidence of retinopathy (DM)
	2024F	7 standard field stereoscopic retinal photos with interpretation by an ophthalmologist or optometrist documented and reviewed: with evidence of retinopathy (DM)
	2025F	7 standard field stereoscopic retinal photos with interpretation by an ophthalmologist or optometrist documented and reviewed: without evidence of retinopathy (DM)
	2026F	Eye imaging validated to match diagnosis from 7 standard field stereoscopic retinal photos results documented and reviewed: with evidence of retinopathy (DM)
	2033F	Eye imaging validated to match diagnosis from 7 standard field stereoscopic retinal photos results documented and reviewed: without evidence of retinopathy (DM)
	3072F	Low risk for retinopathy (no evidence of retinopathy in the prior year) (DM)

Measure	CPT-II Code	Description
GSD	3044F	Most recent hemoglobin A1c (HbA1c) level less than 7.0% (DM)
	3046F	Most recent hemoglobin A1c level greater than 9.0% (DM)
	3048F	Most recent LDL-C less than 100 mg/dL (CAD) (DM)
	3049F	Most recent LDL-C 100-129 mg/dL (CAD) (DM)
	3050F	Most recent LDL-C greater than or equal to 130 mg/dL (CAD) (DM)
	3051F	Most recent hemoglobin A1c (HbA1c) level greater than or equal to 7.0% and less than 8.0% (DM)
	3052F	Most recent hemoglobin A1c (HbA1c) level greater than or equal to 8.0% and less than or equal to 9.0% (DM)
CBP	3074F	Most recent systolic blood pressure less than 130 mm Hg (DM) (HTN, CKD, CAD)
	3075F	Most recent systolic blood pressure 130-139 mm Hg (DM) (HTN, CKD, CAD)
	3077F	Most recent systolic blood pressure greater than or equal to 140 mm Hg (HTN, CKD, CAD) (DM)
	3078F	Most recent diastolic blood pressure less than 80 mm Hg
	3079F	Most recent diastolic blood pressure 80-89 mm Hg
	3080F	Most recent diastolic blood pressure greater than or equal to 90 mm Hg

This list should not be considered comprehensive of all available codes. The codes listed are those commonly used codes.

Appendix E: Stratifications by Race and Ethnicity

Measures reporting Race and Ethnicity stratifications

Race	White	AIS-E	Adult Immunizations Status
	Black or African-American	BPD-E	Blood Pressure Control for Patients with Hypertension
	American Indian and Alaska Native	BCS-E	Breast Cancer screening
	Asian	CCS-E	Cervical Cancer Screening
	Middle Eastern or North African	WCV	Child and Adolescent Well-Care Visits
	Native Hawaiian and Other Pacific Islander	CIS-E	Childhood Immunization Status (Combination 10 only)
	Some Other Race	COL-E	Colorectal Cancer Screening
	Two or More Races	CBP	Controlling High Blood Pressure
	Asked but No Answer	FUA	Emergency Department Visits for Substance Use Disorder
	Unknown	EED	Eye Exam for Patients with Diabetes
		FUM	Follow-Up after Emergency Department Visit for Mental Illness
		FUA	Follow-Up after Emergency Department Visit for Substance Use
		FUH	Follow-Up after Hospitalization for Mental Illness
		GSD	Glycemic Status Assessment for Patients with Diabetes
Ethnicity	Hispanic/Latino	IMA-E	Immunizations for Adolescents
	Not Hispanic/Latino	IET	Initiation and Engagement of Substance Use Disorder Treatment
	Asked but No Answer	KED	Kidney Health Evaluation for Patients with Diabetes
	Unknown	POD	Pharmacotherapy for Opioid Use Disorder
		PDS-E	Postpartum Depression Screening and Follow-Up
		PPC	Prenatal and Postpartum Care
		PND-E	Prenatal Depression Screening and Follow-Up
		W30	Well -Child Visits up to 36 Months

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Appendix F: Sources and Resources

1. HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA)
2. Coding may change periodically without notification: Download the Coding and Value Set Guide (XLSX)
3. *ICD-9 codes.* ICD-9 codes can be mapped to ICD-10 codes ***only*** for concepts with a time frame that looks back "any time during the person's history.
4. Medication updates periodically without notification
5. https://www.ncqa.org/programs/data-and-information-technology/data-purchase-and-licensing/quality-compass/
6. HEDIS Measures | ncqa.org
7. National Committee for Quality Assurance. HEDIS® 2025 Volume 2 Technical Specifications for Health Plans
8. Case Management | Blue Cross and Blue Shield of Kansas: bcbsks.com
9. Disease Management | Blue Cross and Blue Shield of Kansas: bcbsks.com
10. Mental Health Resources:

- Refer patients to MiResource for mental health needs| Blue Cross and Blue Shield of Kansas
- MiResource: your guide to mental health care resources| Blue Cross and Blue Shield of Kansas
- Blood Pressure Quick Reference guide | Blue Cross and Blue Shield of Kansas
- Managing Your High Blood Pressure brochure | Blue Cross and Blue Shield of Kansas
- Lower Back Pain Quick Reference guide | Blue Cross and Blue Shield of Kansas

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