Quality Measure Description Table

	Quality Measures	Brief Measure Description	Eligible Population Description	Line of Business	Detailed Compliance Description	Period
HEDIS®/PQA/Network Health Homegrown Measure						
1	Eye Exam for Patients with Diabetes (EED) **Allows Alternative Supplemental Data (ASD) to be submitted**	Retinal Eye Exam	Members 18-75 years of age with diabetes (types 1 and 2) by meeting at least one of the following conditions during the current or prior measurement year: • At least two diagnoses of diabetes on different dates of services. • Were dispensed insulin or hypoglycemic/antihyperglycemics and have at least one diagnosis of diabetes. Exclude members who meet any of the following criteria: • Members in hospice or using hospice services anytime during the measurement year. • Members receiving palliative care during the measurement year. • Members who die in the measurement year. Required exclusion for EED (new in MY2025): Bilateral or two unilateral eye enucleations any time during the member's history through December 31 of the current measurement year. <u>Other exclusions:</u> • Medicare members 66 years or age and older as of December 31 of measurement year who meet either of the following:	Commercial/ Medicare	Patient had either of the following: • A retinal or dilated eye exam by an eye care professional (optometrist or ophthalmologist) in the measurement year. • A negative retinal or dilated eye exam (negative for retinopathy) by an eye care professional in the current or prior measurement year. • Additional codes as listed in HEDIS© Value Set for qualifying eye exams – see HEDIS 101 Reference Guide. • Retinal imaging with interpretation and reporting by a qualified reading center billed by any provider type during the measurement year. • Automated eye exam (CPT 92229) billed by any provider type during the measurement year. • Note: blindness is not an exclusion for diabetic eye exam Stratification for the eye exam measure: • Medicare only: Socioeconomic Status (SES): Low Income Subsidy (LIS), Disability (DIS), Dual Eligible D-SNP (DE) • All Product Lines: race and ethnicity	Current calendar year or prior calendar year. Needs to be annually if patient has retinopathy.

2	Glycemic Status Assessment for Patients with Diabetes (GSD) **Allows Alternative Supplemental Data (ASD) to be submitted**	Glycemic Status or Glucose Management Indicator <8.0% Glycemic Status or Glucose Management Indicator >9.0%	○ Enrolled in an Institutional SNP any time during the measurement year. ○ Living long-term in an institution (LTI) any time during the measurement year. • Members 66 years of age and older as of December 31 of the measurement year (all product lines) with frailty and advanced illness. Members must meet BOTH frailty and advanced illness criteria to be excluded. In addition, members must be continuously enrolled with Network Heath during the measurement year with no more than one gap in continuous enrollment of up to 45 days.	Commercial/ Medicare	For A1c<8%: Patient is numerator compliant if the most recent HbA1c level or glucose management indicator (GMI) performed during the measurement year is <8.0%. The patient is not numerator compliant if the result for the glycemic status or glucose management indicator is ≥8.0% or is missing a result, or if a glycemic status or glucose management indicator was not done during calendar year. For A1c>9%: Patient is numerator compliant if the most recent HbA1c done in the calendar year is >9.0%. The patient is not numerator compliant if the result for the glycemic status or glucose management indicator is ≤ 9.0% or is missing a result, or if a glycemic status or glucose management indicator was not done during calendar year. Of note, for Network Health's aligned incentive contracts, **this measure is reported as an "inverse" result**, so some people refer to it as "HbA1c ≤ 9.0%" which can get confusing. A1c or GMI results reported by the patient and documented in the medical record are eligible for use in reporting and should include medical record documentation of the date (month/day/year) of the result as well as the A1c or GMI value reported by the patient. When identifying the most recent glycemic status assessment (HbA1c or GMI), GMI values must include documentation of the continuous glucose monitoring data date range used to derive the value. The terminal date in the range should be used to assign assessment date. If multiple glycemic status assessments were recorded for a single date, use the lowest result. Ranges and thresholds do not meet criteria for this indicator. For the glycemic status measure, data needs to be submitted to allow reporting based on: • Race • Ethnicity	Current calendar year

3	Blood Pressure Control for Patients with Diabetes (BPD) **Allows Alternative Supplemental Data (ASD) to be submitted**	Adequately controlled blood pressure based on LAST measurement of the calendar year		Commercial / Medicare	The percentage of members aged 18-75 with diabetes (type 1 and type 2) whose blood pressure (BP) was controlled (<140/90) during the calendar year, using the most recent BP level taken in the calendar year. For medical record review (alternative supplemental data submission), HEDIS tech specs require that we do not include BP readings: • Taken during an acute inpatient stay or an ED visit. • Taken on the same day as a diagnostic test or diagnostic or therapeutic procedure that requires a change in diet or change in medication on or one day before the day of the test or procedure, except for fasting blood tests. • Taken by the patient using a non-digital device such as with a manual blood pressure cuff and stethoscope. Identify the lowest systolic and lowest diastolic BP reading from the most recent BP notation in the medical record. If multiple readings were recorded for a single date, use the lowest systolic and lowest diastolic BP on that date as the representative BP. The systolic and diastolic results do not need to be from the same reading. BP readings taken by the patient with digital cuff and documented in the medical record are eligible for use in reporting (provided the BP does not meet any exclusion criteria). Ranges and thresholds do not meet criteria for this measure. A distinct numeric result for both the systolic and diastolic BP is required. A BP documented as an "average BP" is eligible for use.	
4	Kidney Health Evaluation for Patients with Diabetes (KED)	Estimated glomerular filtration rate (eGFR) **and** urine albumin-	The percentage of members 18–85 years of age with diabetes (type 1 and type 2) who received a kidney health evaluation, defined by an eGFR ***and*** a uACR, during the measurement year.	Commercial/ Medicare	Patients who received **both** an eGFR and a uACR during the calendar year on the same or different dates of service: • At least one eGFR • At least one uACR identified by either of the following:	Current calendar year

