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

Measurement Year 2027 Technical Specifications

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Measure Copyright Information

Abbreviation	Measure Name	Steward	Copyright
AAF-E	Follow-Up After Acute and Urgent Care Visits for Asthma	NCQA	ii
BPC-E	Blood Pressure Control for Patients With Hypertension	NCQA	ii
CBP	Controlling High Blood Pressure	NCQA	ii
PDC-RASA	Proportion of Days Covered by Medications—(RAS) Antagonists	PQA	iii
PDC-STA	Proportion of Days Covered by Medications—Statins	PQA	iii
PDC-DR	Proportion of Days Covered by Medications—Diabetes All Class	PQA	iii
GSD	Glycemic Status Assessment for Patients With Diabetes	NCQA	ii
EED	Eye Exam for Patients With Diabetes	NCQA	ii
KED	Kidney Health Evaluation for Patients With Diabetes	NCQA	ii
SUPD	Statin Use in Persons With Diabetes	PQA	iii
OMW	Osteoporosis Management in Women Who Had a Fracture	NCQA	ii
WCV	Child and Adolescent Well-Care Visits	NCQA	ii
W30	Well-Child Visits in the First 30 Months of Life	NCQA	ii
CIS-E	Childhood Immunization Status	NCQA	ii
IMA-E	Immunizations for Adolescents	NCQA	ii
CCS-E	Cervical Cancer Screening	NCQA	ii
BCS-E	Breast Cancer Screening	NCQA	ii
COL-E	Colorectal Cancer Screening	NCQA	ii
TRC	Transitions of Care	NCQA	ii
PPC	Prenatal and Postpartum Care	NCQA	ii
PRS-E	Prenatal Immunization Status	NCQA	ii
DSF-E	Depression Screening and Follow-Up for Adolescents and Adults	NCQA	ii
ENRST	Encounter Rate by Service Type	NCQA/IHA	i
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RDM	Race/Ethnicity Description of Membership	NCQA	ii
PCR[1]	All-Cause Readmissions	NCQA	ii
EDU[1]	Emergency Department Utilization	NCQA	ii
AHU[1]	Acute Hospital Utilization	NCQA	ii
TCOC	Total Cost of Care	HealthPartners	v
PCS	Primary Care Spending	IHA/OHCA	vi
COF-E	Follow-Up After Positive Colorectal Cancer Non-Invasive Screening Test	NCQA	ii
PND-E	Prenatal Depression Screening	NCQA	ii
PDS-E	Postpartum Depression Screening	NCQA	ii

[1] IHA normalizes the All-Cause Readmissions, Emergency Department Utilization, and Acute Hospital Utilization measure results. NCQA has granted IHA permission for such adjustments from the AMP HEDIS specifications, but has not reviewed the methodology and disclaims all liability for use of the AMP All-Cause Readmissions, AMP Emergency Department Utilization, and AMP Acute Hospital Utilization results.

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iii. The PQA measures were developed by and are owned by the Pharmacy Quality Alliance ("PQA"). PQA retains the rights to these measures and can rescind or alter the measures at any time. No license is required for noncommercial use of the measures solely to report quality data for the IHA performance programs. All other uses, including reproduction, distribution, and publication must be approved by PQA and are subject to a license at the discretion of PQA. PQA reserves the right to determine the conditions under which it will approve use and/or license the measures. Users of PQA measures shall not have the right to alter, enhance, or otherwise modify the measures.

NOTE: A PQA license is required for all vendor organizations that are seeking or have earned NCQA Measure Certification of PQA measures used in AMP or other quality programs. Please contact contracts@pqaalliance.org for information on licensing.

The HEDIS Hospice Value Sets developed by the National Committee for Quality Assurance ("NCQA") is used in association with the PQA-owned measures. Proprietary coding is contained in the HEDIS Hospice Value Sets. Users of the proprietary code set should obtain all necessary licenses from the owners of the code set. NCQA disclaims all liability for use of the HEDIS Hospice Value Sets or accuracy of any coding contained in the HEDIS Hospice Value Sets.

iv. The use of measures developed and owned by IHA is restricted to reporting to IHA. IHA retains the rights to the measure specifications.

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HEDIS value sets developed by NCQA are also used in association with the HealthPartners-owned Total Cost of Care measure. Proprietary coding is contained in the HEDIS value sets. Users of the proprietary code sets should obtain all necessary licenses from the owners of the code sets. NCQA disclaims all liability for use of the HEDIS value sets or accuracy of any coding contained in the value sets.

vi. IHA adapted this measure for AMP from the Office of Health Care Affordability (OHCA)'s Primary Care Spending Measurement Definition and Methodology.

Overview

Background

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

IHA provides detailed programmatic and technical information to its participants to support accurate and complete data collection for the AMP programs. The programmatic guidelines are included in the AMP Program Guide, and the measure specifications are included in the AMP Technical Specifications **(this document)**.

The AMP Program Guide and the Technical Specifications follow this release schedule:

- The *Draft MY 2027 AMP Technical Specifications*, released on October 12, 2026, includes draft technical specifications for all measures in the AMP program for MY 2027, and reflects applicable changes in *HEDIS MY 2027 Volume 2: Technical Specifications* (released in August 2026).
- The *Final MY 2027 AMP Technical Specifications*, to be released on June 1, 2027, will include final technical specifications for all measures in the AMP program for MY 2027, and reflects applicable changes in *HEDIS MY 2027 Volume 2: Technical Specifications Update* (released on March 31, 2027).
- The *Preliminary MY 2027 AMP Program Guide*, to be released on June 1, 2027, will include AMP programmatic information such as background on AMP programs, reporting guidance, and timelines for data submission.
- The *Final MY 2027 AMP Program Guide*, to be released on December 15, 2027, will include all information previously included in the *Preliminary MY 2027 AMP Program Guide*, as well as additional AMP programmatic information which was not yet available in time for the release of the *Preliminary AMP Program Guide* on June 1, 2027.

The *MY 2027 Data Collection and Reporting* timeline for audited submission is included in the *Preliminary MY 2027 AMP Program Guide,* released on June 1, 2027. The MY 2027 timelines for *Health Plan Claims and Encounter Data Submission to Cozeva*, as well as *AMP Report Release Dates and Review Period*, will be available in the *Final MY 2027 AMP Program Guide*, to be released on December 15, 2027.

The HEDIS MY 2027 Medication List Directory (MLD) and the HEDIS MY 2027 Risk Adjustment Tables are available for free order and for download in the "Download" section of My NCQA. Health plans and POs are accountable for all future changes included in the corresponding *Final MY 2027 AMP Technical Specifications* and the MLD lists. Auditors assess compliance based on the *Final MY 2027 AMP Technical Specifications* and the MLD lists.

What's New in AMP?

Overall Changes

- Added the following new measures to the MY 2027 AMP measure set for testing:
  - Follow-Up After Positive Colorectal Cancer Non-Invasive Screening Test (COF-E)
  - Prenatal Depression Screening (PND-E)
  - Postpartum Depression Screening (PDS-E)
- Removed Chlamydia Screening (CHL) from the MY 2027 AMP measure set.
- Added a link to HEDIS Measure Library & Historical Data webpage for clinical rationale to all HEDIS measures.
- Updated the clinical recommendation statement/rationale and citations in various measure specifications to align with the most up to date clinical references.
- Expanded the death exclusion criteria in HEDIS measures to include members who died any time on or before the last day of the measurement period.
- Modified the value sets and codes used to identify the palliative care exclusion in HEDIS measures.
- Replaced references to "chemical dependency" benefit type with "substance use disorder treatment" in applicable HEDIS measures. This is an alignment with industry terminology, not a change to benefit requirements.

If You Have Questions About the Specifications

Policy Clarification Support

IHA partners with NCQA to maintain measure specifications used in the AMP programs. Participants who have questions regarding a measure specification should submit them through My NCQA.

Step 1 Go to the My NCQA page.

Step 2 Complete the **Register** section.

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

- To ask a new question, click **Ask a Question.**
- Click **PCS Policy/Program Clarification Support.**
- For *Product/Program Type,* click **IHA — AMP Programs** in the drop-down box.
- For *General Content Area,* select the appropriate category for your question.
- For *Specific Area,* scroll down and click the appropriate measure for your question, or click **Not Applicable** if your question type is not listed.
- For *Publication Year,* click **2027** for MY 2027 from the drop-down box.
- For *Subject*, enter a short subject for your question.
- Type your question (3,000 characters or less).

Step 4 Click **Submit Your Question**.

AMP Technical FAQ

The AMP Technical FAQ clarifies HEDIS and AMP uses and specifications, and is posted to the IHA website, as needed.

Read the entire guidelines section and measure specifications before implementing MY 2027 measures.

General Guidelines for Data Collection and Reporting

For MY 2027
Health Plans and Self-Reporting POs

General Guidelines for Data Collection and Reporting

GUIDANCE UPDATES OCTOBER 2026 FOR AMP MY 2027.

- Removed references to Medicare Advantage-Medi-Cal Managed Care (MMP) from Members with Dual Enrollment guideline because this is no longer a reporting option for MY 2027.
- Replaced references to "chemical dependency" with "substance use disorder treatment" in the *General Guidelines for Data Collection and Reporting*.
- Updated General Guideline: *Supplemental Data* to streamline wording and refer users to *AMP Audit Review Guidelines* for full details.
- Updated General Guideline: *Race and Ethnicity Stratifications* to capture declinations and unknown race and/or ethnicity more precisely by revising the reporting categories and associated codes.

Reporting Options

Two Data Sources

Health plan reporting

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

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

Health plans must submit member-level enrollment, claims, encounter, and supplemental data files to the data aggregator (Cozeva) for all contracted POs that have signed the Consent Agreement, regardless of PO eligibility for incentive payments from the health plan. Cozeva applies the Utilization measure specifications and produces PO results.

Self-reporting PO

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

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

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

Electronic data only

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

Reporting Level

IHA aggregates data at the PO level. For IHA to report data at a more granular "subgroup" level for a PO (e.g., by region), all the PO's contracted health plans must be willing and able to report clinical data at the PO subgroup level. If even one health plan cannot report at the subgroup level, all health plans must report the PO's data at the PO parent level (i.e., the "00" level).

Encounter/Claims Submission

Submitting Data

All eligible POs—self-reporting or not—must submit encounter data to their contracted health plans throughout the year. POs should follow the dates in the *Data Collection and Reporting* timeline in the AMP Program Guide and other information communicated by contracted health plans to maximize the probability that their data are included in any health plan-generated PO results. Because complete encounter data are integral to accurately reflecting care provided, and affects health plan and provider risk scores, full encounter submission is expected.

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

Reporting Policies

Handling Mergers and Acquisitions

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

Consent Agreement

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

Attribution to POs

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

- Enrollment at the health plan level, communicated to the PO.
- Encounter data from the PO, including member identification or physician identification (so health plans can correctly attribute it), ***and***
- Continuous enrollment in the PO, no gaps in enrollment in the PO on the specified dates, and required benefits, as specified for each measure.

Peer Groups

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

Risk Adjustment

Clinical Quality	NCQA is the measure developer for most AMP Clinical Quality measures; therefore, IHA follows NCQA's risk adjustment protocol. NCQA's Committee on Performance Measurement and its Board of Directors determined that risk adjustment would not be appropriate for the HEDIS Clinical Quality measures because the processes and outcomes being measured should be achieved regardless of the nature of the population. NCQA also creates or adapts the technical specifications for non-HEDIS Clinical Quality measures. Because they are also process and outcome measures, NCQA determined that risk adjustment was not appropriate.
Data Quality	Data Quality measures are not risk adjusted.
Utilization	Utilization measures are risk adjusted. The measure specifications describe the type of risk adjustment used for each measure.
Cost	The Total Cost of Care (TCOC) measure is risk- and geography-adjusted. Risk adjustment is performed using the Johns Hopkins' Adjusted Clinical Grouper (ACG). Geographic adjustment is performed using the geographic adjustment factors published by CMS, and is based on the hospital wage index. Refer to the Total Cost of Care measure specification for details on risk adjustment determination for cost.

Reliability Testing/Minimum Number of Observations

IHA considers measurement error and reliability for Clinical Quality measures. For these measures, the organization uses administrative data based on the PO member population. There is no sampling. Because statistical errors can result from small numbers, IHA requires a total denominator of 30 or more for a particular measure and excludes any measure with a bias of 5% or more, as determined by the auditor.

Initial Population

The **initial population** for any measure is all members who satisfy all criteria specified in the measure, including age, continuous enrollment (including allowable gap), benefit, or event requirement. Organizations must include all members (regardless of benefit type) in the appropriate AMP report, except for self-insured members in the Commercial HMO/POS product line who meet the criteria in *General Guideline: Reporting ASO and Self-Insured Members.*

For the Administrative Method and the Electronic Clinical Data Systems (ECDS) Method, calculate the rate using the denominator (initial population minus denominator exclusions).

Product-Line Reporting

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

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

Results should not include PPO members for Commercial HMO/POS Reporting.

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

Members with Dual Enrollment

Dual enrollment is assessed using the continuous enrollment criteria in each measure. To meet criteria for dual enrollment, members must have dual enrollment at the end of the continuous enrollment period. Per *General Guideline: Members Who Switch Products/Product Lines*, if a measure allows a gap at the end of the continuous enrollment period, members must have dual enrollment as of the last enrollment segment. For measures without a continuous enrollment requirement, members must have dual enrollment on the date of service or the date of discharge.

Medicare Advantage members who have only Part D coverage do not qualify for dual enrollment.

This guideline must be applied to the following enrollment situations; all decisions based on the guideline must be used consistently across all measures.

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

- *If products are reported separately,* include members with dual enrollment in both products in both AMP Commercial HMO/POS submissions.
- *If the different product types are reported combined,* include members once in the combined submission.

Dual Commercial HMO/POS/Medicare Advantage enrollment

Members with dual Commercial HMO/POS and Medicare Advantage enrollment must be included only in the product line that provides their primary enrollment (Commercial HMO/POS or Medicare Advantage).

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

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

Include these members in *both* the AMP Medi-Cal Managed Care and AMP Medicare Advantage reports *only* if they are enrolled in the organization's Medicare Advantage contract required to report, *and* in the organization's Medi-Cal Managed Care contract. For All-Cause Readmissions, Emergency Department Utilization and Acute Hospital Utilization, remove these members from Medi-Cal Managed Care reporting and only include them in Medicare Advantage reporting.

Reporting ASO and Self-Insured Members

Administrative Services Only (ASO) and self-insured members

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

- The contract prohibits the health plan/PO from contacting members for any reason.
- The **contractual agreement**, which is a contract or other written agreement between the organization (HMO/POS) and the ASO client (e.g., employer), states that the health plan/PO may not contact these ASO and self-insured members under any circumstances, or include them in reporting.

  Note: *Exclusion from disease management, case management, or quality improvement projects does not meet criteria for exclusion from AMP reporting.*

  – The agreement to exclude members in the reporting year must be in place (fully executed by both parties, in the case of a contract, or communicated, in the case of a written agreement) by January 1 of the measurement year.
- The health plan/PO is not responsible for administering both in-network and out-of-network claims for ASO and self-insured members (employer carve-out for both in-network and out-of-network claims).

  Note: *If claims are administered through a third party on behalf of the plan/PO (i.e., a claims delegation arrangement), the plan/PO is considered responsible for administering claims and members may not be excluded.*

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

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

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

If a health plan/PO excludes these ASO and self-insured members, it must also exclude them from AMP Commercial HMO/POS reporting.

Members Who Refuse Services

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

Membership Changes

Members Who Switch Health Plans or POs

Members who switch to a different organization may be counted as continuously enrolled if they joined an organization that assumes ownership of or responsibility for members' administrative data for the entire period of continuous enrollment specified in the measure.

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

Members Who Switch Health Plans or POs as the Result of a Merger or Acquisition

Measures with a continuous enrollment period	Members who switch organizations because of a merger that occurred during the measurement year may be counted as continuously enrolled.
Measures without a continuous enrollment period	The surviving organization may include members from the non-surviving entity in the initial population, starting on the official date of the merger or acquisition. For example, if the merger or acquisition occurred on March 1 of the measurement year, the surviving organization excludes members acquired from the non-surviving entity from the initial population for January and February.

This guideline must be used consistently across all measures.

Members Who Switch Products/Product Lines

Measures with a continuous enrollment requirement	Members enrolled in different products or product lines (Commercial HMO/POS, Medi-Cal Managed Care, Exchange, Medicare Advantage) in the time specified for continuous enrollment for a measure are continuously enrolled and are included in the product and product-line specific AMP report in which they were enrolled as of the end of the continuous enrollment period. For example, a member enrolled in the Commercial HMO or POS product line, who switches to the Medicare Advantage product line during the continuous enrollment period, is reported in the AMP Medicare Advantage report. If a measure allows a gap at the end of the continuous enrollment period, report members in the product and product line-specific AMP report in which they were enrolled as of the last enrollment segment. Members who "age in" to a Medicare Advantage product line mid-year are considered continuously enrolled if they were members of the organization through another product line (e.g., Commercial HMO/POS) during the continuous enrollment period and their enrollment did not exceed allowable gaps. The organization must use claims data from all products/product lines, even when there is a gap in enrollment.
Measures without a continuous enrollment requirement	Members who enrolled in different products or product lines are reported in the product and product line-specific AMP report in which they were enrolled on the date of service (visits) or date of discharge (inpatient stays).

Required Enrollment Periods and Benefits

Continuous Enrollment

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

A **gap** is the time when a member is not covered by the organization (i.e., the time between disenrollment and reenrollment). For example, if a member disenrolls on June 30 and re-enrolls on July 1, there is no gap because the member is covered by the organization on both June 30 and July 1. If the member disenrolls on June 30 and reenrolls on July 2, there is a one-day gap because the member is without coverage on July 1.

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

If a measure requires a member to be enrolled and have a benefit on a specific date, the allowable gap must not include that date; the member must also have the benefit on that date. For example, a 70-year-old member who has only one gap in enrollment from November 30 through December 31 of the measurement year is not eligible for the Eye Exam for Patients With Diabetes measure. The member meets the continuous enrollment criteria, but does not meet the allowable gap criterion, which requires enrollment as of the last day of the measurement year.

Medi-Cal Managed Care Continuous Enrollment

If the organization applies a full-month eligibility criterion to Medi-Cal Managed Care beneficiaries and verifies enrollment prospectively in monthly intervals (in 1-month increments), the one gap in enrollment during the continuous enrollment period may not exceed 45 days. For example, a member whose coverage lapses for 2 months (60 days) is not considered continuously enrolled.

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

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

Continuous Enrollment Over Multiple Years

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

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

***Note:** IHA is considering changes to the PO continuous enrollment requirements for BCS-E, CCS-E, and COL-E for MY 2027. Refer to the 2026 Public Comment materials on IHA.org for more information. Any approved changes will be reflected in the Final MY 2027 AMP Technical Specifications.

Continuous Enrollment for Health Plans

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

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

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

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

Step 3 Determine that any gaps in enrollment in the plan and PO (parent level) do not exceed the allowable gaps.

Step 4 For POs eligible to report at the subgroup level, if a measure requires a member to be enrolled on a specific date, determine the subgroup to which the member was assigned on that date.

Continuous Enrollment for Self-Reporting POs

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

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

Step 2 Determine that any gaps in enrollment in the PO (parent level) and a participating health plan do not exceed the allowable gaps.

Step 3 For POs eligible to report at the subgroup level, if a measure requires a member to be enrolled on a specific date, determine the subgroup to which the member was assigned on that date.

Note

- *Each PO approved to self-report at the subgroup level must also ensure that all plans reporting data for that PO report at the subgroup level.*
- *Members assigned to a PO must be included, whether or not they sought services from the PO.*
- *Members who change subgroups within a PO during the continuous enrollment period are considered continuously enrolled if they meet the other continuous enrollment criteria.*

Required Benefits

Measures evaluate performance and hold organizations accountable for services provided in their members' benefits package. Measure specifications include benefits (medical, pharmacy, mental health, and substance use disorder treatment) required during the continuous enrollment period.

Measures do not define benefits at the service level (e.g., if the organization offers a pharmacy benefit but does not cover a specific medication class, the member has a pharmacy benefit and is included in the applicable measures requiring this benefit; similarly, if the member has partial coverage of mental health services (either by service or diagnosis), they are included as having a mental health benefit). Organizations must assess benefits first at the organization level and then at the individual member level using continuous enrollment data. IHA follows the HEDIS protocol for required benefits for all measures in AMP.

…at the health plan/PO level Health plans and POs report AMP measures that require a specific benefit if the plan provides the benefit, either directly or through a contractor.

Health plans and POs are not required to report measures specifying a benefit that the plan does not offer.

Before reporting a measure specifying a benefit, the organization must be able to determine if a member has the required benefit.

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

…at the member level Members who do not have a specified benefit are not counted in the measure by health plans or POs. For example, the Proportion of Days Covered by Medications: Renin Angiotensin System Antagonists measure requires a pharmacy benefit during the measurement year. Exclude members who do not have a pharmacy benefit during the measurement year. When members are dual enrolled, organizations must assess the benefit requirements based on the submission in which the member is included. Refer to *General Guideline: Members With Dual Enrollment*.

Exhausted benefits *(optional)*

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

For measures with a continuous enrollment criterion, the required benefits must be active for the period of continuous enrollment, accounting for any allowable gap. Exclude a member if the period when the benefit is exhausted exceeds any allowable gap. For example, the Osteoporosis Management in Women Who Had a Fracture measure requires a pharmacy benefit during the 365 days prior to the episode date through 180 days after the episode date. Exclude a member whose pharmacy benefit is exhausted 100 days after the episode date, because this exceeds the 45-day allowable gap period.

Carved-out benefits *(optional)*

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

Organizations must apply this guideline consistently across all measures.

Data Collection

Data Collection Methods

Each AMP measure specifies the data collection method that must be used for reporting.

Administrative Method

Health plans and POs use transaction or supplemental electronic clinical data from acceptable sources (e.g., administrative databases, registries, electronic health records [EHR]). The reported rate is based on all members who meet the denominator criteria and who are found, through administrative data, to have received the service identified in the numerator.

ECDS Method

Measures reported using ECDS are specified for the electronic method of data collection. The specifications in this publication provide a summary of measures that may be reported using ECDS. Additional information for the digital measure specifications, for programming purposes, is available in the AMP Digital Measure Packages in the NCQA Store. Organizations are accountable for all potential updates included in the Digital Measure Packages.

Data sets for ECDS reporting must contain data whose structure allow queries by a HEDIS digital quality measure (dQM). Each electronic data source used for AMP ECDS reporting must have:

- Policies and procedures for establishing and maintaining database management systems.
- Standard layout requirements.
- An automated process for extraction, transformation and loading of all data elements to the master file.

Proof-of-service and validation requirements are outlined in *General Guideline: Supplemental Data.*

Administrative and non-administrative data may be used to identify the initial population.

To qualify for AMP ECDS reporting, data must use standard layouts, meet the measure's technical specification requirements, and be accessible by the care team upon request. Health plans and POs meet this requirement if they can provide the requested information (e.g., phone, secure email, direct feed, provider portal, file request) to providers. Health plans and POs should have documented processes for tracking these requests, to be reviewed as part of the AMP audit.

Practitioners or practitioner groups that are accountable for clinical services provided to individuals must not be prevented from accessing data used by an organization for quality measure reporting.

Health plans and POs may use several data sources to provide complete information about the quality of health services. Data systems that may be eligible for AMP ECDS reporting include, but are not limited to, member eligibility files, EHRs, personal health records (PHR), clinical registries, health information exchanges (HIE), administrative claims systems, electronic laboratory reports (ELR), electronic pharmacy systems, immunization information systems (IIS) and disease/case management registries.

The data in these systems come in a variety of formats. The format type determines how the source is audited. Member-reported services are acceptable if the information is recorded, dated and maintained in the legal health record. Member-reported data must follow *General Guideline: Member-Reported Services and Biometric Values.*

Supplemental Data

Supplemental data uses

To supplement claims data for calculating AMP measures, organizations may use sources other than claims and encounters to collect data about their members and about delivery of health services to their members. Validation and review of these data differ by the processes used to collect and report them. When evidence to support the measure is found in multiple data sources, a hierarchy is applied. Supplemental data are considered last as long as the specifications are followed as written (e.g., if the organization uses a combination of data sources to identify the Glycemic Status <8.0% indicator in the Glycemic Status Assessment for Patients With Diabetes measure, the most recent test must be used, regardless of data source).

Supplemental data may help determine:

- Numerators that are labeled as *numerators* in the specifications.
- Members in hospice and members who have died.
- Exclusions labeled *denominator exclusions* in the specifications.

Supplemental data may not be used for:

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

Supplemental Data Definitions

The auditor determines the classification of all supplemental data, not the organization. For information on supplemental data validation requirements, refer to the *AMP Audit Review Guidelines MY 2027*, which will be released in November 2027.

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

Nonstandard supplemental data Data used to capture missing service data not received through administrative sources (claims or encounters) or in the standard electronically generated files described above, whether collected by a plan, an organization, a provider or a contracted vendor. These types of data might be collected from sources on an irregular basis, and could be in files or formats that are not stable over time.

Organizations must have clear policies and procedures that describe how the data are collected, and by whom, and how they are validated and used for AMP reporting.

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

CCDs Continuity of Care Documents. CCDs are used for the electronic exchange of clinical data without loss of meaning. The files provide a summary of a patient's care as a snapshot in time, but they are not a replacement for an EHR. These files are typically XML-based and are considered nonstandard supplemental data for at least the first year of use. The organization must demonstrate the quality and integrity of these data.

NCQA Data Aggregator Validation Organizations participating in the NCQA Data Aggregator Validation program are identified on the directory available on NCQA's website.

Organizations with a Validated Data Stream evaluation product that has a validated status and an expiration date may share data as standard supplemental data. Data from ingestion sites or clusters that failed validation are considered nonstandard supplemental data, and may not be shared as standard supplemental data.

Organizations with a Certified Data Partner evaluation product may not share data.

The Roadmap documentation and validation requirements for data received from an NCQA-Validated Data Aggregator Validation organization are detailed in the *AMP Audit Review Guidelines MY 2027,* scheduled for release in November 2027.

Proof-of-service Proof-of-service documentation allowed for validation:

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

Proof-of-service documentation not allowed for validation:

- Surveys.
  - Organizations and providers may not use information obtained from surveys or other documents completed by the member, except for data collected for the Race/Ethnicity Description of Membership measure.
- Phone calls.
  - Recorded phone calls to collect information about services rendered are not proof of service.

Required Data Elements

Standard supplemental data

Organizations must have policies and procedures for using data files as standard supplemental data. Data files must have standard file layouts, standard data fields, and industry standard codes, and must include all elements required by measure specifications, including payment status, when applicable, and evidence that tests or services were performed and not merely ordered.

Nonstandard supplemental data

Nonstandard supplemental data files must have all data elements required to meet the criteria specified by the measure specifications, including:

- Payment status, when applicable.
- Evidence that tests or services were performed, not just ordered.
  - When data are abstracted from medical record sources to be used as supplemental data, codes alone (without additional documentation of the service provided) do not meet criteria for proof of service. If a provider performs a service, it is expected that there is additional documentation in the medical record or in the primary source document. Auditors must validate all elements required by the measure specification.
- Evidence of provider accountability from the practitioner or practitioner group (signed contracts with accountability tied to passwords, signatures, or TIN/NPI data). For home visits, if clinical services are rendered, there must be evidence of accountability by the practitioner, and at a minimum include the date, name, and signature on each in-home form. Documentation of the practitioner's TIN/NPI is not required; however, documentation of TIN/NPI with date, name, and signature is preferred.
- More than a simple yes or no attestation on provider forms. Forms must have all necessary data elements and be signed by the rendering practitioner.
- All data elements for a measure must be captured for member-reported services (date and place of service, procedure, prescription, test result or finding, practitioner type). When using supplemental data derived from medical records to meet administrative specifications, documentation must be clinically synonymous with the codes included in the measure's value sets. Refer to *General Guideline: Member-Reported Services and Biometric Values.*

All supplemental data

All proof-of-service documents must show that services were rendered by the deadline established for the measure.