	Allows Alternative Supplemental Data (ASD) to be submitted	creatinine (uACR)	• At least two diagnoses of diabetes on different dates of services. • Were dispensed insulin or hypoglycemic/antihyperglycemics and have at least one diagnosis of diabetes. Exclude members who meet any of the following criteria: • Members with diagnosis of ESRD or who had dialysis any time during the member's history on or prior to December 31 of the measurement year. • Members in hospice or using hospice services anytime during the measurement year. • Members receiving palliative care during the measurement year. • Members who die in the measurement year. Other exclusions: • Medicare members 66 years or age and older as of December 31 of measurement year who meet either of the following: o Enrolled in an Institutional SNP any time during the measurement year o Living long-term in an institution any time during the measurement year as identified by the LTI flag in the Monthly Membership Detail Data File • Members age 66 – 80 years as of December 31 of the measurement year (all product lines) must meet BOTH frailty and advanced illness criteria to be excluded, while age 81 and older need at least two indications of frailty with different dates of service to be excluded. In addition, members must be continuously enrolled with Network Heath during the measurement year with no more than one gap in continuous enrollment of up to 45 days.		o Both a quantitative urine albumin test and a urine creatinine test with service dates four days or less apart o A uACR Stratification for the KED measure: • All Product Lines: race and ethnicity • Age in three groups and total rate: o 18-64 years o 65-75 years o 76-85 years o Total	
5	Osteoporosis Management in Women Who Had a Fracture (OMW)	Have a bone mineral density test, or prescribed a drug to treat or prevent osteoporosis in	Female members age 67-85 who had one or more fractures from July of the prior calendar year through June of current calendar year (intake period). If member had more than one fracture, use the first fracture to determine timeframe for compliance.	Medicare	Appropriate testing or treatment for osteoporosis after the fracture defined by any of the following criteria: • A BMD test in any setting, on the initial fracture diagnosis date of service (also referred to as index episode start date or	12-month period that begins on July 1 of the year prior to the measurement

	Allows Alternative Supplemental Data (ASD) to be submitted	the six months after the fracture	Exclude members who meet any of the following criteria: • Fractures of finger, toe, face and skull are not included in this measure • Had a BMD test during the two years prior to the fracture • Had osteoporosis therapy during the one year prior to the fracture • Patient dispensed prescription to treat osteoporosis during the one year prior to the fracture. • In hospice or using hospice services anytime during the measurement year • Received palliative care any time in the measurement year • Died any time in the measurement year. Other exclusions: • Medicare members 67 years or age and older as of December 31 of measurement year who meet either of the following: o enrolled in an Institutional SNP any time during the measurement year o Living long-term in an institution any time during the measurement year as identified by the LTI flag in the Monthly Membership Detail Data File • Members 67-80 years of age as of December 31 of the measurement year (all product lines) with frailty and advanced illness. Members must meet BOTH frailty and advanced illness criteria to be excluded. • Members 81 years of age and older as of December 31 of the measurement year with two indications of frailty with different dates of service during the intake period through the end of the measurement year In addition, members must be continuously enrolled with Network Heath for 12 months before the IESD through six months after the IESD with no more than one gap in continuous enrollment of up to 45 days.		IESD) or in the 6-month period after the IESD • If the IESD was an inpatient stay, a BMD test during the inpatient stay • Osteoporosis therapy on the IESD or in the 6-month period after the IESD • If the IESD was an inpatient stay, long-acting osteoporosis therapy during the inpatient stay • Dispensed a prescription to treat osteoporosis on the IESD or in the 6-month period after the IESD If provider systems have a member who is struggling to get into provider site to complete a DEXA scan, **contact Network Health to arrange an in-home bone density screening**, with intention for the patient and provider to then decide if a follow-up DEXA scan would be indicated later. There are no measure stratifications required for this measure.	year and ends on June 30 of the measurement year
6	Colorectal Cancer Screening (COL-E)	One or more screenings: Yearly fecal occult blood	Includes members age 45-75 years old. Exclude patients who meet any of the following criteria:	Commercial/ Medicare	Patient had one or more screenings for colorectal cancer within the following timeframes. **FOBT:** Current calendar year	Current calendar year to previous

	Allows Alternative Supplemental Data (ASD) to be submitted	test (FOBT), or every three years FIT-DNA test or every five years flexible sigmoidoscopy or every 10-years colonoscopy	• In hospice or using hospice services anytime during the measurement year.
			• Received palliative care during the measurement year
			• Died any time in the measurement year.
			• Colorectal cancer any time during patient's history
			• Total colectomy any time during patient's history
			Other exclusions:
			• Members 66 years or age and older as of December 31 of measurement year who meet either of the following:
			  ○ Members enrolled in an Institutional SNP any time during the measurement year
			  ○ Living long-term in an institution (LTI) any time during the measurement year as identified by LTI flag in the Monthly Membership Detail
			
			• Members 66 years of age and older as of December 31 of the measurement year (all product lines) with frailty and advanced illness. Members must meet BOTH frailty and advanced illness criteria to be excluded.
			
			In addition, members must be continuously enrolled with Network Heath during the current calendar year and the prior calendar year with no more than one gap in continuous enrollment of up to 45 days.
					FIT-DNA Test: Current calendar year to previous two calendar years
					Flexible Sigmoidoscopy or CT Colonography: Current calendar year to previous four calendar years
					Colonoscopy: Current calendar year to previous nine calendar years.
					
					Documentation in the medical record including date when specific type of colorectal cancer screening done. A result is not required if the documentation is clearly part of the member's "medical history"; if this is not clear, the result or finding must also be present to ensure that the screening was performed and not merely ordered. A **pathology report** that indicates the type of screening and the date when test done will meet for this measure.
					
					COL-E is an ECDS (electronic clinical data set) measure.
					
					Stratification for the colorectal cancer screening measure include:
					• Medicare only: Socioeconomic Status (SES): Low Income Subsidy (LIS), Disability (DIS), Dual Eligible D-SNP (DE)
					• All Product Lines:
					  ○ Race
					  ○ Ethnicity
					  ○ Age in two groups:
					  ▪ 46-50 years
					  ▪ 51-75 years
						nine calendar years

7	Breast Cancer Screening (BCS - E)
	
	Allows Alternative Supplemental Data (ASD) to be submitted
		One mammogram every two years (27 months in total, going back to October 1 prior to the full two year look back)	Includes patients age 40-74 years old who were recommended for routine breast cancer screening and assigned female gender at birth.
			
			Excludes members who meet any of the following criteria:
			  ○ In hospice or using hospice services anytime during the measurement year
			  ○ Received palliative care during the measurement year
			  ○ Died any time in the measurement year.
				Commercial/ Medicare	Patient had one or more mammograms during the measurement period.
					
					Result not required, date last completed in medical history enough evidence for compliance.
					
					BCS-E is an ECDS measure.
					
					Stratification for the breast cancer screening measure include:
						Current or prior calendar year (plus three months, going back to October 1 prior to full two year look back)

			○ Had bilateral mastectomy, any time during the member's history ○ Had unilateral mastectomy with a bilateral modifier ○ Had gender-affirming chest surgery with a diagnosis of gender dysphoria any time during the member's history Other exclusions: ○ Medicare members 66 years or age and older as of December 31 of measurement year who meet either of the following: ○ enrolled in an Institutional SNP any time during the measurement year ○ Living long-term in an institution (LTI) any time during the measurement year as identified by LTI flag in the Monthly Membership Detail ○ Members 66 years of age and older as of December 31 of the measurement year (all product lines) with frailty and advanced illness. Members must meet BOTH frailty and advanced illness criteria to be excluded. In addition, members must be continuously enrolled with Network Heath from October 1 two years prior to the current calendar year through the end of the current calendar year with no more than one gap in continuous enrollment of up to 45 days.		• Medicare only: Socioeconomic Status (SES): Low Income Subsidy (LIS), Disability (DIS), Dual Eligible D-SNP (DE) • All Product Lines: ○ Race ○ Ethnicity	
8	Cervical Cancer Screening (CCS-E) **Allows Alternative Supplemental Data (ASD) to be submitted**	Appropriate screening for cervical cancer	The percentage of members aged 21 - 64 who were recommended for routine cervical cancer screening and assigned female gender at birth who had appropriate screening for cervical cancer: • Women 21–64 years of age who had cervical cytology performed within the last 3 years. • Women 30–64 years of age who had cervical high-risk human papillomavirus (hrHPV) testing performed within the last 5 years. • Women 30–64 years of age who had cervical cytology/high-risk human papillomavirus (hrHPV) co-testing within the last 5 years	Commercial	For medical record review or submission of alternative supplemental data, documentation in the medical record will count for cervical cytology and hrHPV if both of the following are documented in the EMR: • A note indicating the date when the cervical cytology or hrHPV was performed. • The result or findings of the test. Do not count lab results that explicitly state the sample was inadequate or that "no cervical cells were present"; this is not considered appropriate screening.	Current calendar year to previous five calendar years

			Excludes members who meet any of the following criteria:
			• In hospice or using hospice services anytime during the measurement year.
			• Received palliative care during the measurement year.
			• Died any time in the measurement year.
			• Had a hysterectomy with no residual cervix, cervical agenesis or acquired absence of cervix any time during the member's history.
			• Assigned male gender at birth.
			
			In addition, commercial members must be continuously enrolled with Network Heath during the measurement period and the 2 years prior. Medicaid members must be enrolled throughout the measurement period. No more than one gap in continuous enrollment of up to 45 days during each year.
					Do not count biopsies because they are diagnostic and therapeutic only and are not valid for primary cervical cancer screening.
					
					CCS-E is an ECDS measure.
					
					Stratification for the breast cancer screening measure include:
					• Commercial and Medicaid Product Lines:
					  ○ Race
					  ○ Ethnicity	

9	Statin Therapy for Patients with Cardiovascular Disease (SPC) **Allows Alternative Supplemental Data (ASD) to be submitted**	Dispensed at least one high or moderate statin medication	The percentage of males 21-75 years and females 40-75 years who were identified with clinical atherosclerotic cardiovascular disease and were dispensed at least one high or moderate intensity statin medication during the measurement year While Network Health's CI contract doesn't include the component of HEDIS's SPC measure pertaining to statin adherence, here are the details of that component: Members (same age ranges above) who remained on a high or moderate intensity statin medication for at least 80% of the treatment period. The treatment period is the period of time beginning on the date of the earliest prescription dispensing date through the last day of the measurement year. Exclude members who meet any of the following criteria: • Members age 66 or older that are enrolled in an institutional SNP or living long-term in an institution anytime during the measurement year are excluded. • Members 66 years of age and older as of December 31 of the measurement year with frailty and advanced illness. Members must meet BOTH frailty and advanced illness to be excluded.	Commercial/ Medicare	Members who were dispensed at least one high-intensity or moderate intensity statin medication during the measurement year. High-intensity statin therapy includes: • Atorvastatin 40-80 mg • Amlodipine-atorvastatin 40-80 mg • Rosuvastatin 20-40 mg • Simvastatin 80 mg • Ezetimibe-simvastatin 80 mg Moderate-intensity statin therapy includes: • 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 mg • Fluvastatin 40-80 mg • Pitavastatin 1-4 mg	Current calendar year