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

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

Supplemental data sharing between POs and health plans

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

Supplemental Data Timeline

Supplemental data may be collected during the measurement year and into the beginning of the reporting year. Supplemental data collection and use must adhere to all applicable deadlines in the *AMP Data Collection and Reporting Timeline* in the AMP Program Guide.

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

The *AMP Data Collection and Reporting Timeline* for audited submission is included in the *Preliminary MY 2027 AMP Program Guide*, to be released on June 1, 2027.

Identifying and Validating Supplemental Data

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

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

- Completed Roadmap documentation.
- Impact of supplemental data source, by measure (e.g., lists of numerator-positive hits from the supplemental data, by measure; year-to-year comparisons of percentage increases associated with supplemental data; proportion of numerator compliance from supplemental data).
- Data quality and integrity validations where required or requested by the auditor.

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

Additional details about audit requirements and validations for supplemental data will be included in the *MY 2027 Audit Review Guidelines,* to be released in November 2027.

Note: *Only health plans that participate in the AMP programs may use audited PO supplemental data for their NCQA HEDIS submission. The PO must provide the health plan with completed Roadmap documentation for each supplemental data source, all applicable attachments, and the auditor's review findings by the deadline noted in the timeline. There are no exceptions. Health plans are not required to also collect proof-of-service documents for audited and approved PO data.*

Which Services Count?

Each measure has its own requirements for using transactional data and administrative claims to report measure components. Information on which services count are located in the measure's *Guidance* section. For Clinical Quality measures, health plans and self-reporting POs should follow the measure-specified guidance. For Utilization measures, Cozeva will generate measure results following measure-specified guidance. Health plans should submit all services to Cozeva.

If a measure requires that all paid, suspended, pending, and denied claims be used for reporting, report all services, whether or not the organization paid for them. For example, report services paid for by a third party, such as a community center, or services for which payment was denied because they were not authorized.

Count the service as paid or expected to be paid if:

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

Count the service as denied if:

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

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

Race and Ethnicity Stratification (RES)

The following HEDIS measures used in AMP instruct health plans and self-reporting POs to categorize Commercial HMO/POS, Medicare Advantage, and Medi-Cal Managed Care members by the race and ethnicity stratification (RES). IHA aligns with the requirements specified for the following HEDIS measures by the measure steward (NCQA), as noted throughout this guideline.

- Breast Cancer Screening.
- Blood Pressure Control for Patients With Hypertension.
- Cervical Cancer Screening.
- Child and Adolescent Well-Care Visits.
- Childhood Immunization Status.
- Immunization for Adolescents.
- Kidney Health Evaluation for Patients With Diabetes.
- Prenatal and Postpartum Care.
- Prenatal Depression Screening *(testing)*.
- Prenatal Immunization Status.

- Colorectal Cancer Screening.
- Controlling High Blood Pressure.
- Eye Exam for Patients With Diabetes.
- Glycemic Status Assessment for Patients With Diabetes.
- Postpartum Depression Screening *(testing)*.
- Well-Child Visits in the First 30 Months of Life.

Reporting categories

NCQA requires reporting race and ethnicity as defined by the Office of Management and Budget (OMB) 1997 and 2024 Standards for Maintaining, Collecting, and Presenting Federal Data on Race and Ethnicity, and best practices identified in the March 2024 updates.[2,3]

Race and ethnicity values must be rolled up into the OMB categories specified in this guideline. If more detailed race and ethnicity data are collected, data must be aggregated and reported in the categories provided. For health plans and self-reporting POs using the CMS classification scheme for race and ethnicity, refer to Table RES-A-1/2/3 for a crosswalk to AMP reporting.

Report member race and ethnicity separately. If a combined race/ethnicity category question is used to collect data, data must be disaggregated, and race and ethnicity categories must be reported separately. When using the combined race/ethnicity data format for collection, refer to Table RES-B-1/2/3 for a crosswalk of reporting categories.

Tables RES-C-1/2/3 and RES-D-1/2/3 crosswalk the HEDIS reporting categories to code values specified by the Race and Ethnicity extensions of the HL7 US Core Implementation Guide. Organizations must use or map to the documented direct reference codes and value sets described here. Code values originate from three code systems:

- "Race & Ethnicity – CDC" (CDCREC) is used to report race and ethnicity categories.
- "Asked But Declined" uses the HL7 version 1 DataAbsentReason code system.
- Unknown uses the HL7 version 2.1 NullFlavor code system.

Determining race reporting category

For each product line, report members in only one of the ten race stratifications listed below and the total.

- *American Indian or Alaska Native*: Identification with any of the original peoples of North, Central and South America. Examples of these groups include, but are not limited to, people who identify as "American Indian" or "Alaska Native" and includes groups such as Navajo Nation, Blackfeet Tribe of the Blackfeet Indian Reservation of Montana, Native Village of Barrow Inupiat Traditional Government, Nome Eskimo Community, Aztec, and Maya.
- *Asian*: Identification with one or more nationalities or ethnic groups originating in any of the original peoples of Central, East, Southeast or South Asia. Examples of these groups include, but are not limited to, Chinese, Asian Indian, Filipino, Vietnamese, Korean, Japanese, Pakistani, Cambodian, Hmong, Thai, Bengali, and Mien.

[2] Office of Management and Budget Revisions to the Standards for the Classification of Federal Data on Race and Ethnicity. https://www.govinfo.gov/content/pkg/FR-2024-03-29/pdf/2024-06469.pdf

[3] OMB Statistical Policy Directive No. 15 on Race and Ethnicity Data Standards: Categories and Definitions: https://spd15revision.gov/content/spd15revision/en/2024-spd15/categories-definitions.html

- *Black or African American*: Identification with one or more nationalities or ethnic groups originating in any of the Black racial groups of Africa. Examples of these groups include, but are not limited to, African American, Jamaican, Haitian, Nigerian, Ethiopian, Somali, Ghanaian, South African, Barbadian, Kenyan, Liberian, and Bahamian.
- *Middle Eastern or North African*: Identification with one or more nationalities or ethnic groups originating in the Middle East or North Africa. Examples of these groups include, but are not limited to, Lebanese, Iranian, Egyptian, Syrian, Iraqi, and Israeli.
- *Native Hawaiian or Pacific Islander*: Identification with one or more nationalities or ethnic groups originating in Hawaii, Guam, Samoa, or other Pacific Islands. Examples of these groups include, but are not limited to, Native Hawaiian, Samoan, Chamorro, Tongan, Fijian, Marshallese, Palauan, Tahitian, Chuukese, Pohnpeian, Saipanese, and Yapese.
- *White*: Identification with one or more nationalities or ethnic groups originating in Europe. Examples of these groups include, but are not limited to, English, German, Irish, Italian, Polish, Scottish, French, Slavic, and Cajun.
- *Other Race*: People whose race information has been collected but does not fit into any of the specified race categories.
- *Two or More Races*: People with any combination of races, including "Other Race."
- *Asked But Declined:* People who the organization asked to identify race but who declined to provide a response.
- *Unknown:* People for whom the organization did not obtain race information and for whom the organization did not receive a declined response (i.e., "Asked But Declined").
- *Total:* Total of all categories above.

Determining ethnicity reporting category

For each product line, report members in only one of the four ethnicity stratifications listed below and the total.

- *Hispanic or Latino*: Identification with one or more nationalities or ethnic groups originating in Mexico, Puerto Rico, El Salvador, Cuba, Dominican Republic, Guatemala and other Central and South American countries and other Spanish cultures. Examples of these groups include, but are not limited to, Mexican or Mexican American, Puerto Rican, Salvadoran, Cuban, Dominican, Guatemalan, and Colombian.
- *Not Hispanic or Latino*: People not of Hispanic, Latino, or Spanish culture or origin.
- *Asked But Declined:* People whom the organization asked to identify ethnicity but who declined to provide a response.
- *Unknown:* People for whom the organization did not obtain ethnicity information and for whom the organization did not receive a declined response (i.e., "Asked But Declined").
- *Total:* Total of all categories above.

Data source

Reporting the data collection source is only required for the Race/Ethnicity Description of Membership (RDM) measure.

Approved data sources include data collected directly from members and data obtained through imputation methods. In cases where a health plan or self-reporting PO has a race or ethnicity value but no data source, the organization must report using the "Unknown" data source category. In cases where the race or ethnicity value and the source are missing, plans and POs must record this as no data. NCQA and IHA strongly encourage health plans and self-reporting POs to report directly collected data when available and emphasize the importance of improving completeness of directly collected member race and ethnicity data. Additionally, NCQA and IHA strongly encourage plans and POs to track the source of their race and ethnicity data in order to facilitate valid disparities assessments.

For the RDM measure, health plans and self-reporting POs will report total race and total ethnicity by data source. Organizations will report the number of members from the direct, imputed, unknown, and no data source categories.

Supplemental data may be used as a data source for the race and ethnicity stratification.

Direct data

Data collected directly from members reflects members' self-identification and is the preferred data source.

Directly collected data includes any source for which the member self-identified race or ethnicity. This includes member self-reported data collected directly from members under the full control of the organization (i.e., no data were obtained through an intermediary), as well as third-party data collected directly from a member by another entity (e.g., the state, CMS, Health Information Exchanges [HIE], or clinical feeds). Direct sources may include, but are not limited to:

- Surveys.
- Health risk assessments.
- Disease management registries.
- Case management systems.
- EHRs.
- CMS/state databases.
- Enrollment information furnished by enrolling entities (e.g., state Medi-Cal Managed Care agencies, employers).
- CCDs.
- HIEs.

Note: *The "Asked But Declined" category is only reported using direct data.*

Imputed data

Health plans and self-reporting POs may choose to report race and ethnicity data supplemented by imputed methods. Imputed assignment of race and ethnicity values include using an alternate data source (e.g., nationally representative data obtained from databases like the American Community Survey) to assign a race or ethnicity value to a member based on their primary location of residence. Some commonly used imputed methods combine geographic data with additional imputation methods such as surname analysis.

NCQA and IHA reiterate that directly collected race and ethnicity is considered the gold standard and is highly preferred to imputed race and ethnicity. For organizations choosing to use imputed methods to report the AMP race and ethnicity stratification, IHA and NCQA emphasize the following:

- When applying imputed methods that involve assignment of race or ethnicity based on geographic data and member's location of residence, the smallest geographic unit possible is preferred. For example, geographic assignment at the census block level is likely to be more accurate than assignment using census tract or ZIP code-level data.
- Imputed data sources and methods should be evaluated for reliability and validity and selection of a source and method should be prioritized based on demonstrated validity and reliability for the population in which it will be applied (e.g., age group, geography, product line).
- Imputed methods of race and ethnicity assignment are to be used for population-level reporting and analysis but are not appropriate for member-level intervention.

Unknown data When the reported value for race or for ethnicity is known, but the source is unknown (i.e., cases where an organization has a race or ethnicity value on file from a legacy system, but does not know the source).

No data When both the race or ethnicity value and the source are missing.

Note: *The "Unknown" category is only reported using the "No Data Source" category because unknown values cannot be attributed to a particular data source.*

Table RES-A-1/2/3: CMS Categories Crosswalked to HEDIS/OMB Race and Ethnicity

CMS Category	HEDIS/OMB Race	HEDIS/OMB Ethnicity
American Indian/Alaska Native	American Indian or Alaska Native	Unknown
Asian/Pacific Islander	Asian	Unknown
Black	Black	Unknown
(No equivalent category)	Middle Eastern or North African	Unknown
White	White	Unknown
Hispanic	Unknown	Hispanic or Latino
Other	Other Race	Unknown
Unknown	Unknown	Unknown
(No equivalent category)	Native Hawaiian or Pacific Islander	Unknown
(No equivalent category)	Two or more races	Unknown

Table RES-B-1/2/3: Combined Categories Crosswalked to HEDIS/OMB Race and Ethnicity

Race/Ethnicity Combined Category (examples)[4]	HEDIS/OMB Race	HEDIS/OMB Ethnicity
American Indian/Alaska Native	American Indian or Alaska Native	Not Hispanic or Latino
Asian	Asian	Not Hispanic or Latino
Black	Black	Not Hispanic or Latino
Middle Eastern or North African	Middle Eastern or North African	Not Hispanic or Latino
Native Hawaiian and Pacific Islander	Native Hawaiian or Pacific Islander	Not Hispanic or Latino
White	White	Not Hispanic or Latino
Hispanic/Latino	Other Race	Hispanic or Latino
Hispanic/Latino/Black	Black	Hispanic or Latino
Hispanic/Latino/White	White	Hispanic or Latino
Other	Other Race	Unknown
Multiple races marked	Two or more races	Unknown
Unknown	Unknown	Unknown

Table RES-C-1/2/3: HEDIS/OMB Race Crosswalked for Use With HEDIS Reporting Categories

HEDIS/OMB Race	CDCREC OMB Category Direct Reference Code*/Value Set	CDCREC Detailed Category: Value Set
American Indian or Alaska Native	1002-5	American Indian or Alaska Native Detailed Race Value Set
Asian	2028-9	Asian Detailed Race Value Set
Black	2054-5	Black or African American Detailed Race Value Set
Middle Eastern or North African	NA	Middle Eastern or North African Detailed Race Value Set
Native Hawaiian or Pacific Islander	2076-8	Native Hawaiian or Pacific Islander Detailed Race Value Set
White	2106-3	White Detailed Race Value Set
Other Race	2131-1	NA
Two or More Races	NA***	NA
Asked But Declined	asked-declined**	NA
Unknown	Unknown Value Set***	NA

[4] Does not reflect the full set of possible combinations but provides examples of how categories should be handled when a combined data collection question is used.

*Codes to identify race and ethnicity are from the CDC Race and Ethnicity code system developed by the U.S. Centers for Disease Control and Prevention (CDC). They resemble, but are not, LOINC codes.

**HL7 v1 Code System DataAbsentReason. The asked-declined code is an approved US Core code per a patch approval for US Core 6.1.0 https://jira.hl7.org/browse/FHIR-49134).

***HL7 v2.1 Code System NullFlavor.

*****This value is defined by the measure calculation logic as the presence of two or more distinct CDCREC category codes and does not map to a specific direct reference code or value set.

Table RES-D-1/2/3: HEDIS/OMB Ethnicity Crosswalked for Use With HEDIS Reporting Categories

HEDIS/OMB Race	CDCREC OMB Category Direct Reference Code*/Value Set	CDCREC Detailed Category: Value Set
Hispanic or Latino	2135-2	Hispanic or Latino Detailed Ethnicity
Not Hispanic or Latino	2186-5	NA
Asked But Declined	asked-declined	NA
Unknown	Unknown Value Set**	NA

*Codes to identify race and ethnicity are from the CDC Race and Ethnicity code system developed by the U.S. Centers for Disease Control and Prevention (CDC). They resemble, but are not, LOINC codes.

**The DataAbsentReason and NullFlavor concepts "Asked But Declined" and "Unknown" are not included in the terminology binding for the US Core Ethnicity FHIR extension on which this digital logic is structured. NCQA allows these concepts to express ethnicity data to align with bound values for the US Core Race extension.

Note

- *Race and ethnicity are social constructs, not biological; stratifying HEDIS measures in AMP by race and ethnicity is intended to be used for further understanding of racial and ethnic disparities in care and to hold organizations accountable to address such disparities, with the goal of achieving equitable health care and outcomes. Data are not to be used to further bias in health care or suggest that race and ethnicity are biological determinants of health.*
- *When multiple sources of data are used for race and ethnicity, there may be disagreements in the data collected. When this happens, data sources should be prioritized based on the evaluation of anticipated accuracy. This includes use of specific categories over nonspecific categories, most frequent or consistently reported category and selection of data with clear provenance (source, method of collection) over data without clear provenance. Known data sources should be prioritized over unknown data sources, and data collected directly by the organization should be prioritized over all other data sources.*
- *Race and ethnicity data may come from different categories of data sources (direct, imputed, unknown, no data). In such cases, use the data source that applies to the data element (race, ethnicity). If the same data element is received from two different data sources, prioritize data sources based on the second bullet above.*

Date of Service for Laboratory Tests

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

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

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

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

A health plan/PO may consider all events with dates no more than 7 days apart to be the *same* test and may use the collected date for reporting. For example:

- If a sample is collected on December 1 of the measurement year and the result is documented on December 8, these dates are not more than 7 days apart and can be considered the same test. The result is present and the collection data is eligible for use.
- If a member had an HbA1c test collected on December 28 of the measurement year and an HbA1c test result on January 2 of the year after the measurement year, the dates are within 7 days and may be considered the same test. The result and the collection date are eligible for use, making the member numerator compliant for the Glycemic Status <8% measure, if the HbA1c level is <8.0%.
- If a member had an HbA1c test collected on December 28 of the measurement year and a HbA1c test result on January 15 of the year after the measurement year, the dates are not within 7 days and may not be considered the same test. There is no result for the HbA1c test collected on December 28, and the member is not numerator compliant for the Glycemic Status <8% measure.
- If a test had a collection date of December 1 and a reported date of December 9, these dates are more than 7 days apart and cannot be considered the same test.

Collecting Data for Measures With Multiple Numerator Events

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

- Childhood Immunization Status.
- Immunizations for Adolescents.
- Well-Child Visits in the First 30 Months of Life.

For only the measures listed above, all events must be at least 14 days apart.

For example, the organization may count two influenza vaccines identified through administrative data if the dates of service are at least 14 days apart; if the service date for the first vaccine was February 1, then the service date for the second vaccine must be on or after February 15.

Facility Data

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

Member-Collected Samples

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

Member-Reported Services and Biometric Values

Member-reported services and biometric values (height, weight, BMI percentile) are acceptable only if the information is collected by a primary care practitioner (refer to *Appendix 2* for the definition of "*PCP*"), or specialist, if the specialist is providing a primary care service related to the condition being assessed while taking a patient's history. The information must be recorded, dated, and maintained in the member's legal health record.

Note: *It is a best practice to collect data directly from members for the Race/Ethnicity Description of Membership measure; therefore, a PCP or specialist is not required to collect this information as part of a patient's history for this measure only.*

Coding Conventions

Using Claims to Identify Events in Conjunction With Diagnoses or Other Events

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

Except for inpatient stays (as described below) and unless otherwise stated in a measure specification, when a measure requires a code be in conjunction with another code the codes must be from the same visit. The organization (health plan or PO) develops a method for identifying claims from the same visit (e.g., the same outpatient visit, the same inpatient stay). The method is subject to review by the auditor.

Identifying acute or nonacute inpatient stays is a two-step process. The first step uses the Inpatient Stay Value Set to identify all acute and nonacute inpatient stays. The second step uses the Nonacute Inpatient Stay Value Set to identify stays that were nonacute. When identifying nonacute codes in step 2, the nonacute code must be on the same claim that was identified in step 1. In addition, any required diagnosis or procedure must be on the same claim.

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

Visits that Result in an Inpatient Stay

Some measures require exclusion of visits that result in an inpatient stay or observation stay.

A visit results in a stay when the visit date of service occurs on the day prior to the admission date or any time during the admission (admission date through discharge date).

Principal vs. Secondary Diagnosis

Principal and secondary diagnoses are mentioned throughout the specifications. Generally, a **principal diagnosis** (or primary diagnosis) is the diagnosis given at discharge and the one listed first on a claim/encounter form. A diagnosis listed on a claim or encounter form that is not classified as the principal diagnosis is a **secondary diagnosis**. A claim or encounter can contain multiple secondary diagnoses. Organizations follow the measure specifications to determine whether a diagnosis must be principal or can be secondary. If the specification does not specify that the principal diagnosis must be used, any applicable diagnosis is used.

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

Code Modifiers

Modifiers are two-digit extensions that, when added to CPT[5] or HCPCS codes, provide additional information about a service or procedure.

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

[5] CPT® is trademarked and copyright 2026 by the American Medical Association. All rights reserved.

Uniform Bill Codes Specificity

AMP reporting requires the four-digit version of Uniform Bill (UB) type of bill codes. Organizations whose data include three-digit versions of the codes must convert the codes to four-digit codes by adding a leading zero.

Mapping Proprietary or Other Codes

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

- *State-specific codes.* The organization must provide the auditor with evidence that the codes are required by the state.
- *NDC codes.* An NDC code that is not in the HEDIS MLD can be mapped if its generic name (or brand name), strength/dose and route match those of a code in the MLD. NDC codes that identify immunizations can be mapped to codes in value sets that identify immunizations.
- *RxNorm codes.* An RxNorm code that is not in the HEDIS MLD can be mapped if its generic name (or brand name), strength/dose and route match those of a code in the MLD.
- *ICD-9 codes.* ICD-9 codes can be mapped to ICD-10 codes ***only*** for concepts with a time frame that looks back "any time during the member's history."

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

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

Retiring Codes

NCQA annually tracks codes that are designated obsolete. NCQA does not remove codes in the year in which they receive the designation of obsolete because of the look-back period in many HEDIS measures. Obsolete codes are deleted from the AMP specifications after the look-back period has passed.

Table Names

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

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

Data Submission

Reporting Small Numbers

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

Reporting Date

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

Note

- *POs that use FinThrive HealthCare, Inc. as the encounter data intermediary must submit all Q1–Q4 2027 encounter data to FinThrive HealthCare, Inc. in February 2028. The* AMP Data Collection and Reporting Timeline *for audited submissions will be included in the Preliminary MY 2027 AMP Program Guide. No new data will be accepted after the specified deadline. POs that use a different data intermediary, or supply encounters directly to health plans, should confirm the final acceptance date of encounter data to be included in AMP reporting.*
- *Self-reporting POs and health plans must submit auditor-locked AMP clinical results in May 2028. The* AMP Data Collection and Reporting Timeline *for audited submissions will be included in the Preliminary MY 2027 AMP Program Guide. No new data will be accepted after the specified deadline. Health plans must submit results for all clinical measures for each contracted PO with a signed Consent Agreement.*

Required Data Elements

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

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

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

The Audit Review

Audit Review Principles

IHA requires health plans and self-reporting POs to undergo an audit review of clinical results by an NCQA Certified Auditor. This review ensures that results are an accurate report of PO performance. The Audit Review incorporates relevant components of the HEDIS Compliance Audit described in the current volume of *HEDIS Compliance Audit™: Standards, Policies and Procedures*. A separate manual with audit specifications will be posted to the IHA website in November 2027. In MY 2027, audit is required for AMP Commercial HMO/POS, Medicare Advantage, and Medi-Cal Managed Care reporting.

The underlying principles of the audit review are:

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

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

All Licensed Organizations and Certified HEDIS Compliance Auditors are required to remain independent, must avoid conflicts of interest, including perceived conflicts of interest, and are prohibited from providing technical assistance or advisory services to organizations they audit. Noncompliance may result in revocation of licensure and certification status.

Audit Components

Audit review components depend on the reporting option.

Health plan reporting

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

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

PO self-reporting

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

Note: *Health plans that use supplemental data audited at the PO level are not required to also collect proof-of-service documents. Requirement details are included in the MY 2027 Audit Review Guidelines, to be released in November 2027.*

Audit Results

In MY 2027, audit is required for Commercial HMO/POS, Medicare Advantage, and Medi-Cal Managed Care reporting.

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

Health plan results

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

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

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

PO results

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

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

Rate/Result	Description	Notes
0–XXX; R	Reportable	A reportable rate was submitted for the measure. The rate of 0 includes instances when the PO calculated the rate but found that no members met the criteria specified in the denominator.
BR	Biased Rate	The calculated rate was materially biased. The auditor determines whether a result is not reportable due to material bias.
SD	Small Denominator	The PO followed the specifications, but the denominator was too small (i.e., between 1 and 29) to report a valid rate.
NB	No Benefit	The health plan did not offer the health benefit required by the measure (e.g., pharmacy). Benefits are assessed at the global level, not the service level (refer to *General Guideline: Required Benefits*).
NR	Not Reported	The PO chose not to report the measure.

Multiple Audit Designations

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

Material Bias

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

Marketing

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

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

Clinical Quality Domain Technical Specifications

For AMP MY 2027
Health Plans and Self-Reporting POs

Overview

This section includes the AMP program technical specifications for use in collecting California PO clinical performance data in 2028 for MY 2027. The AMP specifications are based on HEDIS measures and non-HEDIS measures. NCQA adapts measures for assessing performance at the PO level. All measures are collected using administrative data systems, including EHRs, registries, and other clinical databases.

The Hybrid Methodology and medical chart review *are not* permitted, and hybrid specifications have been removed from respective HEDIS measures.

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

Follow-Up After Acute and Urgent Care Visits for Asthma (AAF-E)

MEASURE UPDATES OCTOBER 2026 FOR AMP MY 2027

- Removed the definition of direct transfer.
- Revised the *Initial population* to add instructions for readmissions or direct transfers readmissions.
- Added a value set to identify urgent care visits billed on facility claims.
- Updated hospice *Denominator exclusion* to align with source specification.

MODIFICATIONS FROM HEDIS

- AMP reports the COPD diagnosis stratification separately from the age stratifications.

To report this measure, refer to the digital measure package available for purchase in the NCQA Store for the complete HEDIS digital measure specification.

Measure title	Follow-Up After Acute and Urgent Care Visits for Asthma	**Measure ID**	AAF-E
Description	The percentage of members 5–64 years of age with an urgent care visit, acute inpatient discharge, observation stay discharge or ED visit with a diagnosis of asthma that had a corresponding outpatient follow-up visit with a diagnosis of asthma within 30 days.		
Measurement period	January 1–December 31.		
Clinical recommendation statement/ rationale	2024 recommendations from the Global Initiative for Asthma underscore the importance of follow-up by an outpatient healthcare provider after acute asthma exacerbations (GINA 2024). This echoes recent clinical guidelines for asthma recommending that providers assess patients for symptom resolution and lung functionality post-exacerbation event. Providers should assess for risk factors, explore potential exacerbation triggers and assess the patient's existing long-term treatment plan or discuss creating one if one does not exist (NAEPP 2020). An accountability mechanism that drives individuals toward non-acute care may help improve poor and disparate asthma outcomes. Refer to the HEDIS Measure Library & Historical Data measure web page for additional information about the clinical rationale.		
Citations	Global Initiative for Asthma (GINA). 2024. Global Strategy for Asthma Management and Prevention. https://ginasthma.org/wp-content/uploads/2024/05/GINA-2024- Strategy-Report-24_05_22_WMS.pdf National Asthma Education and Prevention Program (NAEPP) Coordinating Committee Expert Working Group. *2020 Focused Updates to the Asthma Management Guidelines*. U.S. Department of Health and Human Services, 2020. https://www.nhlbi.nih.gov/resources/2020-focused-updatesasthma-management-guidelines		

Characteristics	
Scoring	Proportion.
Type	Process.
Product lines	• Commercial HMO/POS. • Medi-Cal Managed Care.
Stratifications	Age as of the episode date. • 5–11 years. • 12–17 years. • 18–50 years. • 51–64 years. • Total. COPD diagnosis. • Members diagnosed with COPD (COPD Value Set*) any time during the member's history through the last day of the measurement period. • Members who did not meet criteria for the stratification above (i.e., did not have a diagnosis of COPD any time during the member's history through the last day of the measurement period). • Total. **Coding Guidance** *Do not include laboratory claims (claims with POS code 81).
Risk adjustment	None.
Improvement notation	Increased score indicates improvement.
Guidance	**Data collection methodology:** ECDS. (Refer to *General Guideline: Data Collection Methods* for additional information.) **Date specificity:** Dates must be specific enough to determine the episode occurred in the period being measured. **Observation stays:** For observation stays (Observation Stay Value Set) that do not have a recorded admission or discharge date, set the admission date to the earliest date of service on the claim and set the discharge date to the last date of service on the claim. **Which services count?** When using claims, include all paid, suspended, pending and denied claims. **Other guidance:** The measure is based on episodes; therefore, it is possible for the denominator to include multiple events for the same member. **Programming guidance:** The MY 2027 HEDIS Implementation Guide (IG) will be available in October 2026. To request access to the HEDIS Implementation Guide, email hedis-ig@ncqa.org.