			Exclude members who meet any of the following criteria: • A diagnosis of pregnancy or in vitro fertilization in the measurement year or the year prior. • Dispensed at least one prescription for clomiphene in the measurement year or the year prior. • ESRD or dialysis in the measurement year or the year prior. • Cirrhosis in the measurement year or the year prior. • Myalgia, myositis, myopathy or rhabdomyolysis in the measurement year. • Myalgia or rhabdomyolysis caused by a statin any time during the member's history through December 31 of the measurement year. • In hospice or using hospice services or member receiving palliative care in the measurement year. • Died any time in the measurement year. • Living long-term in an institution (LTI) any time during the measurement year as identified by LTI flag in the Monthly Membership Detail In addition, members must be continuously enrolled with Network Heath during the measurement year with no more than one gap in continuous enrollment of up to 45 days.		Stratification for SPC measure include: • Males 21-75 years • Females 40-75 years • Total rates	
10	Statin Use in Persons with Diabetes (SUPD)	Dispensed at least one statin medication (any dose intensity level)	Includes percentage of members ages 40 – 75 years as of January 1 of the measurement year who meet continuous enrollment requirements for the full measurement year (no more than one month gap in coverage) with diabetes who take the most effective cholesterol-lowering drug to meet their clinical needs (of any dose intensity level). Members are included in this measure when they have been dispensed at least two diabetes medication fills in the measurement year. Excludes members with the following any time during the measurement year: • Pre-diabetes • Polycystic Ovary Syndrome • Pregnancy, lactation or fertility • ESRD or dialysis	Medicare	Members who were dispensed at least one statin medication (any dose intensity level) during the measurement year. Note: Network Health uses the PQA specifications rather than HEDIS for this measure.	Current calendar year

			• Cirrhosis – Liver Disease • Rhabdomyolysis and myopathy • Hospice enrollment			
11	Controlling High Blood Pressure (CBP) **Allows Alternative Supplemental Data (ASD) to be submitted**	Adequately controlled blood pressure based on LAST measurement of the year	Patients 18-85 years of age who had a diagnosis of hypertension (HTN) and whose blood pressure (BP) was adequately controlled (<140/90 mm Hg) on or after the second diagnosis of HTN. Visit type does not have to be the same for the two visits. Any of the following visits meet criteria: outpatient visit, telephone visit, e-visit, or virtual check-in. Exclude patients who meet any of the following criteria: • In hospice or using hospice services or receiving palliative care in the measurement year. • Died any time in the measurement year. • ESRD or dialysis in the measurement year. • Pregnancy in the measurement year. • Patients 66 years of age or older that are enrolled in an Institutional SNP or living long-term in an institution (LTI) any time during the measurement year as identified by LTI flag in the Monthly Membership Detail • Patients 66-80 years of age with frailty and advanced illness. Patients must meet both the frailty and advanced illness criteria to be excluded. • Patients 81 years of age or older with two diagnoses on different dates of service for frailty during the measurement year. In addition, members must be continuously enrolled with Network Heath during the review period with no more than one gap in continuous enrollment of up to 45 days.	Commercial/ Medicare	For medical record review (ASD submission), HEDIS tech specs require that we do not include BP readings: • Taken during an acute inpatient stay or an ED visit. • Taken on the same day as a diagnostic test or diagnostic or therapeutic procedure that requires a change in diet or change in medication on or one day before the day of the test or procedure, except for fasting blood tests. • Taken by the patient using a non-digital device such as with a manual blood pressure cuff and stethoscope. Identify the lowest systolic and lowest diastolic BP reading from the most recent BP notation in the medical record used by patient's PCP or provider managing the patient's HTN. If multiple readings were recorded for a single date, use the lowest systolic and lowest diastolic BP on that date as the representative BP. The systolic and diastolic results do not need to be from the same reading. BP readings taken by the patient and documented in the medical record are eligible for use in reporting (provided the BP does not meet any exclusion criteria). Ranges and thresholds do not meet criteria for this measure. A distinct numeric result for both the systolic and diastolic BP is required. A BP documented as an "average BP" is eligible for use. Stratification for the controlling BP measure include (all product lines): • Race • Ethnicity	Current calendar year
12	Transition of Care (TRC) 30 day follow up	Transition of Care Coordination after inpatient stay	The percentage of discharges for members 18 years of age and older who had each of the following: • Patient Engagement After Inpatient Discharge. Documentation of patient engagement (e. g., office visits, visits to the home, telephone visit, synchronous telehealth visit, asynchronous e-visit	Medicare	Please note the denominator for this measure is based on inpatient discharges, not on members. If members have more than one discharge, include all discharges on or between January 1 and December 1 of the measurement year.	Discharge between January 1 and December 1 of calendar year