Definitions	
Asthma episode	An encounter between January 1 and December 1 with a diagnosis of asthma. *For urgent care visits that result in an ED visit*, the ED visit is the episode. *For urgent care or ED visits that result in a nonacute inpatient stay*, the urgent care or ED visit is the episode. *For acute inpatient or observation stays that result in a nonacute inpatient stay*, the acute inpatient or observation stay discharge is the episode.
Asthma episode date	The date of service for the asthma episode. *For acute inpatient or observation stay discharges,* the episode date is the date of discharge. *For direct transfers,* the episode date is the discharge date from the last transfer admission. *For ED or urgent care visits,* the episode date is the date of service.
Initial population	*Measure item count:* Episode. *Attribution basis:* Enrollment. • *Benefits:* Medical. • *Continuous enrollment:* – For self-reporting POs: Episode date through 30 days after episode date (31 total days) in the PO (parent level). – For health plans: Episode date through 30 days after episode date (31 total days) in the health plan and in the PO (parent level). • *Allowable gap:* None. *Ages:* 5–64 years of age as of the episode date. *Event:* **Acute visits for asthma on or between January 1 and December 1 of the measurement period.** **Step 1.** Identify all urgent care visits, ED visits, acute inpatient discharges and observation stay discharges on or between January 1 and December 1 of the measurement period: • An urgent care visit (Outpatient and Telehealth Value Set ***with*** POS code 20) ***with*** a diagnosis of asthma (Asthma Value Set). • An urgent care facility visit (Urgent Care Clinic Facility Revenue Value Set) ***with*** a diagnosis of asthma (Asthma Value Set). • An ED visit (ED Value Set) ***with*** a diagnosis of asthma (Asthma Value Set). • An acute inpatient or observation stay discharge with a diagnosis of asthma (Asthma Value Set) on the discharge claim. To identify acute inpatient and observation discharges: 1. Identify all observation, acute and nonacute inpatient stays (Inpatient and Observation Facility Revenue Value Set).

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

Step 2. Exclude ED and urgent care visits followed by admission to an acute inpatient or observation stay care setting on the date of the ED or urgent care visit, or within 30 days after the ED or urgent care visit (31 total days), regardless of diagnosis for the admission.

To identify admissions to an acute inpatient or observation stay care setting:

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

Step 3. Test for readmissions or direct transfers.

For discharges from inpatient or observation stays with a diagnosis of asthma followed by a readmission or direct transfer to an acute inpatient or observation stay for any diagnosis on the date of discharge through 30 days after discharge (31 days total), the episode date is the discharge date from the last admission.

To identify readmissions and direct transfers from acute inpatient or observation stays:

1. Identify all observation, acute and nonacute inpatient stays (Inpatient and Observation Facility Revenue Value Set).
2. Exclude nonacute inpatient stays (Nonacute Inpatient Stay Value Set).
3. Identify the admission date for the stay (the admission date must occur during the 31-day period).
4. Identify the discharge date for the stay.

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

Include only the discharge date from the last admission for discharges followed by a readmission or direct transfer to an acute inpatient care setting on the date of discharge through 30 days after discharge (31 days total).

- *For example,* consider the following events:
  - Acute inpatient stay 1: March 5 - 10.
  - Acute inpatient stay 2: April 4 - 22.

  Include the acute inpatient discharge on April 22 as a denominator event. Exclude the discharge on March 10.

Step 4. Calculate continuous enrollment.

Step 5. Determine all eligible asthma episode dates.

Step 6. Deduplicate eligible episodes. If a member has more than one eligible episode in a 31-day period, include only the first eligible episode. Identify visits chronologically, including only one per 31-day period.

- *For example,* consider the following events:
  - ED visit: January 1.

	– Urgent care visit: January 15. – ED visit: January 20. Include the ED visit on January 1 as a denominator event. Exclude the urgent care visit on January 15 and the ED visit on January 20. • *For example,* consider the following events: – Acute inpatient discharge: March 5. – ED visit: March 12. – Urgent care visit: March 20. Include the acute inpatient discharge on March 5 as a denominator event. Exclude the ED visit on March 12 and urgent care visit on March 20.
Denominator exclusions	**Deceased members.** Members who died any time on or before the last day of the measurement period, identified using data sources determined by the organization. Method and data sources are subject to review during the AMP audit. **Members in hospice or using hospice services.** Members who use hospice services (Hospice Encounter Value Set; Hospice Intervention Value Set) or elect to use a hospice benefit any time during the measurement period. Organizations that use the Monthly Membership Detail Data File to identify these members must use only the run date of the file. **Members with a diagnosis of cystic fibrosis.** Members with a diagnosis of cystic fibrosis (Cystic Fibrosis Value Set*) at any time in the member's history through the last day of the measurement period. **Coding Guidance** *Do not include laboratory claims (claims with POS code 81).
Denominator	The initial population minus denominator exclusions.
Numerator	**30-day follow-up.** An outpatient visit, telephone visit, e-visit or virtual check-in (Outpatient and Telehealth Value Set) with a diagnosis of asthma (Asthma Value Set) within 30 days after the asthma episode. Do not include visits that occur on the same day as the asthma episode. Do not include services provided in an urgent care setting (POS code 20).

Blood Pressure Control for Patients With Hypertension (BPC-E)

MEASURE UPDATES OCTOBER 2027 FOR AMP MY 2027.

- Updated the race and ethnicity stratification categories to capture declinations and unknown race and/or ethnicity more precisely.
- Updated value set name for nephrectomy in the end-stage renal disease *Denominator exclusion*.

MODIFICATIONS FROM HEDIS

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

To report this measure, refer to the digital measure package available for purchase in the NCQA Store for the complete HEDIS digital measure specification.

Measure title	Blood Pressure Control for Patients With Hypertension	**Measure ID**	BPC-E
Description	The percentage of members 18–85 years of age who had a diagnosis of hypertension (HTN) and whose most recent blood pressure (BP) was <140/90 mm Hg during the measurement period.		
Measurement period	January 1–December 31.		
Clinical recommendation statement/rationale	The American Academy of Family Physicians (AAFP) strongly recommends clinicians treat adults who have hypertension to a standard blood pressure target (<140/90 mm Hg) to reduce the risk of all-cause and cardiovascular mortality. Refer to the HEDIS Measure Library & Historical Data measure web page for additional information about the clinical rationale.		
Citations	Coles, S., L. Fisher, K. Lin, C. Lyon, A. Vosooney, and M. Bird. November 14, 2022. *Blood Pressure Targets in Adults With Hypertension: A Clinical Practice Guideline From the AAFP*.		
Characteristics			
Scoring	Proportion.		
Type	Outcome.		
Product lines	• Commercial HMO/POS. • Medicare Advantage. • Medi-Cal Managed Care.		
Stratifications	Race. (Refer to *General Guideline: Race and Ethnicity Stratification.*) • American Indian or Alaska Native. • Asian. • Black or African American.		

	• Middle Eastern or North African. • Native Hawaiian or Pacific Islander. • White. • Other Race. • Two or More Races. • Asked But Declined. • Unknown. • Total. Ethnicity. (*Refer to General Guideline: Race and Ethnicity Stratification.*) • Hispanic or Latino. • Not Hispanic or Latino. • Asked But Declined. • Unknown. • Total.
Risk adjustment	None.
Improvement notation	Increased score indicates improvement.
Guidance	**Data collection methodology:** ECDS. (Refer to *General Guideline: Data Collection Methods fo*r additional information.) **Date specificity:** Dates must be specific enough to determine the event occurred in the period being measured. **Which services count?** When using claims, include all paid, suspended, pending, and denied claims. **Programming guidance:** The MY 2027 HEDIS Implementation Guide (IG) will be available in October 2026. To request access to the HEDIS IG, email hedis-ig@ncqa.org.
Initial population	*Measure item count:* Member. *Attribution basis:* Enrollment. • *Benefits:* Medical. • *Continuous enrollment:* – For self-reporting POs: The measurement period in the PO (parent level). – For health plans: The measurement period in the health plan and the PO (parent level). • *Allowable gap:* – For self-reporting POs: No more than one gap of ≤45 days during the measurement period. No gaps in enrollment in the PO (parent level, or, for eligible POs, subgroup level) or in an AMP plan on the last day of the measurement period. – For health plans: No more than one gap of ≤45 days during the measurement period. No gaps in enrollment in the health plan or

	the PO (parent level, or, for eligible POs, subgroup level) on the last day of the measurement period. *Ages:* 18–85 years of age as of the last day of the measurement period. *Event:* **Members with a diagnosis of hypertension.** Members who meet either of the following criteria: • At least two outpatient visits, telephone visits, e-visits or virtual check-ins (Outpatient and Telehealth Without UBREV Value Set) on different dates of service with a diagnosis of hypertension (Essential Hypertension Value Set) on or between January 1 of the year prior to the measurement period and June 30 of the measurement period. • At least one outpatient visit, telephone visit, e-visit or virtual check-in (Outpatient and Telehealth Without UBREV Value Set) with a diagnosis of hypertension (Essential Hypertension Value Set) and at least one dispensed antihypertensive medication (Antihypertensive Medications List) on or between January 1 of the year prior to the measurement period and June 30 of the measurement period.
Denominator exclusions	**Deceased members.** Members who died any time on or before the last day of the measurement period, identified using data sources determined by the organization. Method and data sources are subject to review during the AMP audit. **Members in hospice or using hospice services.** Members who use hospice services (Hospice Encounter Value Set; Hospice Intervention Value Set) or elect to use a hospice benefit any time during the measurement period. Organizations that use the Monthly Membership Detail Data File to identify these members must use only the run date of the file. **Members receiving palliative care.** Members receiving palliative care (Palliative Care Observations Value Set; Palliative Care Procedures Value Set) or who had an encounter for palliative care (ICD-10-CM code Z51.5*) any time during the measurement period. **Medicare Advantage members, 66 years of age and older by the last day of the measurement period, in an institutional SNP (I-SNP) or living long-term in an institution (LTI).** • Enrolled in an Institutional SNP (I-SNP) any time during the measurement period. • Living long-term in an institution any time during the measurement period as identified by the LTI flag in the Monthly Membership Detail Data File. Use the run date of the file to determine if a member had an LTI flag during the measurement period. ** The exclusion for members living long-term in an institution is optional for POs that do not have access to the LTI flag in the Monthly Membership Detail Data File.* **Members 66–80 years of age by the last day of the measurement period, with both frailty and advanced illness.** 1. **Frailty.** At least two indications of frailty (Frailty Device Value Set; Frailty Diagnosis Value Set*; Frailty Encounter Value Set; Frailty Symptom Value Set*) with different dates of service during the measurement period.

	2. **Advanced illness.** Either of the following during the measurement period or the year prior to the measurement period: – Advanced illness (Advanced Illness Value Set*) on at least two different dates of service. – Dispensed dementia medication (Dementia Medications List). **Members 81 years of age or older as of the last day of the measurement period, with frailty.** Members 81 years of age and older as of the last day of the measurement period with at least two indications of frailty (Frailty Device Value Set; Frailty Diagnosis Value Set*; Frailty Encounter Value Set; Frailty Symptom Value Set*) with different dates of service during the measurement period. **End-stage renal disease (ESRD).** Members with any of the following during their history on or prior to the last day of the measurement period: • Diagnosis that indicates end-stage renal disease (ESRD) (ESRD Diagnosis Value Set*; History of Nephrectomy or Kidney Transplant Value Set*). • Procedure that indicates ESRD: dialysis (Dialysis Procedure Value Set), nephrectomy (Total and Partial Nephrectomies Value Set) or kidney transplant (Kidney Transplant Value Set). **Diagnosis of pregnancy.** Members with a diagnosis of pregnancy (Pregnancy Value Set*) any time during the measurement period. **Nonacute inpatient admission.** Members with a nonacute inpatient admission during the measurement period. To identify nonacute inpatient admissions: 1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set). 2. Confirm the stay was for nonacute care based on the presence of a nonacute code (Nonacute Inpatient Stay Value Set) on the claim. 3. Identify the admission date for the stay. **Coding Guidance** *Do not include laboratory claims (claims with POS code 81).
Denominator	The initial population minus denominator exclusions.
Numerator	**Both a systolic and diastolic reading <140/90 mm Hg.** Identify the most recent systolic and diastolic BP readings (Systolic Blood Pressure Value Set; Diastolic Blood Pressure Value Set) taken during the measurement period *on or after* the second diagnosis of hypertension event (identified using the initial population criteria). Do not include CPT Category II codes (Systolic and Diastolic Result Value Set) with a modifier (CPT CAT II Modifier Value Set). Do not include BPs taken in an acute inpatient setting (Acute Inpatient Value Set; Acute Inpatient POS Value Set) or ED visit (ED Value Set; POS code 23).

	If multiple readings were recorded for a single date, use the lowest systolic and lowest diastolic BP on that date as the representative BP. The systolic and diastolic results do not need to be from the same reading. • *Compliant*: BP is <140/90 mm Hg. • *Non-compliant*: BP is ≥140/90 mm Hg; no BP reading during the measurement period; or if the reading is incomplete (e.g., the systolic or diastolic level is missing). If the most recent blood pressure was identified based on a CPT Category II code (Systolic and Diastolic Result Value Set) use the following to determine compliance: • *Systolic Compliant:* Systolic Less Than 140 Value Set. • *Systolic not compliant*: CPT-CAT-II code 3077F. • *Diastolic compliant*: Diastolic Less Than 90 Value Set. • *Diastolic not compliant*: CPT-CAT-II code 3080F.

Controlling High Blood Pressure (CBP)

MEASURE UPDATES OCTOBER 2026 FOR AMP MY 2027

- Updated the race and ethnicity stratification categories to capture declinations and unknown race and/or ethnicity more precisely.
- Updated value set name for nephrectomy in the end-stage renal disease *Denominator exclusion*.

MODIFICATIONS FROM HEDIS

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

Measure title	Controlling High Blood Pressure	**Measure ID**	CBP
Description	The percentage of members 18–85 years of age who had a diagnosis of hypertension (HTN) and whose blood pressure (BP) was adequately controlled (<140/90 mm Hg) during the measurement period.		
Measurement period	January 1–December 31.		
Clinical recommendation statement/ rationale	The American Academy of Family Physicians (AAFP) strongly recommends clinicians treat adults who have hypertension to a standard blood pressure target (<140/90 mm Hg) to reduce the risk of all-cause and cardiovascular mortality. Refer to the HEDIS Measure Library & Historical Data measure web page for additional information about the clinical rationale.		
Citations	Coles, S., L. Fisher, K. Lin, C. Lyon, A. Vosooney, and M. Bird. "Blood Pressure Targets in Adults With Hypertension: A Clinical Practice Guideline From the AAFP." November 14, 2022.		
Characteristics			
Scoring	Proportion.		
Type	Outcome.		
Product lines	• Commercial HMO/POS. • Medicare Advantage. • Medi-Cal Managed Care.		
Stratifications	Race. (Refer to *General Guideline: Race and Ethnicity Stratification.*) • American Indian or Alaska Native. • Asian. • Black or African American. • Middle Eastern or North African. • Native Hawaiian or Pacific Islander.		

	• White. • Other Race. • Two or More Races. • Asked But Declined. • Unknown. • Total. Ethnicity. (Refer to *General Guideline: Race and Ethnicity Stratification.*) • Hispanic or Latino. • Not Hispanic or Latino. • Asked But Declined. • Unknown. • Total.
Risk adjustment	None.
Improvement notation	Increased score indicates improvement.
Guidance	**Data collection methodology:** Administrative. (Refer to *General Guideline: Data Collection Methods* for additional information.) **Date specificity:** Dates must be specific enough to determine the event occurred in the period being measured. **Which services count?** When using claims, include all paid, suspended, pending and denied claims.
Definitions	
Adequate control	Both a representative systolic BP <140 mm Hg and a representative diastolic BP of <90 mm Hg.
Representative BP	The most recent BP reading during the measurement period on or after the second diagnosis of hypertension. If multiple BP measurements occur on the same date, or are noted in the chart on the same date, use the lowest systolic and lowest diastolic BP reading. If no BP is recorded during the measurement period, assume the BP is "not controlled."
Initial population	*Measure item count:* Member. *Attribution basis:* Enrollment. • *Benefits:* Medical. • *Continuous enrollment:* – For self-reporting POs: The measurement period in the PO (parent level). – For health plans: The measurement period in the health plan and the PO (parent level).

	• *Allowable gap:* – For self-reporting POs: No more than one gap of ≤45 days during the measurement period. No gaps in enrollment in the PO (parent level, or, for eligible POs, subgroup level) or in an AMP plan on the last day of the measurement period. – For health plans: No more than one gap of ≤45 days during the measurement period. No gaps in enrollment in the health plan or the PO (parent level, or, for eligible POs, subgroup level) on the last day of the measurement period. *Ages:* 18–85 years of age as of the last day of the measurement period. *Event:* **Members with a diagnosis of hypertension.** **Step 1.** Identify members who had at least two outpatient visits, telephone visits, e-visits, or virtual check-ins (Outpatient and Telehealth Without UBREV Value Set) on different dates of service with a diagnosis of hypertension (Essential Hypertension Value Set) on or between January 1 of the year prior to the measurement period and June 30 of the measurement period. **Step 2.** Remove members who had a nonacute inpatient admission during the measurement period. To identify nonacute inpatient admissions: 1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set). 2. Confirm the stay was for nonacute care based on the presence of a nonacute code (Nonacute Inpatient Stay Value Set) on the claim. 3. Identify the admission date for the stay.
Denominator exclusions	**Deceased members.** Members who died any time on or before the last day of measurement period, identified using data sources determined by the organization. Method and data sources are subject to review during the AMP audit. **Members in hospice or using hospice services.** Members who use hospice services (Hospice Encounter Value Set; Hospice Intervention Value Set) or elect to use a hospice benefit any time during the measurement period. Organizations that use the Monthly Membership Detail Data File to identify these members must use only the run date of the file. **Members receiving palliative care.** Members receiving palliative care (Palliative Care Observations Value Set; Palliative Care Procedures Value Set) or who had an encounter for palliative care (ICD-10-CM code Z51.5*) any time during the measurement period. **Medicare Advantage members, 66 years of age and older by the last day of the measurement period, in an institutional SNP (I-SNP) or living long-term in an institution (LTI).** • Enrolled in an Institutional SNP (I-SNP) any time during the measurement period. • Living long-term in an institution any time during the measurement period as identified by the LTI flag in the Monthly Membership Detail Data File. Use the run date of the file to determine if a member had an LTI flag during the measurement period.

	** The exclusion for members living long-term in an institution is optional for POs that do not have access to the LTI flag in the Monthly Membership Detail Data File.* **Members 66–80 years of age by the last day of the measurement period, with both frailty and advanced illness.** 1. **Frailty.** At least two indications of frailty (Frailty Device Value Set; Frailty Diagnosis Value Set*; Frailty Encounter Value Set; Frailty Symptom Value Set*) with different dates of service during the measurement period. 2. **Advanced Illness.** Either of the following during the measurement period or the year prior to the measurement period: – Advanced illness (Advanced Illness Value Set*) on at least two different dates of service. – Dispensed dementia medication (Dementia Medications List). **Members 81 years of age and older as of the last day of the measurement period, with frailty.** Members with at least two indications of frailty (Frailty Device Value Set; Frailty Diagnosis Value Set*; Frailty Encounter Value Set; Frailty Symptom Value Set*) with different dates of service during the measurement period. **End-stage renal disease (ESRD).** Members with any of the following during their history on or prior to the last day of the measurement period: • Diagnosis that indicates end-stage renal disease (ESRD) (ESRD Diagnosis Value Set*; History of Nephrectomy or Kidney Transplant Value Set*). • Procedure that indicates ESRD: dialysis (Dialysis Procedure Value Set), nephrectomy (Total and Partial Nephrectomies Value Set) or kidney transplant (Kidney Transplant Value Set). **Diagnosis of pregnancy.** Members with diagnosis of pregnancy (Pregnancy Value Set*) any time during the measurement period. **Coding Guidance** *****Do not include laboratory claims (claims with POS code 81).
Denominator	The initial population minus denominator exclusions.
Numerator	**Both a systolic and diastolic reading <140/90 mm Hg.** Identify the most recent BP reading (Systolic Blood Pressure Value Set; Diastolic Blood Pressure Value Set) taken during the measurement period. Do not include CPT Category II codes (Systolic and Diastolic Result Value Set) with a modifier (CPT CAT II Modifier Value Set). Do not include BPs taken in an acute inpatient setting (Acute Inpatient Value Set; Acute Inpatient POS Value Set) or during an ED visit (ED Value Set; POS code 23). The BP reading must occur *on or after* the date of the second diagnosis of hypertension (identified using the initial population criteria). 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. • *Compliant*: BP is <140/90 mm Hg.

	• *Non-compliant*: BP is ≥140/90 mm Hg; no BP reading during the measurement period; or if the reading is incomplete (e.g., the systolic or diastolic level is missing). If the most recent blood pressure was identified based on a CPT Category II code (Systolic and Diastolic Result Value Set) use the following to determine compliance: • *Systolic Compliant:* Systolic Less Than 140 Value Set. • *Systolic Not Compliant*: CPT-CAT-II code 3077F. • *Diastolic Compliant*: Diastolic Less Than 90 Value Set. • *Diastolic Not Compliant*: CPT-CAT-II code 3080F.

Proportion of Days Covered by Medications: Renin Angiotensin System Antagonists (PDC-RASA)

MEASURE UPDATES OCTOBER 2026 FOR AMP MY 2027

- None.

MODIFICATIONS FROM PQA

- None.

Measure title	Proportion of Days Covered: Renin Angiotensin System Antagonists	**Measure ID**	PDC-RASA
Description	The percentage of members ≥18 years of age who met the proportion of days covered (PDC) threshold of 80% for RAS antagonists during the measurement period. ***Note:*** *Refer to the PQA Value Set in the MY 2027 AMP Product Bundle download in the NCQA Store for a comprehensive list of PQA medications and associated codes (PQA NDC Code List and PQA ICD Code List). Do not distribute NDC lists outside your organization.* *Unique biosimilar medications are no longer noted in the associated medication tables. For biologic reference products in the Medication Table biosimilars associated with the reference product, regardless of interchangeable status, are included in the associated value sets, unless otherwise noted. For associated value sets, the NDC lists comprise all relevant NDCs (including available biosimilar medications) with a through date of July 1, 2025, or later.* *Deceased members may not be excluded for this measure.*		
Measurement period	January 1–December 31.		
Clinical recommendation statement/ rationale	The body of evidence linking adherence to reduced costs and improved outcomes is substantial and consistent, as adherence has been the subject of extensive research over the past several decades. Multiple studies have indicated that adherence to RAS antagonists exceeding the 80% threshold is associated with fewer inpatient, outpatient, and emergency visits, lower all-cause mortality, and lower total healthcare costs. The Centers for Medicare & Medicaid Services (CMS) 2024 Impact Assessment Report found that health care costs avoided due to improved patient medication adherence were estimated at $4.2 billion–$25.9 billion, providing robust evidence of the economic benefits of medication adherence. For RAS antagonists specifically, the CMS 2024 Impact Assessment estimated health care costs avoided due to improved adherence to be $12.4 billion–$15.8 billion (Medicare Part D), and $405.5 million to $515.6 million (Health Insurance Marketplace).		

Citations	Sokol MC, McGuigan KA, Verbrugge RR, Epstein RS. Impact of medication adherence on hospitalization risk and healthcare cost. Med Care. 2005;43:521-30. PMID: 15908846. Ho PM, Magid DJ, Masoudi FA, et al. Adherence to cardioprotective medications and mortality among patients with diabetes and ischemic heart disease. BMC Cardiovasc Disord. 2006;6:48. PMID: 17173679. Roebuck MC, Liberman JN, Gemmill-Toyama M, et al. Medication adherence leads to lower health care use and costs despite increased drug spending. Health Aff. 2011; 30:91-9. PMID: 21209444. Choudhry NK, Glynn RJ, Avorn J, et al. Untangling the relationship between medication adherence and post-myocardial infarction outcomes: medication adherence and clinical outcomes. Am Heart J. 2014;167:51-58.e5. PMID: 24332142. Roebuck MC, Kaestner RJ, Dougherty JS. Impact of Medication Adherence on Health Services Utilization in Medicaid. Med Care. 2018;56:266-273. PMID: 29309392. Centers for Medicare & Medicaid Services. *2024 National Impact Assessment of the Centers for Medicare & Medicaid Services (CMS) Quality Measures Report*. 2024. Accessed August 12, 2025. https://www.cms.gov/files/document/2024-national-impact-assessment-report.pdf.
Characteristics	
Scoring	Proportion.
Type	Intermediate outcome.[6]
Product line	• Medicare Advantage.
Stratifications	None.
Risk adjustment	None.
Improvement notation	Increased score indicates improvement.
Guidance	**Data collection methodology:** Administrative. (Refer to *General Guideline: Data Collection Methods* for additional information.) **Date specificity:** Date must be specific enough to determine the event occurred in the period being measured. **Which services count?** Only paid, non-reversed prescription claims are included in the data set to calculate the measure. **Supplemental data exceptions:** Supplemental data may only be used for the hospice exclusion.

[6] The current HL7 FHIR version (v4) does not include *Intermediate outcome* as a measure type. It is currently being requested to be added to HL7 FHIR R6; updates will be communicated to AMP participants.

	Other guidance: • Members must have ≥2 prescription claims in a given medication category on different dates of service during the treatment period to be included in the measure. • If a PO receives pharmacy claim information for a member, it can assume the member has a pharmacy benefit and that the pharmacy benefit dates align with the medical benefit dates. • Do not include members who disenroll and reenroll more than 1 day later any time during the measurement period after the treatment period.
Definitions	
Renin angiotensin system (RAS) antagonists	ACEI/ARB/direct renin inhibitor or ACEI/ARB/direct renin inhibitor combination product. Refer to the Renin Angiotensin System (RAS) Antagonists Value Set.
IPSD	Index prescription start date. The earliest date of service for a target medication during the measurement period.
Treatment period	The member's treatment period begins on the IPSD and extends through whichever comes first: the last day of enrollment during the measurement period, death, or the end of the measurement period. The treatment period should be at least 91 days.
PDC	Proportion of days covered. The proportion of days in the treatment period "covered" by prescription claims for the same medication or another in its therapeutic category.
PDC threshold	The level of PDC above which the medication has a reasonable likelihood of achieving most of the potential clinical benefit (i.e., 80% for diabetes and cardiovascular drugs, and many chronic conditions).
Initial population	*Measure item count:* Member. *Attribution basis:* Enrollment. • *Benefits:* Medical and Pharmacy. • *Continuous enrollment:* – For self-reporting POs: *Treatment period.* The IPSD through the end of the measurement period or until death or disenrollment from the PO (parent level). – For health plans: *Treatment period.* The IPSD through the end of the measurement period or until death or disenrollment from the health plan and from the PO (parent level). • *Allowable gap:* Exclude members with more than one 1-day gap in enrollment during the treatment period. ***Note:*** *This allows only a single 1-day gap to compensate for discrepancies in the enrollment data. For example, a member who was eligible from January 1–April 1 and April 3–December 31 would still be continuously enrolled despite the 1-day gap in eligibility on April 2.* *Ages:* ≥18 years of age as of the first day of the measurement period.

	Event: **Members with ≥2 prescription claims for any RAS antagonist on different dates of service in the treatment period.** **Step 1.** Identify members ≥18 years of age as of the first day of the measurement period. **Step 2.** Identify members with ≥2 prescription claims on different dates of service for any RAS antagonist (Renin Angiotensin System (RAS) Antagonists Value Set) during the measurement period. The prescription claims can be for the same or different medications. **Step 3.** Determine each member's treatment period. **Step 4.** Identify members with a treatment period that is ≥91 days during the measurement period. **Step 5**. Identify members meeting the continuous enrollment requirement during the treatment period.
Denominator exclusions	**Members in hospice or using hospice services.** Members who use hospice services (Hospice Encounter Value Set; Hospice Intervention Value Set) or elect to use a hospice benefit any time during the measurement period. Organizations that use the Monthly Membership Detail Data File to identify these members must use only the run date of the file. **End-stage renal disease (ESRD) diagnosis.** Members with a diagnosis of ESRD (ESRD Exclusion Value Set*) any time during the measurement period. An ESRD diagnosis is defined as having ≥1 claim with ESRD in the primary diagnosis or any other diagnosis fields during the measurement period. **Sacubitril/valsartan medication.** Members with ≥1 prescription claims for the medication sacubitril/valsartan (Sacubitril/Valsartan Exclusion Value Set) during the treatment period. **Coding Guidance** *Do not include laboratory claims (claims with POS code 81).
Denominator	Initial population minus denominator exclusions.
Numerator	**Members who met the PDC threshold during the measurement period.** Follow the steps below for each member to determine whether the member meets the PDC threshold. **Step 1.** Determine the treatment period. **Step 2.** Within the treatment period, count the days the member was covered by at least one RAS antagonist medication (Renin Angiotensin System [RAS] Antagonists Value Set) based on the date of service and days' supply on the prescription claims. If the days' supply for prescription claims with the same target drug (generic ingredient) overlap, then adjust the prescription claim's start date to be the day after the last days' supply for the previous prescription claim. Adjustment of overlap should also occur when there is overlap of a single drug product to a combination product containing the single target drug or when there is an overlap of a combination product to another combination product where at least one of the target drugs is common.

	Step 3. Divide the number of covered days found in step 2 by the number of days found in step 1. Multiply this number by 100 to obtain the PDC (as a percentage) for each member. Then round the PDC to the nearest hundredth (e.g., 79.996% is rounded to 80.00%, 79.992% is rounded to 79.99%). **Step 4.** Count the number of members who had a PDC of ≥80.00% and then divide by the total number of eligible members.

Proportion of Days Covered: Statins (PDC-STA)

MEASURE UPDATES OCTOBER 2026 FOR AMP MY 2027

- Added *Denominator exclusions* for (1) rhabdomyolysis, myopathy, or myositis diagnosis, (2) pregnancy diagnosis, lactation diagnosis, invitro fertilization, or fertility prescription, (3) cirrhosis diagnosis, and (4) myalgia diagnosis.

MODIFICATIONS FROM PQA

- None.

Measure title	Proportion of Days Covered: Statins	**Measure ID**	PDC-STA
Description	The percentage of members ≥18 years of age who met the proportion of days covered (PDC) threshold of 80% for statins during the measurement period. ***Note:*** *Refer to the PQA Value Set in the MY 2027 AMP Product Bundle download in the NCQA Store for a comprehensive list of PQA medications and associated codes (PQA NDC Code List and PQA ICD Code List). Do not distribute NDC lists outside your organization.* *Unique biosimilar medications are no longer noted in the associated medication tables. For biologic reference products in the Medication Table biosimilars associated with the reference product, regardless of interchangeable status, are included in the associated value sets, unless otherwise noted. For associated value sets, the NDC lists comprise all relevant NDCs (including available biosimilar medications) with a through date of July 1, 2025, or later.* *Deceased members may not be excluded for this measure.*		
Measurement period	January 1–December 31.		
Clinical recommendation statement/ rationale	The body of evidence linking adherence to reduced costs and improved outcomes is substantial and consistent, as adherence has been the subject of extensive research over the past several decades. Multiple studies have indicated that adherence to statins exceeding the 80% threshold is associated with fewer inpatient, outpatient, and emergency visits, lower all-cause mortality, and lower total health care costs. The Centers for Medicare & Medicaid Services (CMS) 2024 Impact Assessment Report found that health care costs avoided due to improved patient medication adherence were estimated at $4.2 billion-$25.9 billion, providing robust evidence of the economic benefits of medication adherence. For statins specifically, the CMS 2024 Impact Assessment estimated health care costs avoided due to improved adherence to be $11.6 billion (Medicare Part D) and $732.5 million (Health Insurance Marketplace).		
Citations	Wei L, Wang J, Thompson P, et al. Adherence to statin treatment and readmission of patients after myocardial infarction: a six year follow up study. Heart. 2002;88:229-33. PMID: 12181210.		

	Sokol MC, McGuigan KA, Verbrugge RR, Epstein RS. Impact of medication adherence on hospitalization risk and healthcare cost. Med Care. 2005;43:521-30. PMID: 15908846. Ho PM, Magid DJ, Masoudi FA, et al. Adherence to cardioprotective medications and mortality among patients with diabetes and ischemic heart disease. BMC Cardiovasc Disord. 2006;6:48. PMID: 17173679. Roebuck MC, Liberman JN, Gemmill-Toyama M, et al. Medication adherence leads to lower health care use and costs despite increased drug spending. Health Aff. 2011; 30:91-9. PMID: 21209444. Choudhry NK, Glynn RJ, Avorn J, et al. Untangling the relationship between medication adherence and post-myocardial infarction outcomes: medication adherence and clinical outcomes. Am Heart J. 2014;167:51-58.e5. PMID: 24332142. Korhonen MJ, Ruokoniemi P, Ilomäki J, et al. Adherence to statin therapy and the incidence of ischemic stroke in patients with diabetes. Pharmacoepidemiol Drug Saf. 2016;25:161-9. PMID: 26687512. Chinthammit C, Axon D, Anderson S, et al. A retrospective database analysis evaluating the association between Pharmacy Quality Alliance cholesterol medication adherence measure and economic outcomes for commercially insured patients. J Manag Care Spec Pharm. 2019;25:3-a Suppl, I17. PMID: 30854912. Centers for Medicare & Medicaid Services. *2024 National Impact Assessment of the Centers for Medicare & Medicaid Services (CMS) Quality Measures Report*. 2024. Accessed August 12, 2025. https://www.cms.gov/files/document/2024-national-impact-assessment-report.pdf.
Characteristics	
Scoring	Proportion.
Type	Intermediate outcome.[7]
Product line	• Medicare Advantage.
Stratifications	None.
Risk adjustment	None.
Improvement notation	Increased score indicates improvement.
Guidance	**Data collection methodology:** Administrative. (Refer to *General Guideline: Data Collection Methods* for additional information.) **Date specificity:** Date must be specific enough to determine the event occurred in the period being measured.

[7] The current HL7 FHIR version (v4) does not include *Intermediate outcome* as a measure type. It is currently being requested to be added to HL7 FHIR R6; updates will be communicated to AMP participants.

	Which services count? Only paid, non-reversed prescription claims are included in the data set to calculate the measure. **Supplemental data exceptions:** Supplemental data may only be used for the hospice exclusion. **Other guidance:** • Members must have ≥2 prescription claims in a given medication category on different dates of service during the treatment period to be included in the measure. • If a PO receives pharmacy claim information for a member, it can assume the member has a pharmacy benefit and that the pharmacy benefit dates align with the medical benefit dates. • Do not include members who disenroll and reenroll more than 1 day later any time during the measurement period after the treatment period.
Definitions	
Statin medications	Statin or statin combination products. Refer to Statins Value Set.
IPSD	Index prescription start date. The earliest date of service for a target medication during the measurement period.
Treatment period	The member's treatment period begins on the IPSD and extends through whichever comes first: the last day of enrollment during the measurement period, death, or the end of the measurement period. The treatment period should be at least 91 days.
PDC	Proportion of days covered. The proportion of days in the treatment period "covered" by prescription claims for the same medication or another in its therapeutic category.
PDC threshold	The level of PDC above which the medication has a reasonable likelihood of achieving most of the potential clinical benefit (i.e., 80% for diabetes and cardiovascular drugs, and many chronic conditions).
Initial population	*Measure item count:* Member. *Attribution basis:* Enrollment. • *Benefits:* Medical and Pharmacy. • *Continuous enrollment:* – For self-reporting POs: *Treatment period.* The IPSD through the end of the measurement period or until death or disenrollment from the PO (parent level). – For health plans: *Treatment period.* The IPSD through the end of the measurement period or until death or disenrollment from the health plan and from the PO (parent level). • *Allowable gap:* Exclude members with more than one 1-day gap in enrollment during the treatment period.

	Note: *This allows only a single 1-day gap to compensate for discrepancies in the enrollment data. For example, a member who was eligible from January 1–April 1 and April 3–December 31 would still be continuously enrolled despite the 1-day gap in eligibility on April 2.* *Ages:* ≥18 years of age as of the first day of the measurement period. *Event:* **Members with ≥2 prescription claims for any statin on different dates of service in the treatment period.** **Step 1.** Identify members ≥18 years of age as of the first day of the measurement period. **Step 2.** Identify members with ≥2 prescription claims on different dates of service for any statin medication (Statins Value Set) during the measurement period. The prescription claims can be for the same or different medications. **Step 3.** Determine each member's treatment period. **Step 4.** Identify members with a treatment period that is ≥91 days during the measurement period. **Step 5.** Identify members meeting the continuous enrollment requirement during the treatment period.
Denominator exclusions	**Members in hospice or using hospice services.** Members who use hospice services (Hospice Encounter Value Set; Hospice Intervention Value Set) or elect to use a hospice benefit any time during the measurement period. Organizations that use the Monthly Membership Detail Data File to identify these members must use only the run date of the file. **End-stage renal disease (ESRD) diagnosis.** Members with an ESRD diagnosis (ESRD Exclusion Value Set*) any time during the measurement period. An ESRD diagnosis is defined as having ≥1 claim with ESRD in the primary diagnosis or any other diagnosis fields during the measurement period. **Rhabdomyolysis, myopathy, or myositis diagnosis.** Members with a diagnosis of rhabdomyolysis, myopathy, or myositis at any time during the measurement period. A rhabdomyolysis, myopathy, or myositis diagnosis is defined as having ≥1 claim with rhabdomyolysis, myopathy, or myositis (Rhabdomyolysis and Myopathy Value Set*) in the primary diagnosis or any other diagnosis fields during the measurement period **Pregnancy diagnosis, lactation diagnosis, in vitro fertilization, or fertility prescription.** Members with a pregnancy, lactation, or IVF any time during the measurement period or ≥1 prescription claim for a medication indicated for fertility during the measurement period. • A pregnancy diagnosis is defined as having ≥1 claim with pregnancy (PREGNANCY Value Set*) in the primary diagnosis or any other diagnosis fields during the measurement period. ***Or*** • A lactation diagnosis is defined as having ≥1 claim with lactation (LACTATION Value Set*) in the primary diagnosis or any other diagnosis fields during the measurement period. ***Or*** • IVF is defined as having ≥1 claim with IVF (IVF Value Set) during the measurement period. ***Or***

	• Fertility treatment is defined as having ≥1 claim for a medication indicated for fertility (Fertility Value Set) during the measurement period. **Cirrhosis diagnosis.** Members with a cirrhosis diagnosis (CIRRHOSIS Value Set*) any time during the measurement period. A cirrhosis diagnosis is defined as having ≥1 claim with cirrhosis in the primary diagnosis or any other diagnosis fields during the measurement period. **Myalgia diagnosis.** Members with a myalgia diagnosis (MYALGIA Value Set*) at any time during the treatment period. Myalgia is defined as having ≥1 claim with myalgia in the primary diagnosis or any other diagnosis fields during the treatment period. **Coding Guidance** *Do not include laboratory claims (claims with POS code 81).
Denominator	Initial population minus denominator exclusions.
Numerator	**Members who met the PDC threshold during the measurement period.** Follow the steps below for each member to determine whether the member meets the PDC threshold. **Step 1.** Determine the treatment period. **Step 2.** Within the treatment period, count the days the member was covered by at least one statin medication (Statins Value Set) based on the date of service and days' supply on the prescription claims. If the days' supply for prescription claims with the same target drug (generic ingredient) overlap, then adjust the prescription claim's start date to be the day after the last days' supply for the previous prescription claim. Adjustment of overlap should also occur when there is overlap of a single drug product to a combination product containing the single target drug or when there is an overlap of a combination product to another combination product where at least one of the target drugs is common. **Step 3.** Divide the number of covered days found in step 2 by the number of days found in step 1. Multiply this number by 100 to obtain the PDC (as a percentage) for each member. Then round the PDC to the nearest hundredth (e.g., 79.996% is rounded to 80.00%, 79.992% is rounded to 79.99%). **Step 4.** Count the number of members who had a PDC of ≥80.00% and then divide by the total number of eligible members.

Proportion of Days Covered: Diabetes All Class (PDC-DR)

MEASURE UPDATES OCTOBER 2026 FOR AMP MY 2027

- Added a definition for Diabetes diagnosis.
- Updated the *Description* and *Event* criteria in the *Initial population* to require a diabetes diagnosis at any time during the measurement period.

MODIFICATIONS FROM PQA

- None.

Measure title	Proportion of Days Covered: Diabetes All Class	**Measure ID**	PDC-DR
Description	The percentage of members ≥18 years of age with a diabetes diagnosis who met the proportion of days covered (PDC) threshold of 80% for diabetes medications during the measurement period. ***Note:*** *Refer to the PQA Value Set in the MY 2027 AMP Product Bundle download in the NCQA Store for a comprehensive list of PQA medications and associated codes (PQA NDC Code List and PQA ICD Code List). Do not distribute NDC lists outside your organization.* *Unique biosimilar medications are no longer noted in the associated medication tables. For biologic reference products in the Medication Table biosimilars associated with the reference product, regardless of interchangeable status, are included in the associated value sets, unless otherwise noted. For associated value sets, the NDC lists comprise all relevant NDCs (including available biosimilar medications) with a through date of July 1, 2025, or later.* *Deceased members may not be excluded for this measure.*		
Measurement period	January 1–December 31.		
Clinical recommendation statement/ rationale	The body of evidence linking adherence to reduced costs and improved outcomes is substantial and consistent, as adherence has been the subject of extensive research over the past several decades. Multiple studies have indicated that adherence to diabetes medications exceeding the 80% threshold is associated with fewer inpatient, outpatient, and emergency visits, lower all-cause mortality, and lower total health care costs. The CMS 2024 Impact Assessment Report found that health care costs avoided based on patient impacts were estimated at $4.2 billion-$25.9 billion, providing robust evidence of the economic benefits of medication adherence. For diabetes medications specifically, the CMS 2024 Impact Assessment estimated health care costs avoided due to improved adherence to be $505.9 million to $1.8 billion (Medicare Part D) and $61.4 million to $214.4 million (Health Insurance Marketplace).		
Citations	Lau DT, Nau DP. Oral antihyperglycemic medication nonadherence and subsequent hospitalization among individuals with type 2 diabetes. Diabetes Care. 2004;27:2149-53. PMID: 15333476.		

	Sokol MC, McGuigan KA, Verbrugge RR, Epstein RS. Impact of medication adherence on hospitalization risk and healthcare cost. Med Care. 2005;43:521-30. PMID: 15908846. Roebuck MC, Liberman JN, Gemmill-Toyama M, et al. Medication adherence leads to lower health care use and costs despite increased drug spending. Health Aff. 2011; 30:91-9. PMID: 21209444. Boye KS, Curtis SE, Lage MJ, et al. Associations between adherence and outcomes among older, type 2 diabetes patients: evidence from a Medicare Supplemental database. Patient Prefer Adherence. 2016;10:1573-81. PMID: 27574406. Roebuck MC, Kaestner RJ, Dougherty JS. Impact of Medication Adherence on Health Services Utilization in Medicaid. Med Care. 2018;56:266-273. PMID: 29309392. Campbell P, Axon D, Mollon L, et al. A retrospective database analysis evaluating the association between Pharmacy Quality Alliance antidiabetic medication measure adherence, healthcare use, and expenditures among commercially insured patients. J Manag Care Spec Pharm. 2019;25:3-a Suppl, S38. PMID: 30854912. Lloyd JT, Maresh S, Powers CA, Shrank WH, Alley DE. How Much Does Medication Nonadherence Cost the Medicare Fee-for-Service Program? Med Care. 2019;57:218-24. PMID: 30676355. Centers for Medicare & Medicaid Services. *2024 National Impact Assessment of the Centers for Medicare & Medicaid Services (CMS) Quality Measures Report*. 2024. Accessed August 12, 2025. https://www.cms.gov/files/document/2024-national-impact-assessment-report.pdf
Characteristics	
Scoring	Proportion.
Type	Intermediate outcome.[8]
Product line	• Medicare Advantage.
Stratifications	None.
Risk adjustment	None.
Improvement notation	Increased score indicates improvement.
Guidance	**Data collection methodology:** Administrative. (Refer to *General Guideline: Data Collection Methods* for additional information.) **Date specificity:** Date must be specific enough to determine the event occurred in the period being measured.

[8] The current HL7 FHIR version (v4) does not include *Intermediate outcome* as a measure type. It is currently being requested to be added to HL7 FHIR R6; updates will be communicated to AMP participants.

	Which services count? Only paid, non-reversed prescription claims are included in the data set to calculate the measure. **Supplemental data exceptions:** Supplemental data may only be used for the hospice exclusion. **Other guidance:** • Members must have ≥2 prescription claims in a given medication category on different dates of service during the treatment period to be included in the measure. • If a PO receives pharmacy claim information for a member, it can assume the member has a pharmacy benefit and that the pharmacy benefit dates align with the medical benefit dates. • Do not include members who disenroll and reenroll more than 1 day later any time during the measurement period after the treatment period.
Definitions	
Diabetes diagnosis[9]	Members with a diabetes diagnosis at any time during the measurement period. Diabetes is defined as having ≥1 claim with diabetes in the primary diagnosis or any other diagnosis fields during the measurement period.
Diabetes medications	Diabetes or diabetes combination products. See the following value sets: • BG: Biguanides Value Set. • SFU: Sulfonylureas Value Set. • TZD: Thiazolidinediones Value Set. • DPP4: DPP-4 Inhibitors Value Set. • GIP/GLP1: GIP/GLP-1 Receptor Agonists Value Set. • MEG: Meglitinides Value Set. • SGLT2: SGLT2 Inhibitors Value Set.
IPSD	Index prescription start date. The earliest date of service for a target medication during the measurement period.
Treatment period	The member's treatment period begins on the IPSD and extends through whichever comes first: the last day of enrollment during the measurement period, death, or the end of the measurement period. The treatment period should be at least 91 days.
PDC	Proportion of days covered. The proportion of days in the treatment period "covered" by prescription claims for the same medication or another in its therapeutic category.
PDC threshold	The level of PDC above which the medication has a reasonable likelihood of achieving most of the potential clinical benefit (i.e., 80% for diabetes and cardiovascular drugs, and many chronic conditions).

[9] The diabetes diagnosis definition is preliminary and remains under development by PQA. The final definition will be published in the Final MY 2027 Technical Specifications, scheduled for release on June 1, 2027.

Initial population	*Measure item count:* Member. *Attribution basis:* Enrollment. • *Benefits:* Medical and Pharmacy. • *Continuous enrollment:* – For self-reporting POs: *Treatment period.* The IPSD through the end of the measurement period or until death or disenrollment from the PO (parent level). – For health plans: *Treatment period.* The IPSD through the end of the measurement period or until death or disenrollment from the health plan and from the PO (parent level). • *Allowable gap:* Exclude members with more than one 1-day gap in enrollment during the treatment period. ***Note:*** *This allows only a single 1-day gap to compensate for discrepancies in the enrollment data. For example, a member who was eligible from January 1–April 1 and April 3–December 31 would still be continuously enrolled despite the 1-day gap in eligibility on April 2.* *Ages:* ≥18 years of age as of the first day of the measurement period. *Event:* **Members with a diabetes diagnosis at any time during the measurement period AND ≥2 prescription claims for any of the diabetes medications on different dates of service in the treatment period.** **Step 1.** Identify members ≥18 years of age as of the first day of the measurement period. **Step 2.** Identify members with a diabetes diagnosis at any time during the measurement period. **Step 3.** Identify members with ≥2 prescription claims on different dates of service for any diabetes medication (BG Value Set, SFU Value Set, TZD Value Set, DPP4 Value Set, GIP/GLP1 Value Set, MEG Value Set, or SGLT2 Value Set) during the measurement period. The prescription claims can be for the same or different medications and can be from any of these seven value sets. **Step 4.** Determine each member's treatment period. **Step 5.** Identify members with a treatment period that is ≥91 days during the measurement period. **Step 6.** Identify members meeting the continuous enrollment requirement during the treatment period. **Coding Guidance** *Do not include laboratory claims (claims with POS code 81).
Denominator exclusions	**Members in hospice or using hospice services.** Members who use hospice services (Hospice Encounter Value Set; Hospice Intervention Value Set) or elect to use a hospice benefit any time during the measurement period. Organizations that use the Monthly Membership Detail Data File to identify these members must use only the run date of the file. **End-stage renal disease (ESRD) diagnosis.** Members with an ESRD diagnosis (ESRD Exclusion Value Set*) any time during the measurement period. An ESRD diagnosis is defined as having ≥1

	claim with ESRD in the primary diagnosis or any other diagnosis fields during the measurement period. **Insulin medication.** Members with ≥1 prescription claims for the medication insulin (Insulin Exclusion Value Set) during the treatment period. **Coding Guidance** *Do not include laboratory claims (claims with POS code 81).
Denominator	Initial population minus denominator exclusions.
Numerator	**Members who met the PDC threshold during the measurement period.** Follow the steps below for each member to determine whether the member meets the PDC threshold. **Step 1.** Determine the treatment period. **Step 2.** Within the treatment period, count the days of the member was covered by at least one diabetes medication (BG Value Set, SFU Value Set, TZD Value Set, DPP4 Value Set, GIP/GLP1 Value Set, MEG Value Set, or SGLT2 Value Set) based on the date of service and days' supply on the prescription claims. If the days' supply for prescription claims with the same target drug (generic ingredient) overlap, then adjust the prescription claim's start date to be the day after the last days' supply for the previous prescription claim. Adjustment of overlap should also occur when there is overlap of a single drug product to a combination product containing the single target drug or when there is an overlap of a combination product to another combination product where at least one of the target drugs is common. **Step 3.** Divide the number of covered days found in step 2 by the number of days found in step 1. Multiply this number by 100 to obtain the PDC (as a percentage) for each member. Then round the PDC to the nearest hundredth (e.g., 79.996% is rounded to 80.00%, 79.992% is rounded to 79.99%). **Step 4.** Count the number of members who had a PDC of ≥80.00% and then divide by the total number of eligible members.

Glycemic Status Assessment for Patients With Diabetes (GSD)

MEASURE UPDATES OCTOBER 2026 FOR AMP MY 2027

- Updated the race and ethnicity stratification categories to capture declinations and unknown race and/or ethnicity more precisely.

MODIFICATIONS FROM HEDIS

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

Measure title	Glycemic Status Assessment for Patients With Diabetes	**Measure ID**	GSD
Description	The percentage of members 18–75 years of age with diabetes (type 1 or type 2) whose most recent glycemic status (hemoglobin A1c [HbA1c] or glucose management indicator [GMI]) was at the following levels during the measurement period: • Glycemic Status <8.0%. • Glycemic Status >9.0%.		
Measurement period	January 1–December 31.		
Clinical recommendation statement/ rationale	The American Diabetes Association recommends assessing glycemic status by A1C (Level of evidence: A) and/or continuous glucose monitoring (CGM) metrics such as time in range, time above range, and time below range (Level of evidence: B). Fructosamine or CGM can be used for glycemic monitoring when an alternative to A1C is required (Level of evidence: B). Glycemic status should be assessed at least two times a year, and more frequently (e.g., every 3 months) for individuals not meeting glycemic goals or with recent treatment changes, frequent or severe hypoglycemia or hyperglycemia, or changes in health status, or during periods of rapid growth and development in youth (Level of evidence: E). An A1C goal of <7% (<53 mmol/mol) is appropriate for many nonpregnant adults without severe hypoglycemia or hypoglycemia affecting health or quality of life (Level of evidence: A). Lower A1C goals (e.g., <6.5% [<48 mmol/mol]) may be appropriate for individuals with diabetes with good health and function and low treatment risks (e.g., hypoglycemia) and burdens (Level of evidence: B). Less stringent glycemic goals may be appropriate for individuals with significant cognitive and/or functional limitations, frailty, or severe comorbidities or where the harms of treatment, including hypoglycemia, are greater than the benefits (Level of evidence: B). Refer to the HEDIS Measure Library & Historical Data measure web page for additional information about the clinical rationale.		

Citations	American Diabetes Association Professional Practice Committee. 2026. "6. Glycemic Goals, Hypoglycemia, and Hyperglycemia: Standards of Care in Diabetes—2026." *Diabetes Care* 49(Suppl. 1):S132–149. https://doi.org/10.2337/dc26-S006
Characteristics	
Scoring	Proportion.
Type	Outcome.
Product lines	• Commercial HMO/POS. • Medicare Advantage. (Glycemic Status >9.0% only.) • Medi-Cal Managed Care.
Stratifications	Race. (Refer to *General Guideline: Race and Ethnicity Stratification.*) • American Indian or Alaska Native. • Asian. • Black or African American. • Middle Eastern or North African. • Native Hawaiian or Pacific Islander. • White. • Other Race. • Two or More Races. • Asked But Declined. • Unknown. • Total. Ethnicity. (Refer to *General Guideline: Race and Ethnicity Stratification.*) • Hispanic or Latino. • Not Hispanic or Latino. • Asked But Declined. • Unknown. • Total.
Risk adjustment	None.
Guidance	**Data collection methodology:** Administrative. (Refer to *General Guideline: Data Collection Methods* for additional information.) **Date specificity:** Dates must be specific enough to determine the event occurred in the period being measured. **Which services count?** When using claims, include all paid, suspended, pending, and denied claims. **Other guidance:** If a combination of administrative and supplemental data is used, the most recent glycemic status assessment must be used, regardless of data source.

	Improvement notation: • *Glycemic status <8.0%.* Increased score indicates improvement. • *Glycemic status >9.0%.* Decreased score indicates improvement.
Initial population	*Measure item count:* Member. *Attribution basis:* Enrollment. • *Benefits:* Medical. • *Continuous enrollment:* – For self-reporting POs: The measurement period in the PO (parent level). – For health plans: The measurement period in the health plan and the PO (parent level). • *Allowable gap:* – For self-reporting POs: No more than one gap of ≤45 days during the measurement period. No gaps in enrollment in the PO (parent level or, for eligible POs, subgroup level) or in an AMP plan on the last day of the measurement period. – For health plans: No more than one gap of ≤45 days during the measurement period. No gaps in enrollment in the health plan or the PO (parent level, or, for eligible POs, subgroup level) on the last day of the measurement period. *Ages:* 18–75 years of age as of the last day of the measurement period. *Event:* **Identify members with a diagnosis of diabetes.** Either of the following meets criteria: • *Claim/encounter data.* At least two diagnoses of diabetes (Diabetes Value Set*) on different dates of service during the measurement period or the year prior to the measurement period. • *Pharmacy data.* At least one diagnosis of diabetes (Diabetes Value Set*) ***and*** at least one diabetes medication dispensing event of insulin or a hypoglycemic/antihyperglycemic medication (Diabetes Medication List) during the measurement period or the year prior to the measurement period. **Coding Guidance** *Do not include laboratory claims (claims with POS code 81).
Denominator exclusions	**Deceased members.** Members who died any time on or before the last day of the measurement period, identified using data sources determined by the organization. Method and data sources are subject to review during the AMP audit. **Members in hospice or using hospice services.** Members who use hospice services (Hospice Encounter Value Set; Hospice Intervention Value Set) or elect to use a hospice benefit any time during the measurement period. Organizations that use the Monthly Membership Detail Data File to identify these members must use only the run date of the file.

	Members receiving palliative care. Members receiving palliative care (Palliative Care Observations Value Set; Palliative Care Procedures Value Set) or who had an encounter for palliative care (ICD-10-CM code Z51.5*) any time during the measurement period. **Medicare Advantage members, 66 years of age and older by the last day of the measurement period in an institutional SNP (I-SNP) or living long-term in an institution (LTI).** • Enrolled in an Institutional SNP (I-SNP) any time during the measurement period. • Living long-term in an institution any time during the measurement period as identified by the LTI flag in the Monthly Membership Detail Data File. Use the run date of the file to determine if a member had an LTI flag during the measurement period. **The exclusion for members living long-term in an institution is optional for POs that do not have access to the LTI flag in the Monthly Membership Detail Data File.* **Members 66 years of age or older by the last day of the measurement period, with both frailty and advanced illness.** 1. **Frailty.** At least two indications of frailty (Frailty Device Value Set; Frailty Diagnosis Value Set*; Frailty Encounter Value Set; Frailty Symptom Value Set*) with different dates of service during the measurement period. 2. **Advanced illness.** Either of the following during the measurement period or the year prior to the measurement period: – Advanced illness (Advanced Illness Value Set*) on at least two different dates of service. – Dispensed dementia medication (Dementia Medications List). **Coding Guidance** *Do not include laboratory claims (claims with POS code 81).
Denominator	The initial population minus denominator exclusions.
Numerator	**Numerator 1: Glycemic status <8%.** Identify the most recent glycemic status assessment (HbA1c or GMI) (HbA1c Lab Test Value Set; HbA1c Test Result or Finding Value Set*†; LOINC code 97506-0) during the measurement period. If there are multiple glycemic status assessments on the same date of service, use the lowest result. • *Compliant*: Most recent glycemic status assessment with a result of <8.0%. • *Not compliant:* Most recent glycemic status assessment is ≥8.0%; is missing a result; or if a glycemic status assessment was not done during the measurement period. If the most recent glycemic status assessment was an HbA1c test identified based on a CPT Category II code (HbA1c Test Result or Finding Value Set), use the following to determine compliance: • *Compliant*: HbA1c Level Less Than 8.0 Value Set. • *Not compliant*: HbA1c Level Greater Than or Equal To 8.0 Value Set.