	Allows Alternative Supplemental Data (ASD) to be submitted		or virtual check-in) provided within 30 days after acute and non-acute inpatient discharge. • Medication Reconciliation Post-Discharge. Documentation of medication reconciliation on the date of discharge through 30 days after discharge (31 total days) conducted by a prescribing provider, clinical pharmacist, or registered nurse. Exclude patients who meet any of the following criteria: • In hospice or using hospice services in the measurement year. • Died any time in the measurement year. • Any member that has their last discharge occur after December 1 of the measurement year.		If discharge is followed by readmission within 31 days, use the date of discharge from the last discharge as the index date. If the organization is unable to confirm the member remained in the acute or non-acute care setting through December 1, disregard the readmission or direct transfer and use the initial discharge date. Do not include patient engagement that occurs on the date of discharge. Stratification for the TRC measure includes: • Age in two groups: ○ 18-64 years ○ 65 years and older ○ Total While these two components are part of the official HEDIS TRC measure, Network Health is not including these two elements in the aligned incentive agreement at this time: • Notification of Inpatient Admission. Documentation of receipt of notification of inpatient admission on the day of admission through 2 days after the admission (3 total days). • Receipt of Discharge Information. Documentation of receipt of discharge information on the day of discharge through 2 days after the discharge (3 total days).	
13	Follow up After ED for Multiple High-Risk Chronic Conditions - 7 day follow up (FMC) **Allows Alternative Supplemental Data (ASD) to be submitted**	Follow up visit after ED visit for member with multiple high-risk chronic conditions	The percentage of emergency department (ED) visits for members 18 years of age and older who have multiple high-risk chronic conditions who had a follow-up service within 7 days of the ED visit. Exclude patients who meet any of the following criteria: • ED visits that result in an inpatient stay and ED visits followed by admission to an acute or nonacute inpatient care setting on the date of the ED visit or within 7 days after the ED visit, regardless of the principal diagnosis for admission. • In hospice or using hospice services in the measurement year. • Died any time in the measurement year.	Medicare	Please note the denominator for this measure is based on ED visits, not on members. If a member has more than one ED visit, identify all ED visits between January 1 and December 24 of the measurement year. A follow-up service within 7 days after the ED visit (8 total days). Include visits that occur on the date of the ED visit. The following meet criteria for follow-up: • Outpatient visit • Telephone visit • Transitional care management services • Case management visits • Complex care management services	ED visit on or between January 1 and December 24 of the measurement year

			Members enrolled with Network Health 365 days prior to the ED visit through 7 days after the ED visit. No more than one gap in enrollment of up to 45 days during the 365 days prior to the ED visit and no gap during the 7 days following the ED visit.		• Outpatient or telehealth behavioral health visit • Intensive outpatient encounter or partial hospitalization • Community mental health center visit • Electroconvulsive therapy • Telehealth visit • Substance use disorder service, counseling or surveillance • E-visit or virtual check-in Stratification for the TRC measure includes: • Age in two groups: o 18-64 years o 65 years and older o Total	
14	Diabetes Medication Adherence (PDC-DR)	80% adherence for use of diabetes medications	The percentage of members 18 years and older who met the Proportion of Days Covered (PDC) threshold of 80 percent for any of the diabetes medications during the measurement year. Exclude patients who meet any of the following criteria: • In hospice or using hospice services in the measurement year. • End-stage renal disease (ESRD) or on dialysis • Members using insulin any time in the measurement year. The measure has been updated to weigh each member equally in the overall rate and not by member year.	Medicare	Includes members with prescription claims ≥ 2 Rx claims for any of the diabetes medications on unique dates of service in the treatment period. The treatment period is the period of time beginning on the date of the earliest prescription dispensing date through the last day of the measurement year. Beneficiaries are only included in the measure calculation if the first fill of their diabetes medication occurs at least 91 days before the end of the enrollment period. Continuous Part D enrollment over the treatment period (from first script) must extend for a minimum of 91 days. Note: Network Health uses the PQA specifications. A higher rate indicates better performance.	Calendar year
15	Medication Adherence for Hypertension (PDC-RASA)	80% adherence for use of renin angiotensin system antagonist medications	The percentage of members 18 years and older who met the Proportion of Days Covered (PDC) threshold of 80 percent for renin angiotensin system antagonists (RASA) during the measurement year. Exclude patients who meet any of the following criteria: • In hospice or using hospice services in the measurement year. • End-stage renal disease (ESRD) or on dialysis • Members using sacubitril/valsartan any time in the measurement year.	Medicare	Includes members with prescription claims ≥ 2 Rx claims for RASA or RASA combination product on different dates of service in the treatment period. The treatment period is the period of time beginning on the date of the earliest prescription dispensing date through the last day of the measurement year. Blood pressure medication includes: • ACEI (angiotensin converting enzyme inhibitor) • ARB (angiotensin receptor blocker)	Calendar year

			The measure has been updated to weigh each member equally in the overall rate and not by member year.		• A direct renin inhibitor drug Beneficiaries are only included in the measure calculation if the first fill of their RAS antagonist medication occurs at least 91 days before the end of the enrollment period. Continuous Part D enrollment over the treatment period (from first script) must extend for a minimum of 91 days. Note: Network Health uses the PQA specifications. A higher rate indicates better performance.	
16	Medication Adherence for Cholesterol - Statins (PDC-STA)	80% adherence for use of statin medications	The percentage of members 18 years and older as of January 1 of the measurement year meeting continuous enrollment criteria during the treatment period with a prescription for a cholesterol medication who fill their prescription often enough to cover 80% or more of the time they are supposed to be taking the medication. Exclude patients who meet any of the following criteria: • In hospice or using hospice services in the measurement year. • End-stage renal disease (ESRD) or on dialysis The measure has been updated to weigh each member equally in the overall rate and not by member year.	Medicare	Includes members with prescription claims ≥ 2 Rx claims for statin or statin combination product on different dates of service in the measurement period. Beneficiaries are only included in the measure calculation if the first fill of their statin medication occurs at least 91 days before the end of the enrollment period Continuous Part D enrollment over the treatment period (from first script) must extend for a minimum of 91 days Note: Network Health uses the PQA specifications. A higher rate indicates better performance.	Calendar year

17	Influenza Vaccination Rate	Influenza vaccination as recommended routine vaccine for adults 19 and older	The percentage of all members who are up to date on recommended routine vaccine for influenza (for adults, we will rely on the sub-measure of Adult Immunization Status – AIS-E- measure). Will use this rate calculation for all commercial members as well, including children.
			