	Numerator 2: Glycemic status >9%. Identify the most recent glycemic status assessment (HbA1c or GMI) (HbA1c Lab Test Value Set; HbA1c Test Result or Finding Value Set*†; LOINC code 97506-0) during the measurement period. If there are multiple glycemic status assessments on the same date, use the lowest result. • *Compliant*: Most recent glycemic status assessment with a result of >9.0% or is missing a result, or if a glycemic status assessment was not done during the measurement period. • *Not compliant*: Most recent glycemic status assessment during the measurement period is ≤9.0%. If the most recent glycemic status assessment was an HbA1c test identified based on a CPT Category II code (HbA1c Test Result or Finding Value Set), use the following to determine compliance: • *Compliant:* CPT Category II code 3046F. • *Not compliant:* HbA1c Level Less Than or Equal To 9.0 Value Set. **Coding Guidance** *****Do not include laboratory claims (claims with POS code 81). †Do not include CPT Category II codes with a modifier (CPT CAT II Modifier Value Set).

Eye Exam for Patients With Diabetes (EED)

MEASURE UPDATES OCTOBER 2026 FOR AMP MY 2027

- Updated the race and ethnicity stratification categories to capture declinations and unknown race and/or ethnicity more precisely.

MODIFICATIONS FROM HEDIS

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

Measure title	Eye Exam for Patients With Diabetes	**Measure ID**	EED
Description	The percentage of members 18–75 years of age with diabetes (type 1 or type 2) who had a retinal eye exam.		
Measurement period	January 1–December 31.		
Clinical recommendation statement/ rationale	The American Diabetes Association recommends adults with type 1 diabetes should have an initial dilated and comprehensive eye examination by an ophthalmologist or optometrist within 5 years after the onset of diabetes (Level of evidence: B). Patients with type 2 diabetes should have an initial dilated and comprehensive eye examination by an ophthalmologist or optometrist at the time of the diabetes diagnosis (Level of evidence: B). If there is no evidence of retinopathy for one or more annual eye exams and glycemic indicators are within the goal range, then screening every 1–2 years may be considered. If any level of diabetic retinopathy is present, subsequent dilated retinal examinations should be repeated at least annually by an ophthalmologist or optometrist. If retinopathy is progressing or sight-threatening, then examinations will be required more frequently (Level of evidence: B). Programs that use retinal photography with remote reading or the use of U.S. Food and Drug Administration–approved artificial intelligence algorithms to improve access to diabetic retinopathy screening are appropriate screening strategies for diabetic retinopathy. Such programs need to provide pathways for timely referral for a comprehensive eye examination when indicated (Level of evidence: B). Refer to the HEDIS Measure Library & Historical Data measure web page for additional information about the clinical rationale.		
Citations	American Diabetes Association Professional Practice Committee. 2026. 12. "Retinopathy, Neuropathy, and Foot Care: Standards of Care in Diabetes—2026." *Diabetes Care* 49(Suppl. 1):S261–76. https://doi.org/10.2337/dc26-S012		

Characteristics	
Scoring	Proportion.
Type	Process.
Product lines	• Commercial HMO/POS. • Medicare Advantage. • Medi-Cal Managed Care.
Stratifications	Race. (Refer to *General Guideline: Race and Ethnicity Stratification.*) • American Indian or Alaska Native. • Asian. • Black or African American. • Middle Eastern or North African. • Native Hawaiian or Pacific Islander. • White. • Other Race. • Two or More Races. • Asked But Declined. • Unknown. • Total. Ethnicity. (Refer to *General Guideline: Race and Ethnicity Stratification.*) • Hispanic or Latino. • Not Hispanic or Latino. • Asked But Declined. • Unknown. • Total.
Risk adjustment	None.
Improvement notation	Increased score indicates improvement.
Guidance	**Data collection methodology:** Administrative. (Refer to *General Guideline: Data Collection Methods* for additional information.) **Date specificity:** Dates must be specific enough to determine the event occurred in the period being measured. **Which services count?** When using claims, include all paid, suspended, pending, and denied claims.

Initial population	*Measure item count:* Member. *Attribution basis:* Enrollment. • *Benefits:* Medical. • *Continuous enrollment:* – For self-reporting POs: The measurement period in the PO (parent level). – For health plans: The measurement period in the health plan and the PO (parent level). • *Allowable gap:* – For self-reporting POs: No more than one gap of ≤45 days during the measurement period. No gaps in enrollment in the PO (parent level, or, for eligible POs, subgroup level) or in an AMP plan on the last day of the measurement period. – For health plans: No more than one gap of ≤45 days during the measurement period. No gaps in enrollment in the health plan or the PO (parent level, or, for eligible POs, subgroup level) on the last day of the measurement period. *Ages:* 18–75 years of age as of the last day of the measurement period. *Event:* **Identify members with a diagnosis of diabetes.** Either of the following meets criteria: • *Claim/encounter data.* At least two diagnoses of diabetes (Diabetes Value Set*) on different dates of service during the measurement period or the year prior to the measurement period. • *Pharmacy data.* At least one diagnosis of diabetes (Diabetes Value Set*) ***and*** at least one diabetes medication dispensing event of insulin or a hypoglycemic/antihyperglycemic medication (Diabetes Medication List) during the measurement period or the year prior to the measurement period. **Coding Guidance** *Do not include laboratory claims (claims with POS code 81).
Denominator exclusions	**Deceased members.** Members who died any time on or before the last day of the measurement period, identified using data sources determined by the organization. Method and data sources are subject to review during the AMP audit. **Members in hospice or using hospice services.** Members who use hospice services (Hospice Encounter Value Set; Hospice Intervention Value Set) or elect to use a hospice benefit any time during the measurement period. Organizations that use the Monthly Membership Detail Data File to identify these members must use only the run date of the file. **Members receiving palliative care.** Members receiving palliative care (Palliative Care Observations Value Set; Palliative Care Procedures Value Set) or who had an encounter for palliative care (ICD-10-CM code Z51.5*) any time during the measurement period.

	Medicare Advantage members, 66 years of age and older by the last day of the measurement period, in an institutional SNP (I-SNP) or living long-term in an institution (LTI). • Enrolled in an Institutional SNP (I-SNP) any time during the measurement period. • Living long-term in an institution any time during the measurement period, as identified by the LTI flag in the Monthly Membership Detail Data File. Use the run date of the file to determine if a member had an LTI flag during the measurement period. **The exclusion for members living long-term in an institution is optional for POs that do not have access to the LTI flag in the Monthly Membership Detail Data File.* **Members 66 years of age or older by the last day of the measurement period, with both frailty and advanced illness.** 1. **Frailty.** At least two indications of frailty (Frailty Device Value Set; Frailty Diagnosis Value Set*; Frailty Encounter Value Set; Frailty Symptom Value Set*) with different dates of service during the measurement period. 2. **Advanced illness.** Either of the following during the measurement period or the year prior to the measurement period: – Advanced illness (Advanced Illness Value Set*) on at least two different dates of service. – Dispensed dementia medication (Dementia Medications List). **Members with bilateral absence of eyes or eye enucleation.** • Bilateral absence of eyes (SNOMED CT code 15665641000119103) any time during the member's history through the last day of the measurement period. • Bilateral eye enucleation any time during the member's history through the last day of the measurement period: – Unilateral eye enucleation (Unilateral Eye Enucleation Value Set) with a bilateral modifier (CPT Modifier code 50). – Two unilateral eye enucleations (Unilateral Eye Enucleation Value Set) with service dates 14 days or more apart. – Left unilateral eye enucleation (ICD-10-PCS code 08T1XZZ) and right unilateral eye enucleation (ICD-10-PCS code 08T0XZZ) on the same or different dates of service. – A unilateral eye enucleation (Unilateral Eye Enucleation Value Set) and a left unilateral eye enucleation (ICD-10-PCS code 08T1XZZ) with service dates 14 days or more apart. – A unilateral eye enucleation (Unilateral Eye Enucleation Value Set) and a right unilateral eye enucleation (ICD-10-PCS code 08T0XZZ) with service dates 14 days or more apart. **Coding Guidance** *Do not include laboratory claims (claims with POS code 81).
Denominator	The initial population minus denominator exclusions.

Numerator	**Retinal eye exam.** Screening or monitoring for diabetic retinal disease. This includes members with diabetes who had one of the following: • A retinal or dilated eye exam by an eye care professional (optometrist or ophthalmologist) in 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†, Eye Exam Without Evidence of Retinopathy Value Set† billed by any provider type during the measurement period. • 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. • Diabetic retinal screening negative in prior year (CPT-CAT-II code 3072F†) billed by any provider type during the measurement period. • 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:** ▪ Retinal exam finding: Any level of retinopathy (LOINC code 71490-7 ***with*** Diabetic Retinopathy Severity Level Value Set) during the measurement period. ▪ Retinal exam finding: No retinopathy (LOINC code 71490-7 ***with*** LOINC code LA18643-9) in the year prior to the measurement period. ▪ Enucleation: ICD-10-PCS code 08T1XZZ any time during the member's history through the last day of the measurement period.

	– **Right eye:** ▪ Retinal exam finding: Any level of retinopathy (LOINC code 71491-5 ***with*** Diabetic Retinopathy Severity Level Value Set) during the measurement period. ▪ Retinal exam finding: No retinopathy (LOINC code 71491-5 ***with*** LOINC code LA18643-9) in the year prior to the measurement period. ▪ Enucleation: ICD-10-PCS code 08T0XZZ any time during the member's history through the last day of the measurement period. **Coding Guidance** †Do not include codes with a modifier (CPT CAT II Modifier Value Set).

*Kidney Health Evaluation for Patients With Diabetes (KED)**

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

MEASURE UPDATES OCTOBER 2026 FOR AMP MY 2027

- Updated the race and ethnicity stratification categories to capture declinations and unknown race and/or ethnicity more precisely.

MODIFICATIONS FROM HEDIS

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

Measure title	Kidney Health Evaluation for Patients With Diabetes*	**Measure ID**	KED
Description	The percentage of members 18–85 years of age with diabetes (type 1 or type 2) who received a kidney health evaluation, defined by an estimated glomerular filtration rate (eGFR) ***and*** a urine albumin-creatinine ratio (uACR), during the measurement period.		
Measurement period	January 1–December 31.		
Clinical recommendation statement/ rationale	American Diabetes Association recommends assessing kidney function with random urine albumin-to-creatinine ratio [UACR]) and estimated glomerular filtration rate [eGFR] at least annually in people with type 1 diabetes with duration of ≥5 years and in all people with type 2 diabetes regardless of treatment (Level of evidence: B). These recommendations are consistent with guidance from the National Kidney Foundation, which supports annual screening for diabetic kidney disease for patients with diabetes. Initial screening should commence 5 years after the diagnosis of Type 1 diabetes (Grade of evidence: A) ***or*** from diagnosis of Type 2 diabetes (Grade of evidence: B). Screening should include measurement of urinary albumin-creatinine ratio (ACR) in a spot urine sample (Grade of evidence: B) and measurement of serum creatinine and estimation of GFR (Grade of evidence: B). For adults with diabetes, guidelines recommend measuring both albumin and creatinine simultaneously from a random spot urine sample to assess albumin-to-creatinine ratio (uACR). The intent of the measure is to align with this recommendation even if separate billing codes are used for urine albumin and urine creatinine. Refer to the HEDIS Measure Library & Historical Data measure web page for additional information about the clinical rationale.		
Citations	American Diabetes Association Professional Practice Committee. 2026. "11. Chronic Kidney Disease and Risk Management: Standards of Care in Diabetes—2026." *Diabetes Care* 49(Suppl. 1):S246–60. https://doi.org/10.2337/dc26-S011		

	National Kidney Foundation. 2012. "KDOQI Clinical Practice Guideline for Diabetes and CKD: 2012 Update." *Am J Kidney Dis* 60(5):850–86. http://dx.doi.org/10.1053/j.ajkd.2012.07.005
Characteristics	
Scoring	Proportion.
Type	Process.
Product lines	• Commercial HMO/POS. • Medicare Advantage. • Medi-Cal Managed Care.
Stratifications	Age as of the last day of the measurement period. • 18–64 years. • 65–75 years. • 76–85 years. • Total. Race. (Refer to *General Guideline: Race and Ethnicity Stratification.*) • American Indian or Alaska Native. • Asian. • Black or African American. • Middle Eastern or North African. • Native Hawaiian or Pacific Islander. • White. • Other Race. • Two or More Races. • Asked But Declined. • Unknown. • Total. Ethnicity. (Refer to *General Guideline: Race and Ethnicity Stratification.*) • Hispanic or Latino. • Not Hispanic or Latino. • Asked But Declined. • Unknown. • Total.
Risk adjustment	None.
Improvement notation	Increased score indicates improvement.

Guidance	**Data collection methodology:** Administrative. (Refer to *General Guideline: Data Collection Methods* for additional information.) **Date specificity:** Dates must be specific enough to determine the event occurred in the period being measured. **What services count?** When using claims, include all paid, suspended, pending and denied claims.
Initial population	*Measure item count:* Member. *Attribution basis:* Enrollment. • *Benefits:* Medical. • *Continuous enrollment:* – For self-reporting POs: The measurement period in the PO (parent level). – For health plans: The measurement period in the health plan and the PO (parent level). • *Allowable gap*: – For self-reporting POs: No more than one gap of ≤45 days during the measurement period. No gaps in enrollment in the PO (parent level or, for eligible POs, subgroup level) or in an AMP plan on the last day of the measurement period. – For health plans: No more than one gap of ≤45 days during the measurement period. No gaps in enrollment in the health plan or the PO (parent level, or, for eligible POs, subgroup level) on the last day of the measurement period. *Ages:* 18–85 years of age as of the last day of the measurement period. *Event:* **Identify members with a diagnosis of diabetes.** Either of the following meets criteria: • *Claim/encounter data.* At least two diagnoses of diabetes (Diabetes Value Set*) on different dates of service during the measurement period or the year prior to the measurement period. • *Pharmacy data.* At least one diagnosis of diabetes (Diabetes Value Set*) ***and*** at least one diabetes medication dispensing event of insulin or a hypoglycemic/antihyperglycemic medication (Diabetes Medication List) during the measurement period or the year prior to the measurement period. **Coding Guidance** *Do not include laboratory claims (claims with POS code 81).

Denominator exclusions	**Deceased members.** Members who died any time on or before the last day of the measurement period, identified using data sources determined by the organization. Method and data sources are subject to review during the AMP audit. **Members in hospice or using hospice services.** Members who use hospice services (Hospice Encounter Value Set; Hospice Intervention Value Set) or elect to use a hospice benefit any time during the measurement period. Organizations that use the Monthly Membership Detail Data File to identify these Members must use only the run date of the file. **Members receiving palliative care.** Members receiving palliative care (Palliative Care Observations Value Set; Palliative Care Procedures Value Set) or who had an encounter for palliative care (ICD-10-CM code Z51.5*) any time during the measurement period. **Medicare Advantage members, 66 years of age and older by the last day of the measurement period, in an institutional SNP (I-SNP) or living long-term in an institution (LTI).** • Enrolled in an Institutional SNP (I-SNP) any time during the measurement period. • Living long-term in an institution any time during the measurement period as identified by the LTI flag in the Monthly Membership Detail Data File. Use the run date of the file to determine if a member had an LTI flag during the measurement period. ** The exclusion for members living long-term in an institution is optional for POs that do not have access to the LTI flag in the Monthly Membership Detail Data File.* **Members 66–80 years of age by the last day of the measurement period, with both frailty and advanced illness.** 1. **Frailty.** At least two indications of frailty (Frailty Device Value Set; Frailty Diagnosis Value Set*; Frailty Encounter Value Set; Frailty Symptom Value Set*) with different dates of service during the measurement period. 2. **Advanced illness.** Either of the following during the measurement period or the year prior to the measurement period: – Advanced illness (Advanced Illness Value Set*) on at least two different dates of service. – Dispensed dementia medication (Dementia Medications List). **Members 81 years of age and older as of the last day of the measurement period, with frailty.** Members with at least two indications of frailty (Frailty Device Value Set*; Frailty Diagnosis Value Set*; Frailty Encounter Value Set; Frailty Symptom Value Set*) with different dates of service during the measurement period. **ESRD or dialysis.** Members with a diagnosis of ESRD (ESRD Diagnosis Value Set*) or who had dialysis (Dialysis Procedure Value Set) any time during the member's history on or prior to the last day of the measurement period. **Coding Guidance** *Do not include laboratory claims (claims with POS code 81).
Denominator	The initial population minus denominator exclusions.

Numerator	**Kidney health evaluation.** Members who received ***both*** an eGFR and a uACR during the measurement period on the same or different dates of service: • At least one eGFR (Estimated Glomerular Filtration Rate Lab Test Value Set). • At least one uACR identified by either of the following: – Both a quantitative urine albumin test (Quantitative Urine Albumin Lab Test Value Set) ***and*** a urine creatinine test (Urine Creatinine Lab Test Value Set) ***with*** service dates four days or less apart. ▪ *For example,* if the service date for the quantitative urine albumin test was December 1 of the measurement period, then the urine creatinine test must have a service date on or between November 27 and December 5 of the measurement period. – A uACR (Urine Albumin Creatinine Ratio Lab Test Value Set).

Statin Use in Persons With Diabetes (SUPD)

MEASURE UPDATES OCTOBER 2026 FOR AMP MY 2027

- Added a definition for Diabetes diagnosis.
- Updated the *Description* and Event criteria in the *Initial population* to require a diabetes diagnosis at any time during the measurement period.
- Renamed "Rhabdomyolysis and Myopathy", to "Rhabdomyolysis, Myopathy, or Myositis" in *Denominator exclusions*.
- Added in vitro fertilization and renamed denominator exclusion to "Pregnancy diagnosis, lactation diagnosis, or in vitro fertilization, or fertility prescription."

MODIFICATIONS FROM PQA

- None.

Measure title	Statin Use in Persons with Diabetes	**Measure ID**	SUPD
Description	The percentage of members ages 40–75 years with a diabetes diagnosis who were dispensed a medication for diabetes that receive a statin medication. ***Note:*** *Refer to the PQA Value Set in the MY 2027 AMP Product Bundle download at the NCQA Store for a comprehensive list of PQA medications and associated codes (PQA NDC Code List and PQA ICD Code List). Do not distribute NDC lists outside your organization.* *Unique biosimilar medications are no longer noted in the associated medication tables. For biologic reference products in the Medication Table, biosimilars associated with the reference product, regardless of interchangeable status, are included in the associated value sets, unless otherwise noted. For associated value sets, the NDC lists comprise all relevant NDCs (including available biosimilar medications) with a through date of July 1, 2025, or later.* *Health plans must report the measure through the FinThrive data submission pipeline. POs may self-report this measure.* *Deceased members may not be excluded for this measure.*		
Measurement period	January 1–December 31.		
Clinical recommendation statement/ rationale	2018 American Heart Association/American College of Cardiology/AACVPR/AAPA/ABC/ACPM/ADA/ AGS/APhA/ASPC/NLA/PCNA Guideline on the Management of Blood Cholesterol: • In adults 40 to 75 years of age with diabetes mellitus, regardless of estimated 10-year ASCVD risk, moderate-intensity statin therapy is indicated (Level of Evidence: A). 2025 American Diabetes Association Guideline: • Recommendation 10.19: For people with diabetes aged 40–75 years without ASCVD, use moderate-intensity statin therapy in addition to lifestyle therapy (Level of evidence: A). • Recommendation 10.21: For people with diabetes aged 40–75 years at higher cardiovascular risk, including those with one or more additional		

	ASCVD risk factors, high-intensity statin therapy is recommended to reduce LDL cholesterol by ≥50% of baseline and to obtain an LDL cholesterol goal of <70 mg/dL (<1.8 mmol/L). (Level of evidence: A). • Recommendation 10.25: In people with diabetes intolerant to statin therapy, treatment with bempedoic acid is recommended to reduce cardiovascular event rates as an alternative cholesterol-lowering plan (Level of evidence: A). • Recommendation 10.29b: For people with diabetes and ASCVD intolerant to statin therapy, PCSK9 inhibitor therapy with monoclonal antibody treatment (Level of evidence: A), bempedoic acid therapy (Level of evidence: A), or PCSK9 inhibitor therapy with inclisiran siRNA (Level of evidence: E) should be considered as an alternative cholesterol-lowering therapy.
Citations	Grundy SM, Stone NJ, Bailey AL, Beam C, Birtcher KK, Blumenthal RS, Braun LT, de Ferranti S, Faiella-Tommasino J, Forman DE, Goldberg R, Heidenreich PA, Hlatky MA, Jones DW, Lloyd-Jones D, Lopez-Pajares N, Ndumele CE, Orringer CE, Peralta CA, Saseen JJ, Smith SC Jr, Sperling L, Virani SS, Yeboah J. 2018 AHA/ACC/AACVPR/AAPA/ABC/ACPM/ADA/AGS/ APhA/ASPC/NLA/PCNA guideline on the management of blood cholesterol: a report of the American College of Cardiology/American Heart Association Task Force on Clinical Practice Guidelines. Circulation. 2019;139:e1082e1143. DOI: 10.1161/CIR.0000000000000625. Arnett DK, Blumenthal RS,Albert MA, Buroker AB, Goldberger ZD, Hahn EJ, Himmelfarb CD, Khera A, Lloyd-Jones D, McEvoy JW, MichosED, Miedema MD, Muñoz D, Smith SC Jr, Virani SS, Williams KA Sr, Yeboah J, Ziaeian B. 2019 ACC/AHA guideline on the primary prevention of cardiovascular disease: a report of the American College of Cardiology/American Heart Association Task Force on Clinical Practice Guidelines. Circulation. 2019;140:e596–e646. DOI: 10.1161/CIR.0000000000000678 American Diabetes Association Professional Practice Committee. Cardiovascular disease and risk management: Standards of Care in Diabetes—2025. Diabetes Care. 2025;48(Suppl. 1):S207-S238. https://doi.org/10.2337/dc25-S010
Characteristics	
Scoring	Proportion.
Type	Process.
Product line	• Medicare Advantage.
Stratifications	None.
Risk adjustment	None.
Improvement notation	Increased score indicates improvement.
Guidance	**Data collection methodology:** Administrative. (Refer to *General Guideline: Data Collection Methods* for additional information.)

	Date specificity: Date must be specific enough to determine the event occurred in the period being measured. **Which services count?** Only paid, non-reversed prescription claims are included in the data set to calculate the measure. **Supplemental data exceptions:** Supplemental data may only be used for the hospice exclusion. **Other guidance:** If a PO receives pharmacy claim information for a member, the PO can assume the member has a pharmacy benefit and that the pharmacy benefit dates align with the medical benefit dates.
Definitions	
Diabetes diagnosis[10]	Members with a diabetes diagnosis at any time during the measurement period. Diabetes is defined as having ≥1 claim with diabetes in the primary diagnosis or any other diagnosis fields during the measurement period.
Diabetes medications	Refer to the Diabetes Medications Value Set.
Statin medications	Refer to the Statins Value Set.
Bempedoic acid	Refer to the Bempedoic Acid Value Set.
Proprotein convertase subtilisin/kexin type 9 (PCSK9) inhibitor	Refer to the PCSK9 Inhibitors Value Set.
IPSD	Index prescription start date. The earliest date of service for diabetes medication during the measurement period.
Denominator exception	The denominator exception removes a member from the denominator after determining whether the numerator criteria are met and whether the member meets the exception criteria.
Initial population	*Measure item count:* Member. *Attribution basis:* Enrollment. • *Benefits:* Medical and Pharmacy. • *Continuous enrollment:* – For self-reporting POs: The measurement period in the PO (parent level). – For health plans: The measurement period in the health plan and the PO (parent level). • *Allowable gap:* No more than one gap in enrollment of up to 31 days during the measurement period.

[10] The diabetes diagnosis definition is preliminary and remains under development by PQA. The final definition will be published in the Final MY 2027 Technical Specifications, scheduled for release on June 1, 2027.

	• *Ages:* 40–75 years as of January 1 of the measurement period. *Event:* **Members with a diabetes diagnosis AND ≥2 prescription claims on different dates of service for any diabetes medication during the measurement period.** **Step 1.** Identify members aged 40–75 years as of the first day of the measurement period. **Step 2.** Identify members meeting the continuous enrollment criteria. **Step 3**. Identify members with a diabetes diagnosis at any time during the measurement period. **Step 4.** Identify members with ≥2 prescription claims on different dates of service for a diabetes medication (Diabetes Medications Value Set) during the measurement period. **Step 5.** Identify members with an IPSD that occurs ≥90 days prior to the end of the measurement period. **Coding Guidance** *Do not include laboratory claims (claims with POS code 81).
Denominator exclusions	**Members in hospice or using hospice services.** Members who use hospice services (Hospice Encounter Value Set; Hospice Intervention Value Set) or elect to use a hospice benefit any time during the measurement period. Organizations that use the Monthly Membership Detail Data File to identify these members must use only the run date of the file. **End-stage renal disease (ESRD) diagnosis.** Members with an ESRD diagnosis (ESRD Exclusion Value Set*) any time during the measurement period. An ESRD diagnosis is defined as having ≥1 claim with ESRD in the primary diagnosis or any other diagnosis fields during the measurement period. **Rhabdomyolysis, myopathy or myositis diagnosis.** Members with a diagnosis of rhabdomyolysis, myopathy or myositis at any time during the measurement period. A rhabdomyolysis, myopathy, or myositis diagnosis is defined as having ≥1 claim with rhabdomyolysis, myopathy, or myositis (Rhabdomyolysis and Myopathy Value Set*) in the primary diagnosis or any other diagnosis fields during the measurement period. **Pregnancy diagnosis, lactation diagnosis, in vitro fertilization, or fertility prescription.** Members with a diagnosis of pregnancy, lactation, or IVF any time during the measurement period or ≥1 prescription claims for a medication indicated for fertility during the measurement period. • A pregnancy diagnosis is defined as having ≥1 claim with pregnancy (PREGNANCY Value Set*) in the primary diagnosis or any other diagnosis fields during the measurement period. ***Or*** • A lactation diagnosis is defined as having ≥1 claim with lactation (LACTATION Value Set*) in the primary diagnosis or any other diagnosis fields during the measurement period. ***Or*** • IVF defined as having ≥1 claim with IVF (IVF Value Set*) during the measurement period. ***Or***

	• Fertility treatment is defined as having ≥1 claim for a medication indicated for fertility (Fertility Value Set) during the measurement period. **Members with cirrhosis diagnosis.** Members with a cirrhosis diagnosis (CIRRHOSIS Value Set*) any time during the measurement period. A cirrhosis diagnosis is defined as having ≥1 claim with cirrhosis in the primary diagnosis or any other diagnosis fields during the measurement period. **Members with pre-diabetes diagnosis.** Members with a pre-diabetes diagnosis (PRE-DIABETES Value Set*) any time during the measurement period. A pre-diabetes diagnosis is defined as having ≥1 claim with pre-diabetes in the primary diagnosis or any other diagnosis fields during the measurement period. **Members with polycystic ovary syndrome (PCOS) diagnosis.** Member with a PCOS (PCOS Value Set*) diagnosis any time during the measurement period. A PCOS diagnosis is defined as having ≥1 claim with PCOS in the primary diagnosis or any other diagnosis fields during the measurement period. **Coding Guidance** *Do not include laboratory claims (claims with POS code 81).
Denominator	The initial population minus denominator exclusions and any members qualifying for the denominator exception (i.e., subtract members identified in the denominator exception from the initial population).
Numerator	The number of members from the denominator with ≥1 prescription claims for a statin medication (Statins Value Set) during the measurement period.
Denominator exception	Any members from the initial population **WITHOUT** ≥1 prescription claims for a statin medication during the measurement period (Statins Value Set) **AND WITH**: • ≥1 prescription claims for bempedoic acid (Bempedoic Acid Value Set) during the measurement period, **OR** • ≥1 prescription claims for a PCSK9 inhibitor (PCSK9 Inhibitors Value Set) during the measurement period. **Step 1.** Identify members from the initial population that did not meet the numerator criteria (i.e., without ≥1 prescription claims for a statin medication [Statins Value Set] during the measurement period). **Step 2.** Identify members with ≥1 prescription claims for bempedoic acid (Bempedoic Acid Value Set) OR a PCSK9 inhibitor (PCSK9 Inhibitors Value Set) during the measurement period.

Osteoporosis Management in Women Who Had a Fracture (OMW)

MEASURE UPDATES OCTOBER 2026 FOR AMP MY 2027

- Updated Value Set name from Bone Mineral Density Test Procedures Value Set to Bone Mineral Density Test Services Value Set.

MODIFICATIONS FROM HEDIS

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

Measure title	Osteoporosis Management in Women Who Had a Fracture	**Measure ID**	OMW
Description	The percentage of women 67–85 years of age who suffered a fracture and who had either a bone mineral density (BMD) test or prescription for a drug to treat osteoporosis in the 180 days (6 months) after the fracture.		
Measurement period	January 1–December 31.		
Clinical recommendation statement/ rationale	Osteoporosis is the most common metabolic bone disease and is characterized by low bone mineral density and structural deterioration of bone tissue, causing bone fragility and increasing the risk of fractures. An estimated 12.3 million people 50 and older have osteoporosis. Osteoporosis affects about 27% of women 65 years and older and about 6% of men 65 and older. Osteoporosis or low bone mass at the femur neck or lumbar spine increases with age. The U.S. Preventive Services Task Force (USPSTF) recommends screening for osteoporosis with bone measurement testing to prevent osteoporotic fractures in women 65 years and older. This is a B recommendation, meaning that the USPSTF recommends the service and there is moderate certainty for the net benefit of screening for osteoporosis. The USPSTF also recommends screening for osteoporosis with bone measurement testing to prevent osteoporotic fractures in postmenopausal women younger than 65 who are at increased risk of osteoporosis, as determined by a formal clinical risk assessment tool. The North American Menopause society recommends osteoporosis drug therapy for postmenopausal women who have had an osteoporotic vertebral or hip fracture and postmenopausal women who have bone mineral density values consistent with osteoporosis. The American Association of Clinical Endocrinologists also recommends pharmacological therapy for all patients who have a history of spine or hip fractures. Osteoporosis-related fractures cost patients, their families and the health care system an estimated $19 billion annually. Refer to the HEDIS Measure Library & Historical Data measure web page for additional information about the clinical rationale.		

Citations	Camacho, P.M., S.M. Petak, N. Binkley, et al. 2020. "American Association of Clinical Endocrinologists/American College of Endocrinology Clinical Practice Guidelines for the Diagnosis and Treatment of Postmenopausal Osteoporosis—2020 Update." *Endocrine Practice* 26:1–46. doi:10.4158/GL-2020-0524SUPPL Looker, A.C., N.S. Isfahani, B. Fan, and J.A. Shepherd. 2017. "Trends in Osteoporosis and Low Bone Mass in Older US Adults, 2005–2006 Through 2013–2014." *Osteoporosis International* 28(6), 1979–88. "Management of Osteoporosis in Postmenopausal Women: The 2021 Position Statement of The North American Menopause Society." 2021. *Menopause* 28(9):973–97. doi:10.1097/GME.0000000000001831 National Institutes of Health. 2017. *Osteoporosis: Overview.* National Institute of Arthritis and Musculoskeletal and Skin Disorders (NIH NIAMS). https://www.bones.nih.gov/health-info/bone/osteoporosis/overview National Osteoporosis Foundation. 2015. *Osteoporosis Fast Facts.* https://cdn.nof.org/wp-content/uploads/2015/12/Osteoporosis-Fast-Facts.pdf U.S. Preventive Services Task Force (USPSTF). 2025. *Final Recommendation Statement: Osteoporosis to Prevent Fractures: Screening.* https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/osteoporosis-screening Wright, N.C., A.C. Looker, K.G. Saag, J.R. Curtis, E.S. Delzell, S. Randall, and B. Dawson-Hughes. 2014. "The Recent Prevalence of Osteoporosis and Low Bone Mass in the United States Based on Bone Mineral Density at the Femoral Neck or Lumbar Spine." *Journal of Bone and Mineral Research* 29(11), 2520–6.
Characteristics	
Scoring	Proportion.
Type	Process.
Product line	• Medicare Advantage.
Stratifications	None.
Risk adjustment	None.
Improvement notation	Increased score indicates improvement.
Guidance	**Data collection methodology:** Administrative. (Refer to *General Guideline: Data Collection Methods* for additional information.) **Date specificity:** Dates must be specific enough to determine the event occurred in the period being measured. **Which services count?** When using claims, include all paid, suspended, pending, and denied claims. **Other guidance:** Fractures of finger, toe, face, and skull are not included in this measure.

Definitions	
Active prescription	A prescription is considered active if the "days supply" indicated on the date when the member was dispensed the prescription is the number of days or more between that date and the relevant service date.
Direct transfer	A **direct transfer** is when the discharge date from the first inpatient setting precedes the admission date to a second inpatient setting by one calendar day or less. • *For example:* – An inpatient discharge on June 1, followed by an admission to another inpatient setting on June 1, is a *direct transfer*. – An inpatient discharge on June 1, followed by an admission to an inpatient setting on June 2, *is a direct transfer.* – An inpatient discharge on June 1, followed by an admission to another inpatient setting on June 3, *is not a direct transfer;* these are two distinct inpatient stays. Use the following method to identify admissions to and discharges from inpatient settings. 1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set). 2. Identify the admission and discharge dates for the stay. ***Note:*** *The direct transfer does not require a fracture diagnosis.*
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.
IESD	Index episode start date. The earliest episode date during the intake period that meets all initial population criteria.
Intake period	July 1 of the year prior to the measurement period to June 30 of the measurement period. The intake period is used to capture the first fracture.
Initial population	*Measure item count:* Member. *Attribution basis:* Enrollment. • *Benefits:* Medical and pharmacy. • *Continuous enrollment:* – For self-reporting POs: 365 days prior to the episode date through 180 days after the episode date in the PO (parent level). – For health plans: 365 days prior to the episode date through 180 days after the episode date in the health plan and PO (parent level). • *Allowable gap*: – For self-reporting POs: No more than one gap of ≤45 days during the continuous enrollment period. No gaps in enrollment in the PO (parent

level or, for eligible POs, subgroup level) or in an AMP plan on the episode date.

  - For health plans: No more than one gap of ≤45 days during the continuous enrollment period. No gaps in enrollment in the health plan or the PO (parent level, or, for eligible POs, subgroup level) on the episode date.

Ages: 67–85 years of age as of the last day of the measurement period.

Gender/sex criteria:

- Administrative Gender of Female (AdministrativeGender code female) any time in the member's history.

Event: **Members who have suffered a fracture.**

Step 1. Identify all members who had either of the following during the intake period.

- An outpatient visit or ED visit (Outpatient and ED Value Set) for a fracture (Fractures Value Set).
  - Do not include visits that result in an inpatient stay (Inpatient Stay Value Set).
- An acute or nonacute inpatient discharge with a fracture (Fractures Value Set) on the discharge claim. To identify acute and nonacute inpatient discharges:
  1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
  2. Identify the discharge date for the stay.

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

Step 2. Test for negative diagnosis history. Remove episodes where either of the following occurred during the 60-day period prior to the episode date:

- An outpatient visit, ED visit, telephone visit, e-visit or virtual check-in (Outpatient, ED and Telehealth Value Set) for a fracture (Fractures Value Set).
  - Do not include visits that result in an inpatient stay (Inpatient Stay Value Set).
- An acute or nonacute inpatient discharge with a fracture (Fractures Value Set) on the discharge claim. To identify acute and nonacute inpatient discharges:
  1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
  2. Identify the discharge date for the stay.

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

For episodes that were direct transfers, use the first admission to determine the negative diagnosis history.

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

	Step 3. Calculate continuous enrollment. **Step 4.** Remove episode dates where any of the following are met: • A BMD test (DXA Bone Density Tests Value Set; Bone Mineral Density Test Services Value Set; Bone Mineral Density Test Diagnostic Reports Value Set) during the 730 days prior to the episode date. • A claim/encounter for osteoporosis therapy (Osteoporosis Medication Therapy Value Set) during the 365 days prior to the episode date. • A prescription dispensed or an active prescription to treat osteoporosis (Osteoporosis Medications List) during the 365 days prior to the episode date. *For an acute or nonacute inpatient event,* use the date of admission to identify the days prior to the episode date. *For direct transfers*, use the first admission date to identify the days prior to the episode date. *For outpatient and ED visits that result in an inpatient stay*, use the date of the outpatient or ED visit to identify the days prior to the episode date. **Step 5.** Select the IESD. The measure examines the earliest eligible episode per member that meets the criteria above.
Denominator exclusions	**Deceased members.** Members who died any time on or before the last day of the measurement period, identified using data sources determined by the organization. Method and data sources are subject to review during the AMP audit. **Members in hospice or using hospice services.** Members who use hospice services (Hospice Encounter Value Set; Hospice Intervention Value Set) or elect to use a hospice benefit any time during the measurement period. Organizations that use the Monthly Membership Detail Data File to identify these members must use only the run date of the file. **Members receiving palliative care.** Members receiving palliative care (Palliative Care Observations Value Set; Palliative Care Procedures Value Set) or who had an encounter for palliative care (ICD-10-CM code Z51.5*) any time during the intake period through the last day of the measurement period. **Medicare Advantage members, 67 years of age and older as of the last day of the measurement period, in an institutional SNP (I-SNP) or living long-term in an institution (LTI).** • Enrolled in an Institutional SNP (I-SNP) any time during the intake period through the last day of the measurement period. • Living long-term in an institution any time during the intake period through the last day of the measurement period as identified by the LTI flag in the Monthly Membership Detail Data File. Use the run date of the file to determine if a member had an LTI flag during the intake period through the last day of the measurement period. **The exclusion for members living long-term in an institution is optional for POs that do not have access to the LTI flag in the Monthly Membership Detail Data File.*

	Members 67–80 years of age as of the last day of the measurement period, with both frailty and advanced illness. 1. **Frailty.** At least two indications of frailty (Frailty Device Value Set; Frailty Diagnosis Value Set*; Frailty Encounter Value Set; Frailty Symptom Value Set*) with different dates of service during the intake period through the last day of the measurement period. 2. **Advanced illness.** Either of the following during the measurement period or the year prior to the measurement period: – Advanced illness (Advanced Illness Value Set*) on at least two different dates of service. – Dispensed dementia medication (Dementia Medications List). **Members 81 years of age and older as of the last day of the measurement period, with frailty.** Members with at least two indications of frailty (Frailty Device Value Set; Frailty Diagnosis Value Set*; Frailty Encounter Value Set; Frailty Symptom Value Set*) with different dates of service during the intake period through the last day of the measurement period. **Coding Guidance** *Do not include laboratory claims (claims with POS code 81).
Denominator	The initial population minus denominator exclusions.
Numerator	**Members with appropriate testing or treatment for osteoporosis in the specified time frames.** Identify any of the following criteria: • A BMD test (DXA Bone Density Tests Value Set; Bone Mineral Density Test Services Value Set; Bone Mineral Density Test Diagnostic Reports Value Set), in any setting, on the IESD or in the 180-day period after the IESD. • If the IESD was an inpatient stay, a BMD test (DXA Bone Density Tests Value Set; Bone Mineral Density Test Services Value Set; Bone Mineral Density Test Diagnostic Reports Value Set) during the inpatient stay. • Osteoporosis therapy (Osteoporosis Medication Therapy Value Set) on the IESD or in the 180-day period after the IESD. • If the IESD was an inpatient stay, long-acting osteoporosis therapy (Long Acting Osteoporosis Medications Value Set) during the inpatient stay. • A dispensed prescription to treat osteoporosis (Osteoporosis Medications List) on the IESD or in the 180-day period after the IESD.

Child and Adolescent Well-Care Visits (WCV)

MEASURE UPDATES OCTOBER 2026 FOR AMP MY 2027

- Removed references to "OB/GYN" to align with the definition of PCP in Appendix 2, which includes OB/GYNs.
- Updated the race and ethnicity stratification categories to capture declinations and unknown race and/or ethnicity more precisely.
- Updated hospice *Denominator exclusion* to align with source specification.

MODIFICATIONS FROM HEDIS

- None.

Measure title	Child and Adolescent Well-Care Visits	**Measure ID**	WCV
Description	The percentage of members 3–21 years of age who had at least one comprehensive well-care visit with a PCP during the measurement period.		
Measurement period	January 1–December 31.		
Clinical recommendation statement/ rationale	This measure is based on the American Academy of Pediatrics Bright Futures guidelines for Health Supervision of Infants, Children and Adolescents. Bright Futures recommends one or more well care visits from age 3–21. Refer to the HEDIS Measure Library & Historical Data measure web page for additional information about the clinical rationale.		
Citations	Bright Futures & American Academy of Pediatrics. "Periodicity Schedule — Recommendations for Preventive Pediatric Health Care." 2025. https://downloads.aap.org/AAP/PDF/periodicity_schedule.pdf		
Characteristics			
Scoring	Proportion.		
Type	Process.		
Product lines	• Commercial HMO/POS. • Medi-Cal Managed Care.		
Stratifications	Age as of the last day of the measurement period. • 3–11 years. • 12–17 years. • 18–21 years. • Total.		

	Race. (Refer to *General Guideline: Race and Ethnicity Stratification*.) • American Indian or Alaska Native. • Asian. • Black or African American. • Middle Eastern or North African. • Native Hawaiian or Pacific Islander. • White. • Other Race. • Two or More Races. • Asked But Declined. • Unknown. • Total. Ethnicity. (Refer to *General Guideline: Race and Ethnicity Stratification*.) • Hispanic or Latino. • Not Hispanic or Latino. • Asked But Declined. • Unknown. • Total.
Risk adjustment	None.
Improvement notation	Increased score indicates improvement.
Guidance	**Data collection methodology:** Administrative. (Refer to *General Guideline: Data Collection Methods* for additional information.) **Date specificity:** Dates must be specific enough to determine the event occurred in the period being measured. **Which services count?** When using claims, include all paid, suspended, pending, and denied claims. **Other guidance:** • Refer to Appendix 2 for the definition of *PCP.* • The well-care visit must occur with a PCP, but the practitioner does not have to be the practitioner assigned to the child/adolescent.
Initial population	*Measure item count:* Member. *Attribution basis:* Enrollment. • *Benefits:* Medical. • *Continuous enrollment:* – For self-reporting POs: The measurement period in the PO (parent level). – For health plans: The measurement period in the health plan and the PO (parent level).

	• *Allowable gap:* – For self-reporting POs: No more than one gap of ≤45 days during the measurement period. No gaps in enrollment in the PO (parent level or, for eligible POs, subgroup level) or in an AMP plan on the last day of the measurement period. – For health plans: No more than one gap of ≤45 days during the measurement period. No gaps in enrollment in the health plan or the PO (parent level, or, for eligible POs, subgroup level) on the last day of the measurement period. *Ages:* 3–21 years as of the last day of the measurement period. *Event:* None.
Denominator exclusions	**Deceased members.** Members who died any time on or before the last day of the measurement period, identified using data sources determined by the organization. Method and data sources are subject to review during the AMP audit. **Members in hospice or using hospice services.** Members who use hospice services (Hospice Encounter Value Set; Hospice Intervention Value Set) or elect to use a hospice benefit any time during the measurement period. Organizations that use the Monthly Membership Detail Data File to identify these members must use only the run date of the file.
Denominator	The initial population minus denominator exclusions.
Numerator	**Members who had one or more well-care visits during the measurement period with a PCP.** Either of the following meet criteria: • A well-care visit (Well Care Visit Value Set). • An encounter for well-care (Encounter for Well Care Value Set*). Do not include telehealth visits (visits billed with a code that indicates telehealth: (Telehealth POS Value Set; Virtual Encounters Value Set). **Coding Guidance** *Do not include laboratory claims (claims with POS code 81).

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

MEASURE UPDATES OCTOBER 2026 FOR AMP MY 2027

- Updated the race and ethnicity stratification categories to capture declinations and unknown race and/or ethnicity more precisely.
- Updated hospice *Denominator exclusion* to align with source specification.

MODIFICATIONS FROM HEDIS

- None.

Measure title	Well-Child Visits in the First 30 Months of Life	**Measure ID**	W30
Description	The percentage of members who had the following number of well-child visits with a PCP during the last 15 months. The following rates are reported: • *Well-Child Visits in the First 15 Months*. Members who turned 15 months old during the measurement period: Six or more well-child visits. • *Well-Child Visits for Age 15 Months–30 Months*. Members who turned 30 months old during the measurement period: Two or more well-child visits.		
Measurement period	January 1–December 31.		
Clinical recommendation statement/rationale	This measure is based on the American Academy of Pediatrics Bright Futures guidelines for Health Supervision of Infants, Children and Adolescents. In addition to the Bright Futures Guidelines, the AAP publishes a recommended schedule of screenings and assessments, known as the periodicity schedule, that outlines what to do at every visit, from infancy to adolescence. Bright Futures recommends more frequent well-child visits in the first years of life and one or more annual well-child visits from age 3–21. They recommend that the well-child visits include, but are not limited to, an initial/interval medical history, physical exam, developmental assessment, immunization and anticipatory guidance. The AAP/Bright Futures guidelines also recommend two or more visits between 15 months and 30 months, an important period for early assessment and screenings. Early identification of developmental disorders is critical to the well-being of children and their families. It is an integral function of the primary care medical home and an appropriate responsibility of all pediatric health care professionals. Research shows that early intervention treatment services can greatly improve a child's development. Early intervention services help children from birth through 3 years of age (36 months) learn important skills. Refer to the HEDIS Measure Library & Historical Data measure web page for additional information about the clinical rationale.		

Citations	Hagan, J.F., J.S. Shaw, and P.M. Duncan, eds. 2017. *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents.* Fourth edition. Elk Grove Village, IL: Bright Futures/American Academy of Pediatrics. Bright Futures & American Academy of Pediatrics. 2025. *Periodicity Schedule—Recommendations for Preventive Pediatric Health Care.* https://downloads.aap.org/AAP/PDF/periodicity_schedule.pdf
Characteristics	
Scoring	Proportion.
Type	Process.
Product lines	• Commercial HMO/POS. • Medi-Cal Managed Care.
Stratifications	Race. (Refer to *General Guideline: Race and Ethnicity Stratification.*) • American Indian or Alaska Native. • Asian. • Black or African American. • Middle Eastern or North African. • Native Hawaiian or Pacific Islander. • White. • Other Race. • Two or More Races. • Asked But Declined. • Unknown. • Total. Ethnicity. (Refer to *General Guideline: Race and Ethnicity Stratification.*) • Hispanic or Latino. • Not Hispanic or Latino. • Asked But Declined. • Unknown. • Total.
Risk adjustment	None.
Improvement notation	Increased score indicates improvement.
Guidance	**Data collection methodology:** Administrative. (Refer to *General Guideline: Data Collection Methods* for additional information.) **Date specificity:** Dates must be specific enough to determine the event occurred in the period being measured.

	Which services count? When using claims, include all paid, suspended, pending, and denied claims. **Other guidance:** • Refer to Appendix 2 for the definition of *PCP.* • The well-child visit must occur with a PCP, but the PCP does not have to be the practitioner assigned to the child.
Initial population	*Measure item count:* Member. *Attribution basis:* Enrollment. • *Benefits:* Medical. • *Continuous enrollment:* – *Initial population 1:* ▪ For self-reporting POs: 31 days through 15 months of age in the PO (parent level). Calculate 31 days of age by adding 31 days to the date of birth. ▪ For health plans: 31 days through 15 months of age in the health plan and the PO (parent level). Calculate 31 days of age by adding 31 days to the date of birth. – *Initial population 2:* ▪ For self-reporting POs: 15 months plus 1 day through 30 months of age in the PO (parent level). Calculate the 15-month birthday plus 1 day as the first birthday plus 91 days. ▪ For health plans: 15 months plus 1 day through 30 months of age in the health plan and the PO (parent level). Calculate the 15-month birthday plus 1 day as the first birthday plus 91 days. • *Allowable gap:* – *Initial population 1:* ▪ For self-reporting POs: No more than one gap of ≤45 days during the continuous enrollment period. No gaps in enrollment in the PO (parent level, or, for eligible POs, subgroup level) or in an AMP plan on the 15-month birthday. ▪ For health plans: No more than one gap of ≤45 days during the continuous enrollment period. No gaps in enrollment in the health plan or the PO (parent level, or, for eligible POs, subgroup level) on the 15-month birthday. – *Initial population 2:* ▪ For self-reporting POs: No more than one gap of ≤45 days during the continuous enrollment period. No gaps in enrollment in the PO (parent level, or, for eligible POs, subgroup level) or in an AMP plan on the 30-month birthday. ▪ For health plans: No more than one gap of ≤45 days during the continuous enrollment period. No gaps in enrollment in the health plan or the PO (parent level, or, for eligible POs, subgroup level) on the 30-month birthday.

	Ages: • *Initial population 1:* Members who turn 15 months old during the measurement period. Calculate the 15-month birthday as the first birthday plus 90 days. • *Initial population 2:* Members who turn 30 months old during the measurement period. Calculate the 30-month birthday as the second birthday plus 180 days. *Event:* None.
Denominator exclusions	**Deceased members.** Members who died any time on or before the last day of the measurement period, identified using data sources determined by the organization. Method and data sources are subject to review during the AMP audit. **Members in hospice or using hospice services.** Members who use hospice services (Hospice Encounter Value Set; Hospice Intervention Value Set) or elect to use a hospice benefit any time during the measurement period. Organizations that use the Monthly Membership Detail Data File to identify these members must use only the run date of the file.
Denominator	**Denominator 1: Well-child visits in the first 15 months.** The initial population 1 minus denominator exclusions. **Denominator 2: Well-child visits for 15 months–30 months of age.** The initial population 2 minus denominator exclusions.
Numerator	**Numerator 1: Well-child visits in the first 15 months.** Members with six or more well-child visits on different dates of service with a PCP on or before the 15-month birthday. Either of the following meets criteria: • A well-care visit (Well Care Visit Value Set). • An encounter for well-care (Encounter for Well Care Value Set*). Do not include telehealth visits (visits billed with a code that indicates telehealth: (Telehealth POS Value Set; Virtual Encounters Value Set). **Numerator 2: Well-child visits for age 15 months–30 months.** Two or more well-child visits on different dates of service with a PCP between the child's 15-month birthday plus 1 day and the 30-month birthday. Either of the following meets criteria: • A well-care visit (Well Care Visit Value Set). • An encounter for well-care (Encounter for Well Care Value Set*). Do not include telehealth visits (visits billed with a code that indicates telehealth: (Telehealth POS Value Set; Virtual Encounters Value Set). **Coding Guidance** *Do not include laboratory claims (claims with POS code 81).

Childhood Immunization Status (CIS-E)

MEASURE UPDATES OCTOBER 2026 FOR AMP MY 2027

- Updated the race and ethnicity stratification categories to capture declinations and unknown race and/or ethnicity more precisely.
- Updated hospice *Denominator exclusion* to align with source specification.

MODIFICATIONS FROM HEDIS

- None.

To report this measure, refer to the digital measure package available for purchase in the NCQA Store for the complete HEDIS digital measure specification.

Measure title	Childhood Immunization Status	**Measure ID**	CIS-E
Description	The percentage of members 2 years of age who had four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV); one measles, mumps and rubella (MMR); three haemophilus influenza type B (HiB); three hepatitis B (HepB), one chicken pox (VZV); four pneumococcal conjugate (PCV); one hepatitis A (HepA); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday. The measure calculates a rate for each vaccine and three combination rates.		
Measurement period	January 1–December 31.		
Clinical recommendation statement/rationale	This measure assesses whether members aged 2 years have received appropriate vaccines for children including DTaP, IPV, MMR, HiB, HepB, VZV, PCV, HepA, RV, and flu. This aligns with recommended immunization schedules for children from the American Academy of Family Physicians (AAFP 2026), the American Academy of Pediatrics (AAP 2026) and the U.S. Centers for Disease Control and Prevention Advisory Committee on Immunization Practices (Issa et al. 2025). Refer to the HEDIS Measure Library & Historical Data measure web page for additional information about the clinical rationale.		
Citations	American Academy of Family Physicians (AAFP). 2026. *Recommended Child and Adolescent Immunization Schedule for Ages 18 Years or Younger*. https://www.aafp.org/assets/image/upload/v1774979609/bhmf8pcgmuhzn7jekdd.pdf American Academy of Pediatrics (AAP). 2026. *Recommended Child and Adolescent Immunization Schedule for Ages 18 Years or Younger.* https://downloads.aap.org/AAP/PDF/AAP-Immunization Schedule.pdf?_gl=1*1qnckkk*_ga*MTc4MTcyNDg1MS4xNzQ5NjUyOTM0*_ga_FD9D3XZVQQ*czE3NzI0Njc5MzckbzU0JGcwJHQxNzcyNDY3OTM3JGo2MCRsMCRoMA Issa, A.N., A.P. Wodi, C.A. Moser, S. Cineas, S. 2025. “Advisory Committee on Immunization Practices Recommended Immunization Schedule for Children and Adolescents Aged 18 Years or Younger—United States, 2025.”		

	Morbidity and Mortality Weekly Report 74*(2). U.S. Centers for Disease Control* and Prevention, 2025. http://dx.doi.org/10.15585/mmwr.mm7402a2.
Characteristics	
Scoring	Proportion.
Type	Process.
Product lines	• Commercial HMO/POS. • Medi-Cal Managed Care.
Stratifications	Combination 10: Race. (Refer to *General Guideline: Race and Ethnicity Stratification*.) • American Indian or Alaska Native. • Asian. • Black or African American. • Middle Eastern or North African. • Native Hawaiian or Pacific Islander. • White. • Other Race. • Two or More Races. • Asked But Declined. • Unknown. • Total. Combination 10: Ethnicity. (Refer to *General Guideline: Race and Ethnicity Stratification.*) • Hispanic or Latino. • Not Hispanic or Latino. • Asked But Declined. • Unknown. • Total.
Risk adjustment	None.
Improvement notation	Increased score indicates improvement.
Guidance	**Data collection methodology:** ECDS. (Refer to *General Guideline: Data Collection Methods* for additional information.) **Date specificity:** Dates must be specific enough to determine the event occurred in the period being measured. **What services count?** Use all paid, suspended, pending, and denied claims. **Other guidance:** Report rates for each vaccine and three combination rates. *Combination rates:* Calculate the following rates for Combinations 3, 7, and 10.