			Exclude members in hospice or using hospice services or members who die anytime during the measurement period.
				Medicare Commercial	For this measure, includes product lines and data is stratified based on:
					• Race
					• Ethnicity
					• Age
					  ○ 19-64 years
					  ○ 65 years and older
					
					Members with anaphylaxis due to the influenza vaccine any time before or during the measurement period will count as a numerator hit.
						July 1 of the year prior to measurement year through June 30 of the measurement year

18	Social Need Screening and Intervention (SNS-E)	Screening and Intervention when unmet need identified	The percentage of members who were screened, using prespecified instruments, at least once during the measurement period for unmet food, housing, and transportation needs, and received a corresponding intervention if they screened positive.	Medicare and Commercial	The measure offers the following for clarity: **Food insecurity:** Uncertain, limited, or unstable access to food that is: adequate in quantity and in nutritional quality;	Calendar year

			Excludes members who meet any of the following criteria: o In hospice or using hospice services anytime during the measurement year o Died any time in the measurement year. Other exclusions: o Medicare members 66 years or age and older as of December 31 of measurement year who meet either of the following: o enrolled in an Institutional SNP any time during the measurement year Living long-term in an institution (LTI) any time during the measurement year as identified by LTI flag in the Monthly Membership Detail In addition, members must be continuously enrolled with Network Heath during the review period with no more than one gap in continuous enrollment of up to 45 days and the member must be enrolled on the last day of the measurement period.		culturally acceptable; safe; and acquired in socially acceptable ways. **Housing instability:** Currently consistently housed but experiencing any of the following circumstances in the past 12 months: being behind on rent or mortgage, multiple moves, cost burden or risk of eviction. **Homelessness:** Currently living in an environment that is not meant for permanent human habitation (e.g., car, park, sidewalk, abandoned building, on the street), not having a consistent place to sleep at night, or because of economic difficulties, currently living in a shelter, motel, temporary or transitional living situation. **Housing inadequacy:** Housing does not meet habitability standards. **Transportation insecurity:** Uncertain, limited or no access to safe, reliable, accessible, affordable, and socially acceptable transportation infrastructure and modalities necessary for maintaining one's health, well-being, or livelihood. Stratification for the SNS measure includes: • Age in three groups: o ≤ 17 years o 18-64 years o 65 years and older	
19	Asthma Medication Ratio (AMR)	Appropriate use of controller medications and total asthma medications in patients with persistent asthma	Members 5-64 years of age who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater during the measurement year. Exclude members who met any of the following criteria: • A diagnosis that requires a different treatment approach than members with asthma • No asthma controller or reliever medications dispensed during the measurement year. • In hospice or using hospice services anytime during measurement year. • Died any time in the measurement year.	Commercial	Stratifications for this measure includes: • Race • Ethnicity • Age: o 5-11 years o 12-18 years o 19-50 years o 51-64 years o Total	Calendar year

20	Avoidance of Antibiotic Treatment for Acute Bronchitis/ Bronchiolitis (AAB)	Antibiotics note dispensed with diagnosis of acute bronchitis/ bronchiolitis	The percentage of episodes for members ages three months and older with a diagnosis of acute bronchitis/bronchiolitis that did not result in an antibiotic dispensing event. Members on hospice and members who die in the measurement year are excluded from this measure. In addition, members are excluded with a qualifying comorbid condition within 12 months prior to the episode date. Members must be continuously enrolled with Network Heath without a gap in coverage from 30 days prior to the Episode Date through 3 days after the Episode Date (34 total days).	Commercial/ Medicare	The denominator for this measure is based on episodes, not on members. All eligible episodes that were not excluded or de-duplicated remain in the denominator. The measure includes all product lines, and stratifications for this measure includes: • Age: ○ 3 months – 17 years ○ 18 - 64 years ○ 65 years and older ○ Total Member must have had no antibiotic prescription claims filed within 30 days prior to the Episode Date. The measure is reported as an inverted rate. A higher rate indicates appropriate acute bronchitis/bronchiolitis treatment. **For Network Health value-based care agreements, the measure is reported on a calendar year basis, January 1 through December 31.**	12-month measurement year period starts on July 1 of the year prior to the measurement year, and ends on June 30 of the measurement year For CI performance, measurement period is the calendar year: Jan 1 through Dec 31
21	Appropriate Testing for Pharyngitis (CWP) **Allows Alternative Supplemental Data (ASD) to be submitted**	Diagnosis of pharyngitis with antibiotics dispense and had a strep test	The percentage of episodes for members three years and older where the member was diagnosed with pharyngitis, dispensed an antibiotic, and received a group A streptococcus (strep) test for the episode. Members on hospice and members who die in the measurement year are excluded from this measure. In addition, members are excluded with a qualifying comorbid condition within 12 months prior to the episode date. Members must be continuously enrolled with Network Heath without a gap in coverage from 30 days prior to the Episode Date through three days after the Episode Date (34 total days).	Commercial/ Medicare	A compliant numerator hit includes a group A streptococcus test in the 7-day period from 3 days prior to the episode date through 3 days after the episode date. The measure includes all product line, and stratifications for this measure includes: • Age: ○ 3 – 17 years ○ 18 - 64 years ○ 65 years and older ○ Total **For Network Health value-based care agreements, the measure is reported on a calendar year basis, January 1 through December 31.**	12-month measurement year period starts on July 1 of the year prior to the measurement year, and ends on June 30 of the measurement year For CI performance, measurement period is the calendar year: Jan 1 through Dec 31