	<table><tr><th>Combination</th><th>DTaP</th><th>IPV</th><th>MMR</th><th>HiB</th><th>Hep B</th><th>VZV</th><th>PCV</th><th>HepA</th><th>RV</th><th>Influenza</th></tr><tr><td>Combination 3</td><td>✓</td><td>✓</td><td>✓</td><td>✓</td><td>✓</td><td>✓</td><td>✓</td><td></td><td></td><td></td></tr><tr><td>Combination 7</td><td>✓</td><td>✓</td><td>✓</td><td>✓</td><td>✓</td><td>✓</td><td>✓</td><td>✓</td><td>✓</td><td></td></tr><tr><td>Combination 10</td><td>✓</td><td>✓</td><td>✓</td><td>✓</td><td>✓</td><td>✓</td><td>✓</td><td>✓</td><td>✓</td><td>✓</td></tr></table> **Programming guidance:** The MY 2027 HEDIS Implementation Guide (IG) will be available in October 2026. To request access to the HEDIS IG, email hedis-ig@ncqa.org.
Initial population	*Measure item count:* Member. *Attribution basis:* Enrollment. • *Benefits:* Medical. • *Continuous enrollment:* – For self-reporting POs: 365 days prior to the member's second birthday and the second birthday in the PO (parent level). – For health plans: 365 days prior to the member's second birthday and the second birthday in the health plan and the PO (parent level). • *Allowable gap:* – For self-reporting POs: No more than one gap of ≤45 days during the continuous enrollment period. No gaps in enrollment in the PO (parent level, or, for eligible POs, subgroup level) or in an AMP plan on the second birthday. – For health plans: No more than one gap of ≤45 days during the continuous enrollment period. No gaps in enrollment in the health plan or the PO (parent level, or, for eligible POs, subgroup level) on the second birthday. *Ages:* Members who turn 2 years of age during measurement period. *Event:* None.
Denominator exclusions	**Deceased members.** Members who died any time on or before the last day of the measurement period, identified using data sources determined by the organization. Method and data sources are subject to review during the AMP audit. **Members in hospice or using hospice services.** Members who use hospice services (Hospice Encounter Value Set; Hospice Intervention Value Set) or elect to use a hospice benefit any time during the measurement period. Organizations that use the Monthly Membership Detail Data File to identify these members must use only the run date of the file. **Contraindication to a childhood vaccine.** Members who had a contraindication to a childhood vaccine (Contraindications to Childhood Vaccines Value Set*; Organ and Bone Marrow Transplants Value Set) on or before their second birthday. **Coding Guidance** *Do not include laboratory claims (claims with POS code 81).

Denominator	The initial population minus denominator exclusions.
Numerator	**Numerator 1: Immunization status—DTaP.** Members who meet any of the following criteria on or before the second birthday: • At least four DTaP vaccinations (DTaP Immunization Value Set; DTaP Vaccine Procedure Value Set), with different dates of service. Do not count a vaccination administered prior to 42 days after birth. • Anaphylaxis due to the diphtheria, tetanus or pertussis vaccine (Anaphylaxis Due to Diphtheria, Tetanus or Pertussis Vaccine Value Set). • Encephalitis due to the diphtheria, tetanus or pertussis vaccine (Encephalitis Due to Diphtheria, Tetanus or Pertussis Vaccine Value Set). **Numerator 2: Immunization status —IPV.** Members who meet either of the following criteria on or before the second birthday: • At least three IPV vaccinations (Inactivated Polio Vaccine (IPV) Immunization Value Set; Inactivated Polio Vaccine (IPV) Procedure Value Set) with different dates of service. Do not count a vaccination administered prior to 42 days after birth. • Anaphylaxis due to the IPV vaccine (SNOMED CT code 471321000124106). **Numerator 3: Immunization status —MMR.** Members who meet any of the following criteria: • At least one MMR vaccination (Measles, Mumps and Rubella (MMR) Immunization Value Set; Measles, Mumps and Rubella (MMR) Vaccine Procedure Value Set) on or between the first and second birthdays. • All of the following any time on or before the second birthday (on the same or different date of service). – History of measles illness (Measles and History of Measles Value Set*). – History of mumps illness (Mumps and History of Mumps Value Set*). – History of rubella illness (Rubella and History of Rubella Value Set*). • Anaphylaxis due to the MMR vaccine (SNOMED CT code 471331000124109) on or before the second birthday. **Numerator 4: Immunization status —HiB.** Members who meet either of the following criteria on or before the second birthday: • At least three HiB vaccinations (Haemophilus Influenzae Type B (HiB) Immunization Value Set; Haemophilus Influenzae Type B (HiB) Vaccine Procedure Value Set), with different dates of service. Do not count a vaccination administered prior to 42 days after birth. • Anaphylaxis due to the HiB vaccine (SNOMED CT code 433621000124101).

Numerator 5: Immunization status —Hepatitis B.
Members who meet any of the following criteria on or before the second birthday:

- At least three hepatitis B vaccinations (Hepatitis B Immunization Value Set; Hepatitis B Vaccine Procedure Value Set), with different dates of service.
  - One of the three vaccinations may be a newborn hepatitis B vaccination (ICD-10-PCS code 3E0234Z) during the 8-day period that begins on the date of birth and ends 7 days after the date of birth.
- History of hepatitis B illness (Hepatitis B and History of Hepatitis B Value Set*).
- Anaphylaxis due to the hepatitis B vaccine (SNOMED CT code 428321000124101).

Numerator 6: Immunization status —VZV.
Members who meet any of the following criteria:

- At least one VZV vaccination (Varicella Zoster (VZV) Immunization Value Set; Varicella Zoster (VZV) Vaccine Procedure Value Set) with a date of service on or between the first and second birthdays.
- History of varicella zoster (e.g., chicken pox) illness (Varicella Zoster and History of Varicella Zoster Value Set*) on or before the second birthday.
- Anaphylaxis due to the VZV vaccine (SNOMED CT code 471341000124104) on or before the second birthday.

Numerator 7: Immunization status —Pneumococcal Conjugate.
Members who meet either of the following criteria on or before the second birthday:

- At least four pneumococcal conjugate vaccinations (Pneumococcal Conjugate Immunization Value Set; Pneumococcal Conjugate Vaccine Procedure Value Set) with different dates of service. Do not count a vaccination administered prior to 42 days after birth.
- Anaphylaxis due to the pneumococcal vaccine (SNOMED CT code 471141000124102).

Numerator 8: Immunization status —Hepatitis A.
Members who meet any of the following criteria:

- At least one hepatitis A vaccination (Hepatitis A Immunization Value Set; CPT code 90633) with a date of service on or between the first and second birthdays.
- History of hepatitis A illness (Hepatitis A and History of Hepatitis A Value Set*) on or before the second birthday.
- Anaphylaxis due to the hepatitis A vaccine (SNOMED CT code 471311000124103) on or before the second birthday.

Numerator 9: Immunization status —Rotavirus.
Members who meet any of the following criteria:

- At least two doses of the two-dose rotavirus vaccine (CVX code 119; CPT code 90681) on different dates of service on or before the second birthday. Do not count a vaccination administered prior to 42 days after birth.

	• At least three doses of the three-dose rotavirus vaccine (Rotavirus (3 Dose Schedule) Immunization Value Set; CPT code 90680) on different dates of service on or before the second birthday. Do not count a vaccination administered prior to 42 days after birth. • At least one dose of the two-dose rotavirus vaccine (CVX code 119; CPT code 90681) and at least two doses of the three-dose rotavirus vaccine (Rotavirus (3 Dose Schedule) Immunization Value Set; CPT code 90680), all on different dates of service, on or before the child's second birthday. Do not count a vaccination administered prior to 42 days after birth. • Anaphylaxis due to the rotavirus vaccine (SNOMED CT code 428331000124103) on or before the second birthday. **Numerator 10: Immunization status —Influenza.** Members who meet either of the following criteria on or before the second birthday: • At least two influenza vaccinations (Influenza Immunization Value Set; Influenza Vaccine Procedure Value Set) with different dates of service. Do not count a vaccination administered prior to 180 days after birth. – An influenza vaccination recommended for children 2 years and older (e.g., LAIV) (Influenza Virus LAIV Immunization Value Set; Influenza Virus LAIV Vaccine Procedure Value Set; NDC code 66019011251) administered on the second birthday meets criteria for one of the two required vaccinations. • Anaphylaxis due to the influenza vaccine (SNOMED CT code 471361000124100). **Numerator 11: Immunization status—Combination 3.** Members who are numerator compliant for DTaP, IPV, MMR, HiB, hepatitis B, VZV and pneumococcal indicators. **Numerator 12: Immunization status—Combination 7.** Members who are numerator compliant for DTaP, IPV, MMR, HiB, hepatitis B, VZV, pneumococcal, hepatitis A and rotavirus indicators. **Numerator 13: Immunization status—Combination 10.** Members who are numerator compliant for DTaP, IPV, MMR, HiB, hepatitis B, VZV, pneumococcal, hepatitis A, rotavirus, and influenza indicators. **Coding Guidance** *Do not include laboratory claims (claims with POS code 81).

*Immunizations for Adolescents (IMA-E)**

Adapted with financial support from the Centers for Disease Control & Prevention (CDC).

MEASURE UPDATES OCTOBER 2026 FOR AMP MY 2027

- Updated the race and ethnicity stratification categories to capture declinations and unknown race and/or ethnicity more precisely.
- Updated hospice *Denominator exclusion* to align with source specification.

MODIFICATIONS FROM HEDIS

- None.

To report this measure, refer to the digital measure package available for purchase in the NCQA Store for the complete HEDIS digital measure specification.

Measure title	Immunizations for Adolescents	**Measure ID**	IMA-E
Description	The percentage of members 13 years of age who had one dose of meningococcal vaccine, one tetanus, diphtheria toxoids, and acellular pertussis (Tdap) vaccine, and have completed the human papillomavirus (HPV) vaccine series by their 13th birthday. The measure calculates a rate for each vaccine and two combination rates.		
Measurement period	January 1–December 31.		
Clinical recommendation statement/rationale	This measure assesses whether individuals aged 13 years have received appropriate vaccines for adolescents including HPV, Tdap and meningococcal. This aligns with recommended immunization schedules for children and adolescents from the American Academy of Family Physicians (AAFP 2026), the American Academy of Pediatrics (AAP 2026) and the U.S. Centers for Disease Control and Prevention Advisory Committee on Immunization Practices (Havers et al. 2019; Issa et al. 2025; Mbaeyi et al. 2020; Meites et al. 2016). Additional information about the clinical rationale is available on HEDIS Measure Library & Historical Data measure web page.		

Citations	American Academy of Family Physicians (AAFP). 2026. *Recommended Child and Adolescent Immunization Schedule for Ages 18 Years or Younger.* https://www.aafp.org/assets/image/upload/v1774979609/bhmf8pcgmuhzn7jcekdd.pdf American Academy of Pediatrics (AAP). 2026. *Recommended Child and Adolescent Immunization Schedule for Ages 18 Years or Younger.* https://downloads.aap.org/AAP/PDF/AAP-Immunization Schedule.pdf?_gl=1*1qnckkk*_ga*MTc4MTcyNDg1MS4xNzQ5NjUyOTM0*_ga_FD9D3XZVQQ*czE3NzI0Njc5MzckbzU0JGcwJHQxNzcyNDY3OTM3JGo2MCRsMCRoMA Havers, F.P., P.L. Moro, P. Hunter, S. Hariri, H. Bernstein. 2019. "Use of Tetanus Toxoid, Reduced Diphtheria Toxoid, and Acellular Pertussis Vaccines: Updated Recommendations of the Advisory Committee on Immunization Practices—United States, 2019. *Morbidity and Mortality Weekly Report* 69(3). U.S. Centers for Disease Control and Prevention. http://dx.doi.org/10.15585/mmwr.mm6903a5 Issa, A.N., P.A. Wodi, C.A. Moser, S. Cineas. 2025. "Advisory Committee on Immunization Practices Recommended Immunization Schedule for Children and Adolescents Aged 18 Years or Younger—United States, 2025." *Morbidity and Mortality Weekly Report* 74(2). U.S. Centers for Disease Control and Prevention. http://dx.doi.org/10.15585/mmwr.mm7402a2 Mbaeyi, S.A., C.H. Bozio, J. Duffy, L.G. Rubin, S. Hariri, D.S. Stephens, J.R. MacNeil. 2020. "Meningococcal Vaccination: Recommendations of the Advisory Committee on Immunization Practices, United States, 2020." *Morbidity and Mortality Weekly Report* 69 (9). U.S. Centers for Disease Control and Prevention. http://dx.doi.org/10.15585/mmwr.rr6909a1. Meites, E., A. Kempe, L.E. Markowitz. 2016. "Use of a 2-Dose Schedule for Human Papillomavirus Vaccination—Updated Recommendations of the Advisory Committee on Immunization Practices." *Morbidity and Mortality Weekly Report 65(49).* U.S. Centers for Disease Control and Prevention. http://dx.doi.org/10.15585/mmwr.mm6549a5.
Characteristics	
Scoring	Proportion.
Type	Process.
Product lines	• Commercial HMO/POS. • Medi-Cal Managed Care.
Stratification	Race. (Refer to *General Guideline: Race and Ethnicity Stratification*.) • American Indian or Alaska Native. • Asian. • Black or African American. • Middle Eastern or North African. • Native Hawaiian or Pacific Islander. • White. • Other Race. • Two or More Races.

	• Asked But Declined. • Unknown. • Total. Ethnicity. (Refer to *General Guideline: Race and Ethnicity Stratification.*) • Hispanic or Latino. • Not Hispanic or Latino. • Asked But Declined. • Unknown. • Total.
Risk adjustment	None.
Improvement notation	Increased score indicates improvement.
Guidance	**Data collection methodology:** ECDS. (Refer to *General Guideline: Data Collection Methods* for additional information.) **Date specificity:** Dates must be specific enough to determine the event occurred in the period being measured. **Which services count?** When using claims, include all paid, suspended, pending, and denied claims. **Other guidance:** To align with ACIP recommendations: • Only the quadrivalent meningococcal vaccine (serogroups A, C, W, Y) is included in the measure. • The minimum interval for the two-dose HPV vaccination schedule is 150 days, with a 4-day grace period (146 days). Report rates for each vaccine and two combination rates. ***Combination rates:*** Calculate the following rates for Combinations 1 and 2.

Combination	Meningococcal	Tdap	HPV
Combination 1	✓	✓	
Combination 2	✓	✓	✓

	Programming guidance: The MY 2027 HEDIS Implementation Guide (IG) will be available in October 2026. To request access to the HEDIS IG, email hedis-ig@ncqa.org.
Initial population	*Measure item count:* Member. *Attribution basis:* Enrollment. • *Benefits:* Medical. • *Continuous enrollment:* – For self-reporting POs: Enrolled in the PO (parent level) 365 days prior to the member's 13th birthday and the 13th birthday. – For health plans: Enrolled in the health plan and in the PO (parent level) 365 days prior to the 13th birthday and the 13th birthday.

	• *Allowable gap:* – For self-reporting POs: No more than one gap of ≤45 days during the measurement period. No gaps in enrollment in the PO (parent level, or, for eligible POs, subgroup level) or in an AMP plan on the 13th birthday. – For health plans: No more than one gap of ≤45 days during the measurement period. No gaps in enrollment in the health plan or the PO (parent level, or, for eligible POs, subgroup level) on the 13th birthday. *Ages:* Members who turn 13 years of age during the measurement period. *Event*: None.
Denominator exclusions	**Deceased members.** Members who died any time on or before the last day of the measurement period, identified using data sources determined by the organization. Method and data sources are subject to review during the AMP audit. **Members in hospice or using hospice services.** Members who use hospice services (Hospice Encounter Value Set; Hospice Intervention Value Set) or elect to use a hospice benefit any time during the measurement period. Organizations that use the Monthly Membership Detail Data File to identify these members must use only the run date of the file.
Denominator	The initial population minus denominator exclusions.
Numerator	**Numerator 1: Immunization status—Meningococcal serogroups A, C, W, Y.** Members who meet either of the following criteria: • At least one meningococcal vaccine (serogroups A, C, W, Y, or A, C, W, Y, B) (Meningococcal Immunization Value Set; Meningococcal Vaccine Procedure Value Set) with a date of service on or between the 10th and 13th birthdays. • Anaphylaxis due to the meningococcal vaccine (SNOMED CT code 428301000124106) any time on or before the 13th birthday. **Numerator 2: Immunization status—Tdap.** Members who meet any of the following criteria: • At least one tetanus, diphtheria toxoids, and acellular pertussis (Tdap) vaccine (CVX code 115; CPT code 90715) with a date of service on or between the 10th and 13th birthdays. • Anaphylaxis due to the tetanus, diphtheria, or pertussis vaccine (Anaphylaxis Due to Diphtheria, Tetanus or Pertussis Vaccine Value Set) any time on or before the 13th birthday. • Encephalitis due to the tetanus, diphtheria, or pertussis vaccine (Encephalitis Due to Diphtheria, Tetanus or Pertussis Vaccine Value Set) any time on or before the 13th birthday. **Numerator 3: Immunization status—HPV.** Members who meet any of the following criteria:

	• At least two HPV vaccines (HPV Immunization Value Set; HPV Vaccine Procedure Value Set) on or between the 9th and 13th birthdays and with dates of service at least 146 days apart. • At least three HPV vaccines (HPV Immunization Value Set; HPV Vaccine Procedure Value Set) with different dates of service on or between the 9th and 13th birthdays. • Anaphylaxis due to the HPV vaccine (SNOMED CT code 428241000124101) any time on or before the 13th birthday. **Numerator 4: Immunization status—Combination 1.** Members who are numerator compliant for both the meningococcal and Tdap indicators. **Numerator 5: Immunization status—Combination 2.** Members who are numerator compliant for all three indicators (meningococcal, Tdap, HPV).

Cervical Cancer Screening (CCS-E)

MEASURE UPDATES OCTOBER 2026 FOR AMP MY 2027

- Updated the race and ethnicity stratification categories to capture declinations and unknown race and/or ethnicity more precisely.
- Added a note regarding potential changes to PO and health plan continuous enrollment requirements under consideration through the 2026 public comment process.
- Updated hospice *Denominator exclusion* to align with source specification.
- Removed the note from the *Numerator*.

MODIFICATIONS FROM HEDIS

- None.

To report this measure, refer to the digital measure package available for purchase in the NCQA Store for the complete HEDIS digital measure specification.

Measure title	Cervical Cancer Screening	**Measure ID**	CCS-E
Description	The percentage of members 21–64 years of age who were recommended for routine cervical cancer screening and were screened for cervical cancer using any of the following criteria: • Members 21–64 years of age who were recommended for routine cervical cancer screening and had cervical cytology performed within the last 3 years. • Members 30–64 years of age who were recommended for routine cervical cancer screening and had cervical high-risk human papillomavirus (hrHPV) testing performed within the last 5 years. • Members 30–64 years of age who were recommended for routine cervical cancer screening and had cervical cytology/high-risk human papillomavirus (hrHPV) cotesting within the last 5 years.		
Measurement period	January 1–December 31.		
Clinical recommendation statement/ rationale	The U.S. Preventive Services Task Force (USPSTF) recommends screening for cervical cancer every 3 years with cervical cytology alone in women aged 21–29 years. This recommendation statement applies to all asymptomatic individuals with a cervix (A recommendation). The USPSTF recommends screening every 3 years with cervical cytology alone, every 5 years with hrHPV testing alone or every 5 years with hrHPV testing in combination with cytology (cotesting) in women aged 30–65 years. This recommendation statement applies to all asymptomatic individuals with a cervix (A recommendation). The USPSTF recommends against screening for cervical cancer in women younger than 21 years. This recommendation statement applies to all asymptomatic individuals with a cervix (D recommendation).		

	The USPSTF recommends against screening for cervical cancer in women older than 65 years who have had adequate prior screening and are not otherwise at high risk for cervical cancer. This recommendation statement applies to all asymptomatic individuals with a cervix (D recommendation). The USPSTF recommends against screening for cervical cancer in women who have had a hysterectomy with removal of the cervix, and do not have a history of a high-grade precancerous lesion or cervical cancer (D recommendation). The American Cancer Society recommends that individuals with a cervix initiate cervical cancer screening at age 25 years and undergo primary HPV testing every 5 years through age 65 years (preferred). If primary HPV testing is not available, individuals aged 25–65 years should be screened with cotesting (HPV testing in combination with cytology) every 5 years, or cytology alone every 3 years (acceptable). The recommendations apply to all asymptomatic individuals with a cervix, regardless of their sexual history or HPV vaccination status, including those who have undergone supracervical hysterectomy and transgender men who retain their cervix (Strong Recommendation). The Fenway Institute recommends that transgender and gender diverse patients who have a cervix have regular cervical pap tests, as per the published guidelines for cisgender women. The University of California San Francisco Center of Excellence for Transgender Health recommends that cervical cancer screening for transgender men, including intervals of screening and age to begin and end screening, follows recommendations for non-transgender women as endorsed by the American Cancer Society, the American Society of Colposcopy and Cervical Pathology, the American Society of Clinical Pathologists, the U.S. Preventive Services Task Force and the World Health Organization. The World Professional Association for Transgender Health recommends that health care professionals offer cervical cancer screening to transgender and gender diverse people who currently have or previously had a cervix, following local guidelines for cisgender women. Refer to the HEDIS Measure Library & Historical Data measure web page for additional information about the clinical rationale.
Citations	American Cancer Society. 2020. *Cervical cancer screening for individuals at average risk: 2020 guideline update from the American Cancer Society.* https://acsjournals.onlinelibrary.wiley.com/doi/full/10.3322/caac.21628 Fenway Health. 2021. *Medical Care of Trans and Gender Diverse Adults.* https://fenwayhealth.org/wp-content/uploads/Medical-Care-of-Trans-and-Gender-Diverse-Adults-Spring-2021-1.pdf Perkins, R.B., A.M.D. Wolf, T.R. Church, et al. 2026. "Self-Collected Vaginal Specimens for Human Papillomavirus Testing and Guidance on Screening Exit: An Update to the American Cancer Society cervical Cancer Screening Guideline." *CA Cancer J Clin* e70041. https://acsjournals.onlinelibrary.wiley.com/doi/10.3322/caac.70041

	University of California San Francisco Center of Excellence for Transgender Health. 2016. *Guidelines for the Primary and Gender-Affirming Care of Transgender and Gender Nonbinary People.* https://transcare.ucsf.edu/guidelines U.S. Preventive Services Task Force. 2018. "Screening for Cervical Cancer: U.S. Preventive Services Task Force Recommendation Statement." *JAMA* 320(7): 674–86. https://pubmed.ncbi.nlm.nih.gov/30140884/ World Professional Association for Transgender Health. 2022. *Standards of Care for the Health of Transgender and Gender Diverse People, Version 8.* https://www.tandfonline.com/doi/pdf/10.1080/26895269.2022.2100644
Characteristics	
Scoring	Proportion.
Type	Process.
Product lines	• Commercial HMO/POS. • Medi-Cal Managed Care.
Stratification	Race. (Refer to *General Guideline: Race and Ethnicity Stratification*.) • American Indian or Alaska Native. • Asian. • Black or African American. • Middle Eastern or North African. • Native Hawaiian or Pacific Islander. • White. • Other Race. • Two or More Races. • Asked But Declined. • Unknown. • Total. Ethnicity. (Refer to *General Guideline: Race and Ethnicity Stratification*.) • Hispanic or Latino. • Not Hispanic or Latino. • Asked But Declined. • Unknown. • Total.
Risk adjustment	None.
Improvement notation	Increased score indicates improvement.
Guidance	**Data collection methodology:** ECDS. (Refer to *General Guideline: Data Collection Methods* for additional information.) **Date specificity:** Dates must be specific enough to determine the event occurred in the period being measured.

	What services count? When using claims, include all paid, suspended, pending, and denied claims. **Programming guidance:** The MY 2027 HEDIS Implementation Guide (IG) will be available in October 2026. To request access to the HEDIS IG, email hedis-ig@ncqa.org.
Initial population	*Measure item count:* Member. *Attribution basis:* Enrollment. • *Benefits:* Medical. • *Continuous enrollment:* – For self-reporting POs: • *For Commercial HMO/POS*: Enrolled in the PO (parent level) throughout the measurement period and the 730 days prior to the measurement period. • *For Medi-Cal Managed Care Reporting*: Enrolled in the PO (parent level) throughout the measurement period. – For health plans: • *For Commercial HMO/POS:* Enrolled in the health plan and in the PO (parent level) throughout the measurement period and the 730 days prior to the measurement period. • *For Medi-Cal Managed Care Reporting:* Enrolled in the health plan and in the PO (parent level) throughout the measurement period. • *Allowable gap:* – For self-reporting POs: No more than one gap of ≤45 days each year of continuous enrollment. No gaps in enrollment in the PO (parent level, or, for eligible POs, subgroup level) or in an AMP plan on the last day of the measurement period. – For health plans: No more than one gap of ≤45 days each year of continuous enrollment. No gaps in enrollment in the health plan or the PO (parent level, or, for eligible POs, subgroup level) on the last day of the measurement period. ***Note:*** *IHA is considering changes to the PO and health plan continuous enrollment requirements for MY 2027. Refer to the 2026 Public Comment materials on IHA.org for more information. Any approved changes will be reflected in the Final MY 2027 AMP Technical Specifications.* *Ages:* 24–64 years of age as of the last day of the measurement period. *Gender/sex criteria (members recommended for routine cervical cancer screening):* • Administrative Gender of Female (AdministrativeGender code female) any time in the member's history. • Sex Assigned at Birth (LOINC code 76689-9) of Female (Female Value Set) any time in the member's history. • Sex Parameter for Clinical Use of Female (SexParameterForClinicalUse code female-typical) during the measurement period.

	Event: None.
Denominator exclusions	**Deceased members.** Members who died any time on or before the last day of the measurement period, identified using data sources determined by the organization. Method and data sources are subject to review during the AMP audit. **Members in hospice or using hospice services.** Members who use hospice services (Hospice Encounter Value Set; Hospice Intervention Value Set) or elect to use a hospice benefit any time during the measurement period. Organizations that use the Monthly Membership Detail Data File to identify these members must use only the run date of the file. **Members receiving palliative care.** Members receiving palliative care (Palliative Care Observations Value Set; Palliative Care Procedures Value Set) or who had an encounter for palliative care (ICD-10-CM code Z51.5*) any time during the measurement period. **Members with a hysterectomy with no residual cervix, cervical agenesis, or acquired absence of cervix.** Hysterectomy with no residual cervix (Hysterectomy With No Residual Cervix Value Set) or cervical agenesis or acquired absence of cervix (Absence of Cervix Diagnosis Value Set*) any time during the member's history through the last day of the measurement period. **Members with sex assigned at birth of male.** Sex Assigned at Birth (LOINC code 76689-9) of Male (Male Value Set) any time during the member's history through the last day of the measurement period. **Coding Guidance** *Do not include laboratory claims (claims with POS code 81).
Denominator	The initial population minus denominator exclusions.
Numerator	**Members recommended for routine cervical cancer screening who were screened for cervical cancer.** Either of the following meets criteria: • Members 24–64 years of age by the last day of the measurement period who were recommended for routine cervical cancer screening and had cervical cytology (Cervical Cytology Lab Test Value Set; Cervical Cytology Result or Finding Value Set) during the measurement period or the 2 years prior to the measurement period. • Members 30–64 years of age by the last day of the measurement period who were recommended for routine cervical cancer screening and had cervical high-risk human papillomavirus (hrHPV) testing (High Risk HPV Lab Test Value Set; SNOMED CT code 718591004) during the measurement period or the 4 years prior to the measurement period, and who were 30 years of age or older on the test date.

Breast Cancer Screening (BCS-E)

MEASURE UPDATES OCTOBER 2026 FOR AMP MY 2027

- Updated the race and ethnicity stratification categories to capture declinations and unknown race and/or ethnicity more precisely.
- Added a note regarding potential changes to PO and health plan continuous enrollment requirements under consideration through the 2026 public comment process.
- Updated value sets in the *Numerator*.

MODIFICATIONS FROM HEDIS

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

To report this measure, refer to the digital measure package available for purchase in the NCQA Store for the complete HEDIS digital measure specification.