22	Adolescent Immunization Combo 2 (IMA-E) **Allows Alternative Supplemental Data (ASD) to be submitted**	Adolescent immunization administered within qualifying timeframe	The percentage of adolescents 13 years of age who had one dose of meningococcal vaccine, one tetanus, diphtheria toxoids and acellular pertussis (Tdap) vaccine, and have completed the human papillomavirus (HPV) vaccine series by their 13th birthday. The measure calculates a rate for each vaccine and two combination rates. Members on hospice and members who die in the measurement year are excluded from this measure . Members must be continuously enrolled with Network Heath without a gap in coverage of up to 45 days during the 12 months prior to the 13th birthday. The member must be participating for 365 days prior to their 13th birthday through the member's 13th birthday.	Commercial	For immunization evidence obtained from the medical record, count members where there is evidence that the antigen was rendered from one of the following. • A note indicating the name of the specific antigen and the date of the immunization. • A certificate of immunization prepared by an authorized health care provider or agency including the specific dates and types of immunizations administered. IMA-E is an ECDS measure. Stratifications for this measure includes: • Race • Ethnicity	Current calendar year
23	Childhood Immunization Status (CIS-E) CIS Combo 3	Childhood immunizations administered within qualifying timeframe	CIS as a HEDIS measure includes the percentage of children two years of age who had four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV); one measles, mumps and rubella (MMR); three haemophilus influenza type B (HiB); three hepatitis B (HepB), one chicken pox (VZV); four pneumococcal conjugate (PCV); one hepatitis A (HepA); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday. The measure calculates a rate for each vaccine and three combination rates. Exclude members who meet any of the following criteria: • In hospice or using hospice services anytime during the measurement year • Died during the measurement year • Contraindication to a childhood vaccine • Organ and bone marrow transplants Members must be continuously enrolled with Network Heath without a gap in coverage of up to 45 days during the 12 months prior to the child's second birthday. The member must be enrolled 365 days prior to the child's second birthday through the child's second birthday.	Commercial	Anaphylaxis due to a specific vaccine on or before the child's second birthday will count as a numerator hit for this measure. For Network Health aligned incentive agreements, the performance metrics focus on: **CIS Combo 3** includes DTaP, IPV, MMR, HiB, HepB, and VZV CIS-E is an ECDS measure. This measure applies to Commercial and Medicaid lines of business.	Current calendar year
24	Concurrent Use of Opioids and Benzodiazepines (COB)	Concurrent use of opioids and	The percentage of individual age 18 year and older with concurrent use of prescription opioids and benzodiazepines.	Medicare	A lower rate indicates better performance. Individuals are included in the denominator with ≥ 2 prescription claims for any benzodiazepines with	Current calendar year

		benzodiazepines	Excludes members with the following any time during the measurement year: • Hospice enrollment • Cancer • Sickle cell disease		different dates of service AND concurrent use of opioids and benzodiazepines for > 30 cumulative days.	
25	Polypharmacy Use of Multiple Anticholinergic Medications in Older Adults (POLY-ACH)	Multiple anticholinergic medications in older adults	The percentage of individual age 65 years and older with concurrent use of 2 or more unique anticholinergic medications. Excludes members with the following any time during the measurement year: • Hospice enrollment	Medicare	A lower rate indicates better performance. Individuals are included in the denominator with concurrent use for ≥ 30 cumulative days of 2 or more anticholinergic medications, each with 2 or more prescription claims on different dates of service during the measurement year.	Current calendar year

CAHPS			**Network Health members that are continuously enrolled during the calendar year are randomly selected and mailed a survey. The following measures are based on enrollees that received the survey and answered questions related to each of the measures. Many questions are preceded by a question asking a member if they have a certain type of provider, have seen a certain type of provider in the past *x* number of months, if they have received certain care or have had a certain experience to ensure that the member should proceed to questions used in the following measures. Please note that all answers provided by members are based on their perception.**			
26	Getting Needed Care	How easy it is for members to get needed care, including care from specialists, tests or treatments	Member answered question(s) on how often they were able to get needed care, including care from specialists, tests or treatments.	Commercial/ Medicare	(Prerequisite) In the last 6 months, did you make any appointments for a check-up or routine care at a doctor's office or clinic? If member answers "Yes" they qualify to answer the following question: **(Q5) In the last 6 months, how often was it easy to get the care, tests or treatment you needed?** (Prerequisite) In the last 6 months, did you make any appointments to see a specialist? If member answers "Yes" or "Someone else made my specialist appointments for me", they qualify to answer the following question: **(Q25 for Medicare; Q22 for Commercial)** **In the last 6 months, how often did you get an appointment to see a specialist as soon as you needed?** The measure is the composite of the two questions (Q5 and Q25/22).	Current calendar year
27	Getting Appointments and Care Quickly	How quickly members get appointments and care	Member answered question(s) on how often they were able to get appointments and receive care as soon as they needed.	Commercial/ Medicare	(Prerequisite) In the last 6 months, did you have an illness, injury, or condition that needed care right away in a clinic, emergency room, or doctor's	Current calendar year

					office? If member answers “Yes”, they qualify to answer the following question: **(Q2) In the last 6 months, when you needed care right away, how often did you get care as soon as you needed?** (Prerequisite) In the last 6 months, did you make any appointment for a check-up or routine care at a doctor’s office or clinic? If member answers “Yes”, they qualify to answer the following question: **(Q4) In the last 6 months, how often did you get an appointment for a check-up or routine care as soon as you needed?** The measure is the composite of the three questions (Q2 and Q4)	
28	Rating of Health Care Quality	Overall rating of the health care members received	Member answered question(s) on how they would rate their health care.	Commercial/ Medicare	(Prerequisite) In the last 6 months, did you make any appointment for a check-up or routine care at a doctor’s office or clinic? If member answers “Yes”, they qualify to answer the following question: **(Q6) Using any number from 0 to 10, where 0 is the worst health care possible and 10 is the best health care possible, what number would you use to rate all your health care in the last 6 months?**	Current calendar year
29a	Care Coordination	How well personal doctors and their office staff coordinated members’ care.	Member answered question(s) from various aspects regarding the coordination of care provided. (This includes whether doctors had the records and information they needed about members’ care and how quickly members got their test results.)	Medicare	(Prerequisite) In the last 6 months, how many times did you have an in-person, phone, or video visit with your personal doctor about your health? If more than 0, they qualify to answer the following questions: In the last 6 months, when your personal doctor ordered a blood test, x-ray or other test for you; **(Q15a) How often did someone from your personal doctor’s office follow up to give you those results?** **(Q15b) How often did you get those results as soon as you needed them?**	Current calendar year

					(Prerequisite) In the last 6 months did you take any prescription medicine? If "Yes" they qualify to answer the following question: **(Q16) In the last 6 months, how often did you and your personal doctor talk about all the prescription medicines you were taking?** **(Q18) In the last 6 months, when you visited your personal doctor for a scheduled appointment, how often did he or she have your medical records or other information about your care?** (Prerequisite) In the last 6 months, did you get care from more than one kind of health care provider or use more than one kind of health care service? If member answers "Yes", they qualify to answer the following questions. **(Q20) In the last 6 months, how often did your personal doctor seem informed and up to date about the care you got from specialists?** **(Q21) In the last 6 months, did you get the help you needed from your personal doctor's office to manage your care among these different providers and services?**	
29b	Care Coordination	How well personal doctors and their office staff coordinated members' care.	Member answered question(s) from various aspects regarding the coordination of care provided. (This includes whether doctors had the records and information they needed about members' care and how quickly members got their test results.)	Commercial	Note: The commercial survey measure uses a lead-in question listed first below, and then is scored based on the second question only. (Q17)In the last 6 months, did you get care from more than one kind of health care provider or use more than one kind of health care service? Yes No – If no, Go to next question **(Q19) In the past 6 months, how often did your personal doctor seem informed and up to date about the care you got from these doctors or other health providers?**	Current calendar year

Health Outcomes Survey Questions (HOS) - Medicare Only					
Network Health members that are continuously enrolled during the calendar year are randomly selected and mailed a survey. The following measures are based on enrollees that received the survey and answered questions related to each of the measures. Each year a random sample of Medicare beneficiaries is drawn and surveyed from each participating Medicare Advantage Organization. Two years later, the baseline respondents are surveyed again (i.e., follow up measurement) ratings are based on improvement/decline in responses. Reponses for CI aligned incentive targets are calculated on an annual basis and not based on improvement. Please note that all answers provided by members are based on their perception.					
30	Monitoring Physical Activity	Members who discussed exercise with their doctor during the year	Member answered question(s) regarding whether their doctor discussed exercise or physical activity during the year.	**(Q22) In the past 12 months, did you talk with a doctor or other health provider about your level of exercise or physical activity?**	Current calendar year
31	Reducing the Risk of Falling	Members with a problem falling, walking, or balancing, who discussed it with their doctor and got treatment for it during the year	Member had a fall or had problems with balance or walking in the past 12 months.	Member was seen by a practitioner in the past 12 months and who have fallen or had a problem with balance or walking. (Prerequisite) A fall is when your body goes to the ground without being pushed. Did you fall, or have you had a problem with balance or walking in the past 12 months? If member answers "Yes", they qualify to answer the following question. **(Q56) Has your doctor or other health provider talked to you to help prevent falls or treat problems with balance or walking?** Some things they might talk about: • Suggest that you use a cane or walker • Check your blood pressure lying or standing • Suggest that you do an exercise or physical therapy program • Suggest a vision or hearing testing • Limit the use of throw rugs	Current calendar year
32	Improving Bladder Control	Management of urinary incontinence	Member reported having urine leakage within the current calendar year and answered question(s) around the management of their urinary incontinence.	Member was seen by a practitioner in the past 12 months and who have urine leakage in the past six months. (Prerequisite) Many people experience leakage of urine, also called urinary incontinence. In the past six months, have you experienced leaking of urine? If member answers "Yes", they qualify to answer the following question: **(Q54) There are many ways to control or manage the leaking of urine, including bladder training exercises, medication, and surgery.**	Current calendar year

				Have you ever talked with a doctor, nurse or other health care provider about any of these approaches?	
33	Improving or Maintaining Physical Health	Members whose physical health was addressed during the year	Member answered question(s) regarding their current physical health.	**(Q51) Compared to one year ago, how would you rate your physical health in general now?**	Current calendar year
34	Improving or Maintaining Mental Health	Members whose emotional health was addressed during the year	Member answered question(s) regarding their current mental or emotional health, such as feeling anxious, depressed, or irritable.	**(Q52) Compared to one year ago, how would you rate your emotional health (such as feeling anxious, depressed, or irritable) in general now?** **(Q23) In the past 6 months, did you talk with your doctor or other health provider about your emotional health?** The measure is the composite of the two questions (Q52 and Q23)	Current calendar year

Net Promoter Scores Related to CI Provider Services* (Medicare members only)					
35	Rating of their Personal Doctor	Member's rating of their personal doctor	Member indicates their rating of their personal doctor. **The NPS scores are not calculated in the CI aligned incentive performance rating* *- updated in 2024 Proxy from likelihood to recommend to rating of personal doctor.*	(Prerequisite) A personal doctor is the one you would talk to if you need a check-up, want advice about a health problem, or get sick or hurt. Do you have a personal doctor? If member answers "Yes", they qualify to answer the following question: **(Q12) On a scale of 0-10, where 0 is worst personal doctor and 10 is best personal doctor, what number would you use to rate your personal doctor?**	Current calendar year