Measure title	Breast Cancer Screening	**Measure ID**	BCS-E
Description	The percentage of members 40-74 years of age who were recommended for routine breast cancer screening and had a mammogram to screen for breast cancer.		
Measurement period	January 1–December 31.		
Clinical recommendation statement/ rationale	The U.S. Preventive Services Task Force (USPSTF) recommends biennial screening mammography for women aged 40–74 years (B recommendation). The Fenway Institute recommends that for patients assigned female at birth who have not undergone chest reconstruction (including those who have had breast reduction), breast/chest screening recommendations are the same as for cisgender women of a similar age and medical history. The University of California San Francisco Center of Excellence for Transgender Health recommends that transgender men who have not undergone bilateral mastectomy, or who have only undergone breast reduction, undergo screening according to current guidelines for non-transgender women. The World Professional Association for Transgender Health recommends health care professionals follow local breast cancer screening guidelines developed for cisgender women in their care of transgender and gender diverse people with breasts from natal puberty who have not had gender-affirming chest surgery. Refer to the HEDIS Measure Library & Historical Data measure web page for additional information about the clinical rationale.		
Citations	U.S. Preventive Services Task Force. Nicholson, W.K., M. Silverstein, J.B. Wong, M.J. Barry, D. Chelmow, T.R. Coker, et al. June 11, 2024. "Screening for Breast Cancer: U.S. Preventive Services Task Force Recommendation Statement." *JAMA* 331, no. 22: 1918. https://doi.org/10.1001/jama.2024.5534		

	Fenway Health. 2021. *Medical Care of Trans and Gender Diverse Adults*. https://fenwayhealth.org/wp-content/uploads/Medical-Care-of-Trans-and-Gender-Diverse-Adults-Spring-2021-1.pdf University of California San Francisco Center of Excellence for Transgender Health. 2016. *Guidelines for the Primary and Gender-Affirming Care of Transgender and Gender Nonbinary People*. https://transcare.ucsf.edu/guidelines World Professional Association for Transgender Health. 2022. *Standards of Care for the Health of Transgender and Gender Diverse People, Version 8.* https://www.tandfonline.com/doi/pdf/10.1080/26895269.2022.2100644
Characteristics	
Scoring	Proportion.
Type	Process.
Product lines	• Commercial HMO/POS. • Medicare Advantage. • Medi-Cal Managed Care.
Stratification	Age as of the last day of the measurement period. • 42–51 years. • 52–74 years. • Total. Race. (Refer to *General Guideline: Race and Ethnicity Stratification*.) • American Indian or Alaska Native. • Asian. • Black or African American. • Middle Eastern or North African. • Native Hawaiian or Pacific Islander. • White. • Other Race. • Two or More Races. • Asked But Declined. • Unknown. • Total. Ethnicity. (Refer to *General Guideline: Race and Ethnicity Stratification*.) • Hispanic or Latino. • Not Hispanic or Latino. • Asked But Declined. • Unknown. • Total.

Risk adjustment	None.
Improvement notation	Increased score indicates improvement.
Guidance	**Data collection methodology:** ECDS. (Refer to *General Guideline: Data Collection Methods* for additional information.) **Date specificity:** Dates must be specific enough to determine the event occurred in the period being measured. **Which services count?** When using claims, include all paid, suspended, pending, and denied claims. **Programming guidance:** The MY 2027 HEDIS Implementation Guide (IG) will be available in October 2026. To request access to the HEDIS IG, email hedis-ig@ncqa.org.
Initial population	*Measure item count:* Member. *Attribution basis:* Enrollment. • *Benefits:* Medical. • *Continuous enrollment:* – For self-reporting POs: Enrolled in the PO (parent level) October 1 two years prior to the measurement period through the last day of the measurement period. – For health plans: Enrolled in the health plan and the PO (parent level) October 1 two years prior to the measurement period through the last day of the measurement period. • *Allowable gap:* – *Measurement period:* – *For self-reporting POs:* No more than one gap of ≤45 days. No gaps in enrollment in the PO (parent level, or, for eligible POs, subgroup level) or in an AMP plan on the last day of the measurement period. – *For health plans:* No more than one gap of ≤45 days. No gaps in enrollment in the health plan or in the PO (parent level, or, for eligible POs, subgroup level) 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 December 31 two years prior to the measurement period*: None. ***Note:*** *IHA is considering changes to the PO and health plan continuous enrollment requirements for MY 2027. Refer to the 2026 Public Comment materials on IHA.org for more information. Any approved changes will be reflected in the Final MY 2027 AMP Technical Specifications.* *Ages:* 42-74 years of age as of the last day of the measurement period. *Gender/sex criteria* (*members recommended for routine breast cancer screening)*:

	• Administrative Gender of Female (AdministrativeGender code female) any time in the member's history. • Sex Assigned at Birth (LOINC code 76689-9) of Female (Female Value Set) any time in the member's history. • Sex Parameter for Clinical Use of Female (SexParameterForClinicalUse code female-typical) during the measurement period. *Event:* None.
Denominator exclusions	**Deceased members.** Members who died any time on or before the last day of the measurement period, identified using data sources determined by the organization. Method and data sources are subject to review during the AMP audit. **Members in hospice or using hospice services.** Members who use hospice services (Hospice Encounter Value Set; Hospice Intervention Value Set) or elect to use a hospice benefit any time during the measurement period. Organizations that use the Monthly Membership Detail Data File to identify these members must use only the run date of the file. **Members receiving palliative care.** Members receiving palliative care (Palliative Care Observations Value Set; Palliative Care Procedures Value Set) or who had an encounter for palliative care (ICD-10-CM code Z51.5*) any time during the measurement period. **Medicare Advantage members, 66 years of age and older by the last day of the measurement period, in an institutional SNP (I-SNP) or living long-term in an institution (LTI).** • Enrolled in an Institutional SNP (I-SNP) any time during the measurement period. • Living long-term in an institution any time during the measurement period, as identified by the LTI flag in the Monthly Membership Detail Data File. Use the run date of the file to determine an LTI flag during the measurement period. **The exclusion for members living long-term in an institution is optional for POs that do not have access to the LTI flag in the Monthly Membership Detail Data File.* **Members 66 years of age or older by the last day of the measurement period, with both frailty and advanced illness.** 1. **Frailty.** At least two indications of frailty (Frailty Device Value Set; Frailty Diagnosis Value Set*; Frailty Encounter Value Set; Frailty Symptom Value Set*) with different dates of service during the measurement period. 2. **Advanced illness.** Either of the following during the measurement period or the year prior to the measurement period: – Advanced illness (Advanced Illness Value Set*) on at least two different dates of service. – Dispensed dementia medication (Dementia Medications List). **Members who had a bilateral mastectomy or both right and left unilateral mastectomies any time during their history through the last day of the measurement period.** Any of the following meet the criteria for bilateral mastectomy. • Bilateral mastectomy (Bilateral Mastectomy Value Set).

	• Unilateral mastectomy (Unilateral Mastectomy Value Set) with a bilateral modifier (CPT Modifier code 50) (same procedure). • History of bilateral mastectomy (History of Bilateral Mastectomy Value Set). • Any combination that indicates a mastectomy of **both** the **left** and **right** side on the same date of service or different dates of service. – **Left mastectomy:** ▪ Unilateral mastectomy (Unilateral Mastectomy Value Set) ***with*** a left-side modifier (CPT Modifier code LT) (same procedure). ▪ Unilateral mastectomy of the left breast found in clinical data (Clinical Unilateral Mastectomy Value Set ***with*** SNOMED CT code 361716006). ***Note:*** *The "clinical" mastectomy value sets identify mastectomy; the word "clinical" refers to the data source, not to the type of mastectomy.* ▪ Absence of the left breast (Absence of Left Breast Value Set*). ▪ Left unilateral mastectomy (Unilateral Mastectomy Left Value Set). – **Right mastectomy:** ▪ Unilateral mastectomy (Unilateral Mastectomy Value Set) ***with*** a right-side modifier (CPT Modifier code RT) (same procedure). ▪ Unilateral mastectomy of the right breast found in clinical data (Clinical Unilateral Mastectomy Value Set ***with*** SNOMED CT code 361715005). ▪ Absence of the right breast (Absence of Right Breast Value Set*). ▪ Right unilateral mastectomy (Unilateral Mastectomy Right Value Set). **Gender-affirming chest surgery.** Members who had gender-affirming chest surgery (CPT code 19318) with a diagnosis of gender dysphoria (Gender Dysphoria Value Set) any time during their history through the last day of the measurement period. **Coding Guidance** *Do not include laboratory claims (claims with POS code 81).
Denominator	The initial population minus denominator exclusions.
Numerator	**At least one mammogram.** One or more mammograms (Mammography Services Value Set; Mammography Diagnostic Reports Value Set) any time on or between October 1 two years prior to the measurement period and the last day of the measurement period.

Colorectal Cancer Screening (COL-E)

MEASURE UPDATES OCTOBER 2026 FOR AMP MY 2027.

- Updated the race and ethnicity stratification categories to capture declinations and unknown race and/or ethnicity more precisely.
- Added a note regarding potential changes to PO and health plan continuous enrollment requirements under consideration through the 2026 public comment process.
- Updated value sets for CT colonography in the *Numerator*.

MODIFICATIONS FROM HEDIS

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

To report this measure, refer to the digital measure package available for purchase in the NCQA Store for the complete HEDIS digital measure specification.

Measure title	Colorectal Cancer Screening	**Measure ID**	COL-E
Description	The percentage of members 45–75 years of age who had appropriate screening for colorectal cancer.		
Measurement period	January 1–December 31.		
Clinical recommendation statement/ rationale	The U.S. Preventive Services Task Force "recommends screening for colorectal cancer in all adults aged 50 to 75 years (A recommendation) and all adults aged 45 to 49 years (B recommendation)." Potential screening methods include an annual guaiac-based fecal occult blood test (gFOBT), annual fecal immunochemical test (FIT), multitargeted stool DNA with FIT test (sDNA FIT) every 3 years, colonoscopy every 10 years, CT colonography every 5 years, flexible sigmoidoscopy every 5 years or flexible sigmoidoscopy every 10 years, with FIT every year. Refer to the HEDIS Measure Library & Historical Data measure web page for additional information about the clinical rationale.		
Citations	USPSTF. 2021. "Screening for Colorectal Cancer: U.S. Preventive Services Task Force Recommendation Statement." *JAMA* 325(19):1965–1977. doi:10.1001/jama.2021.6238		
Characteristics			
Scoring	Proportion.		
Type	Process.		
Product lines	• Commercial HMO/POS. • Medicare Advantage. • Medi-Cal Managed Care.		

Stratifications	Age as of the last day of the measurement period. • 46–50 years. • 51–75 years. • Total. Race. (Refer to *General Guideline: Race and Ethnicity Stratification*.) • American Indian or Alaska Native. • Asian. • Black or African American. • Middle Eastern or North African. • Native Hawaiian or Pacific Islander. • White. • Other Race. • Two or More Races. • Asked But Declined. • Unknown. • Total. Ethnicity. (Refer to *General Guideline: Race and Ethnicity Stratification*.) • Hispanic or Latino. • Not Hispanic or Latino. • Asked But Declined. • Unknown. • Total.
Risk adjustment	None.
Improvement notation	Increased score indicates improvement.
Guidance	**Data collection methodology:** ECDS. (Refer to *General Guideline: Data Collection Methods* for additional information.) **Date specificity:** Dates must be specific enough to determine the event occurred in the period being measured. **Which services count?** When using claims, include all paid, suspended, pending, and denied claims. **Programming guidance:** The MY 2027 HEDIS Implementation Guide (IG) will be available in October 2026. To request access to the HEDIS IG, email hedis-ig@ncqa.org.

Initial population	*Measure item count:* Member. *Attribution basis:* Enrollment. • *Benefits:* Medical. • *Continuous enrollment:* – For self-reporting POs: ▪ The measurement period and the year prior to the measurement period in the PO (parent level). ▪ *For Medi-Cal Managed Care reporting*: The measurement period in the PO (parent level). – For health plans: ▪ The measurement period and the year prior to the measurement period in health plan and the PO (parent level). ▪ *For Medi-Cal Managed Care reporting:* The measurement period in the health plan and the PO (parent level). • *Allowable gap:* – For self-reporting POs: No more than one gap of ≤45 days during each year of the continuous enrollment period. No gaps in enrollment in the PO (parent level, or, for eligible POs, subgroup level) or in an AMP plan on the last day of the measurement period. – For health plans: No more than one gap of ≤45 days during each year of the continuous enrollment period. No gaps in enrollment in health plan or the PO (parent level, or, for eligible POs, subgroup level) on the last day of the measurement period. ***Note:*** *IHA is considering changes to the PO and health plan continuous enrollment requirements for MY 2027. Refer to the 2026 Public Comment materials on IHA.org for more information. Any approved changes will be reflected in the Final MY 2027 AMP Technical Specifications.* *Ages:* 46–75 years of age as of the last day of the measurement period. *Event:* None.
Denominator exclusions	**Deceased members.** Members who died any time on or before the last day of the measurement period, identified using data sources determined by the organization. Method and data sources are subject to review during the AMP audit. **Members in hospice or using hospice services.** Members who use hospice services (Hospice Encounter Value Set; Hospice Intervention Value Set) or elect to use a hospice benefit any time during the measurement period. Organizations that use the Monthly Membership Detail Data File to identify these members must use only the run date of the file. **Members receiving palliative care.** Members receiving palliative care (Palliative Care Observations Value Set; Palliative Care Procedures Value Set) or who had an encounter for palliative care (ICD-10-CM code Z51.5*) any time during the measurement period.

	Medicare Advantage members 66 years of age and older by the last day of the measurement period, in an institutional SNP (I-SNP) or living long-term in an institution (LTI). • Enrolled in an Institutional SNP (I-SNP) any time during the measurement period. • Living long-term in an institution any time during the measurement period as identified by the LTI flag in the Monthly Membership Detail Data File. Use the run date of the file to determine if a member had an LTI flag during the measurement period. **The exclusion for members living long-term in an institution is optional for POs that do not have access to the LTI flag in the Monthly Membership Detail Data File.* **Members 66 years of age and older by the last day of the measurement period, with both frailty and advanced illness.** **1. Frailty.** At least two indications of frailty (Frailty Device Value Set; Frailty Diagnosis Value Set*; Frailty Encounter Value Set; Frailty Symptom Value Set*) with different dates of service during the measurement period. **2. Advanced illness.** Either of the following during the measurement period or the year prior to the measurement period: – Advanced illness (Advanced Illness Value Set*) on at least two different dates of service. – Dispensed dementia medication (Dementia Medications List). **History of colorectal cancer and/or total colectomy.** Colorectal cancer (Colorectal Cancer and History of Colorectal Cancer Value Set*) or a total colectomy (Total Colectomy Value Set; SNOMED CT code 119771000119101) any time during the member's history through the last day of the measurement period. **Coding Guidance** *Do not include laboratory claims (claims with POS code 81).
Denominator	The initial population minus denominator exclusions.
Numerator	**Members with one or more screenings for colorectal cancer.** Any of the following meet criteria: • Fecal occult blood test (FOBT Lab Test Value Set; FOBT Test Result or Finding Value Set) during the measurement period. For administrative data, assume the required number of samples were returned, regardless of FOBT type. • Stool DNA (sDNA) with FIT test (sDNA FIT Lab Test Value Set; SNOMED CT code 708699002) during the measurement period or the 2 years prior to the measurement period. • Flexible sigmoidoscopy (Flexible Sigmoidoscopy Value Set; SNOMED CT code 841000119107) during the measurement period or the 4 years prior to the measurement period. • CT colonography (CT Colonography Services Value Set; CT Colonography Diagnostic Reports Value Set) during the measurement period or the 4 years prior to the measurement period.

	• Colonoscopy (Colonoscopy Value Set; SNOMED CT code 851000119109) during the measurement period or the 9 years prior to the measurement period.

Transitions of Care (TRC)

MEASURE UPDATES OCTOBER 2026 FOR AMP MY 2027

- Clarified that medication reconciliation performed by a pharmacist (no longer limited to just clinical) meets criteria.

MODIFICATIONS FROM HEDIS

- AMP only reports the Medication Reconciliation Post-Discharge indicator.

Measure title	Transitions of Care	**Measure ID**	TRC
Description	The percentage of discharges for members 18 years of age and older who had the following: • *Medication Reconciliation Post-Discharge*. Documentation of medication reconciliation on the date of discharge through 30 days after discharge (31 total days).		
Measurement period	January 1–December 31.		
Clinical recommendation statement/ rationale	Transitions from an inpatient setting to home often result in poor care coordination, including communication lapses between inpatient and outpatient providers; intentional and unintentional medication changes; incomplete diagnostic work-ups; and inadequate beneficiary, caregiver and provider understanding of diagnoses, medication and follow-up needs. Poor hospital transitions are not only associated with poor health outcomes, but also with increased health care utilization and cost, including duplicate medical services, medication errors and increased emergency department visits and readmissions. Effective care coordination efforts must include medication reconciliation post-discharge. Refer to the HEDIS Measure Library & Historical Data measure web page for additional information about the clinical rationale.		
Citations	Rennke, S., O.K. Nguyen, M.H. Shoeb, Y. Magan, R.M. Wachter and S.R. Ranji. 2013. "Hospital-Initiated Transitional Care as a Patient Safety Strategy: A Systematic Review." *Annals of Internal Medicine* 158(5, Pt. 2), 433–40. Sato, M., T. Shaffer, A.I. Arbaje and I.H. Zuckerman. 2011. "Residential and Health Care Transition Patterns Among Older Medicare Beneficiaries Over Time." *The Gerontologist* 51(2), 170–8. Centers for Disease Control and Prevention (CDC). 2010. *Number, Rate, and Average Length of Stay for Discharges From Short-Stay Hospitals, by Age, Region, and Sex: United States, 2010.* Kripalani, S., A.T. Jackson, J.L. Schnipper and E.A. Coleman. 2007. "Promoting Effective Transitions of Care at Hospital Discharge: A Review of Key Issues for Hospitalists." *Journal of Hospital Medicine* 2(5).		

Characteristics	
Scoring	Proportion.
Type	Process.
Product line	• Medicare Advantage.
Stratifications	Age as of the last day of the measurement period. • 18–64 years. • 65 years and older. • Total.
Risk adjustment	None.
Improvement notation	Increased score indicates improvement.
Guidance	**Data collection methodology:** Administrative. (Refer to the *General Guideline: Data Collection Methods* for additional information.) **Date specificity:** Dates must be specific enough to determine the event occurred in the period being measured. **Which services count?** When using claims, include all paid, suspended, pending, and denied claims. **Other guidance:** • The measure is based on episodes; therefore, it is possible for the denominator to include multiple events for the same member.
Definitions	
Medication list	A list of medications in the medical record. May include medication names only, or may include dosages, frequency, over-the-counter (OTC) medications and herbal or supplemental therapies.
Medication reconciliation	A type of review in which the discharge medications are reconciled with the most recent medication list in the outpatient medical record.
Initial population	*Measure item count:* Episode. *Attribution basis:* Enrollment. • *Benefits:* Medical. • *Continuous enrollment:* – For self-reporting POs: Date of discharge through 30 days after discharge (31 total days) in the PO (parent level). – For health plans: Date of discharge through 30 days after discharge (31 total days) in the health plans and the PO (parent level). • *Allowable gap:* None. *Ages:* 18 years of age and older as of the last day of the measurement period.

	Event: **Acute and nonacute inpatient discharges.** An acute or nonacute inpatient discharge on or between January 1 and December 1 of the measurement period. To identify acute and nonacute inpatient discharges: 1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set). 2. Identify the discharge date for the stay. ***Readmission or direct transfer.*** If the discharge is followed by a readmission or direct transfer to an acute or nonacute inpatient care setting on the date of discharge through 30 days after discharge (31 days total), use the admit date from the first admission and the discharge date from the last discharge. To identify readmissions and direct transfers during the 31-day period: 1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set). 2. Identify the admission date for the stay (the admission date must occur during the 31-day period). 3. Identify the discharge date for the stay (the discharge date is the event date). Exclude both the initial and the readmission/direct transfer discharge if the last discharge occurs after December 1 of the measurement period. If the admission date and the discharge date for an acute inpatient stay occur between the admission and discharge dates for a nonacute inpatient stay, include only the nonacute inpatient discharge. To identify acute inpatient discharges: 1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set). 2. Exclude nonacute inpatient stays (Nonacute Inpatient Stay Value Set). 3. Identify the admission date for the stay. 4. Identify the discharge date for the stay. To identify nonacute inpatient discharges: 1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set). 2. Confirm the stay was for nonacute care based on the presence of a nonacute code (Nonacute Inpatient Stay Value Set). 3. Identify the admission date for the stay. 4. Identify the discharge date for the stay. ***Note:*** *If a member remains in an acute or nonacute facility through December 1 of the measurement period, the discharge is not included in the measure, but the organization must have a method for identifying the member's status for the remainder of the measurement period, and may not assume the member remained admitted based only on the absence of a discharge before December 1.*

	If the organization is unable to confirm the member remained in the acute or nonacute care setting through December 1, disregard the readmission or direct transfer and use the initial discharge date.
Denominator exclusions	**Deceased members.** Members who died any time on or before the last day of the measurement period, identified using data sources determined by the organization. Method and data sources are subject to review during the AMP audit. **Members in hospice or using hospice services.** Members who use hospice services (Hospice Encounter Value Set; Hospice Intervention Value Set) or elect to use a hospice benefit any time during the measurement period. Organizations that use the Monthly Membership Detail Data File to identify these members must use only the run date of the file.
Denominator	The initial population minus denominator exclusions.
Numerator	**Medication reconciliation post-discharge.** Medication reconciliation (Medication Reconciliation Encounter Value Set, Medication Reconciliation Intervention Value Set†) conducted by a prescribing practitioner, pharmacist, physician assistant or registered nurse on the date of discharge through 30 days after discharge (31 total days). **Coding Guidance** †Do not include codes with a modifier (CPT CAT II Modifier Value Set).

Prenatal and Postpartum Care (PPC)

MEASURE UPDATES OCTOBER 2026 FOR AMP MY 2027

- Updated the race and ethnicity stratification categories to capture declinations and unknown race and/or ethnicity more precisely.
- Added a note to step 1 of the *Initial population* for additional guidance on delivery dates.
- Updated hospice *Denominator exclusion* to align with source specification.
- Updated value sets names in *Numerator* to align with 2027 changes to maternity billing.

MODIFICATIONS FROM HEDIS

- None.

Measure title	Prenatal and Postpartum Care	**Measure ID**	PPC
Description	The percentage of deliveries of live births on or between October 8 of the year prior to the measurement period and October 7 of the measurement period. For these members, the measure assesses the following facets of prenatal and postpartum care: • *Timeliness of Prenatal Care.* The percentage of deliveries that received a prenatal care visit in the first trimester on or before the enrollment start date or within 42 days of enrollment in the organization. • *Postpartum Care.* The percentage of deliveries that had a postpartum visit on or between 7 and 84 days after delivery.		
Measurement period	January 1–December 31.		
Clinical recommendation statement/ rationale	According to the National Institutes of Health (NIH), prenatal care can minimize the risk of pregnancy complications and negative birth outcomes. Similarly, comprehensive postpartum care is critical for setting the stage for the long-term health and well-being of new mothers and their infants. Common issues after birth include lack of sleep, fatigue, pain, stress, breastfeeding difficulties, mental health disorders and pre-existing health and social concerns. In addition, more than half of maternal deaths occur after birth. Joint guidelines published by ACOG and the American Academy of Pediatrics (AAP) recommend a prenatal visit in the first trimester of pregnancy. In May 2018, ACOG published a committee opinion recommending that all women have an initial assessment with a maternal care provider within 21 days after birth to address acute postpartum issues. The initial assessment should then be followed by ongoing care as needed and conclude with a comprehensive visit within 12 weeks after birth. The Department of Defense, Veteran's Administration (DoD/VA) clinical practice guidelines recommend a postpartum visit within 6 weeks, and no later than 8 weeks, after delivery. Refer to the HEDIS Measure Library & Historical Data measure web page for additional information about the clinical rationale.		

Citations	National Institutes of Health (NIH). 2012. Eunice Kennedy Shriver National Institute of Child Health and Human Development. *What Is Prenatal Care & Why Is It Important?* www.nichd.nih.gov/health/topics/pregnancy/conditioninfo/Pages/prenatal-care.asp American College of Obstetricians and Gynecologists (ACOG). 2018. "Optimizing Postpartum Care." ACOG Committee Opinion No. 736. *Obstet Gynecol* 131:140–50. Kassebaum, N., A. Bertozzi-Villa, M. Coggeshall, K. Shackelford, C. Steiner, K. Heuton, and D. Gonzalez-Medina.2015. "Global, Regional, and National Levels and Causes of Maternal Mortality During 1990-2013." *Obstetric Anesthesia Digest* 35(4), 196–7. doi:10.1097/01.aoa.0000472714.57328.86. American Academy of Pediatrics, American College of Obstetricians and Gynecologists. 2017. *Guidelines for Perinatal Care.* 8th Ed. Elk Grove Village, Ill. American Academy of Pediatrics, and Washington, DC. Department of Veteran's Affairs. Department of Defense. 2018. VA/DoD *Clinical Practice Guideline for Management of Pregnancy.* https://www.healthquality.va.gov/guidelines/WH/up/VADoDPregnancyCPG4102018.pdf
Characteristics	
Scoring	Proportion.
Type	Process.
Product lines	• Commercial HMO/POS. • Medi-Cal Managed Care.
Stratifications	Race. (Refer to *General Guideline: Race and Ethnicity Stratification*.) • American Indian or Alaska Native. • Asian. • Black or African American. • Middle Eastern or North African. • Native Hawaiian or Pacific Islander. • White. • Other Race. • Two or More Races. • Asked But Declined. • Unknown. • Total. Ethnicity. (Refer to *General Guideline: Race and Ethnicity Stratification*.) • Hispanic or Latino. • Not Hispanic or Latino. • Asked But Declined. • Unknown. • Total.

Risk adjustment	None.
Improvement notation	Increased score indicates improvement.
Guidance	**Data collection methodology:** Administrative. (Refer to *General Guideline: Data Collection Methods* for additional information.) **Date specificity:** Dates must be specific enough to determine the event occurred in the period being measured. **What services count?** • When using claims, include all paid, suspended, pending, and denied claims. • Services that occur over multiple visits count toward this measure if all services are within the time frame established in the measure. Ultrasound and lab results alone are not considered a visit; they must be combined with an office visit with an appropriate practitioner in order to count for this measure. **Other guidance:** • Criteria for identifying prenatal care for members who were not enrolled during the first trimester allow more flexibility than criteria for members who were enrolled. – *For members who were enrolled at least 219 days before delivery,* the organization has sufficient opportunity to provide prenatal care by the end of the first trimester. – *For members who were not enrolled at least 219 days before delivery,* the organization has sufficient opportunity to provide prenatal care within 42 days after enrollment. • Refer to Appendix 2 for the definition of *PCP* and *OB/GYN and other prenatal care practitioner.* • Ancillary services (lab, ultrasound) may be delivered by an ancillary provider. Nonancillary services (e.g., fetal heart tone, prenatal risk assessment) must be delivered by the required provider type. • For both rates, services provided during a telephone visit, e-visit or virtual check-in are eligible for use in reporting. • For each member, the organization must use one date (date of delivery or estimated delivery date [EDD]) to define the start and end of the first trimester. If multiple EDDs are documented, the organization must define a method to determine which EDD to use, and use that date consistently. The LMP may not be used to determine the first trimester. • The EDD may be used to identify the first trimester for the Timeliness of Prenatal Care rate and use the date of delivery for the Postpartum Care rate. • The measure is based on deliveries; therefore, it is possible for denominator to include multiple deliveries for the same member.
Definitions	
First trimester	280–176 days prior to delivery (or estimated delivery date [EDD]).

Initial population	*Measure item count:* Episode. *Attribution basis:* Enrollment. • *Benefits:* Medical. • *Continuous enrollment:* – For self-reporting POs: 43 days prior to delivery through 60 days after delivery in the PO (parent level). – For health plans: 43 days prior to delivery through 60 days after delivery in the health plan and the PO (parent level). • *Allowable gap:* None. *Ages:* None. *Event:* **Deliveries.** Live birth deliveries in any setting on or between October 8 of the year prior to the measurement period and October 7 of the measurement period. **Step 1.** Identify all members with a delivery (Deliveries Value Set) on or between October 8 of the year prior to the measurement period and October 7 of the measurement period. ***Note:*** *Delivery Date: The intent is to identify the date of delivery using the date as of the end of the delivery procedure; when available, use that date. When using inpatient claims to identify delivery date, use the following hierarchy to determine the date:* • *When a procedure date or date of service is available, use that date.* • *When a procedure date or date of service is not available, use the discharge date from the inpatient claim.* **Step 2.** Remove non-live births (Non Live Births Value Set). **Step 3.** Identify continuous enrollment. Determine if enrollment was continuous 43 days prior to delivery through 60 days after delivery, with no gaps. **Step 4.** Remove multiple deliveries in a 180-day period. If a member has more than one delivery in a 180-day period, include only the first eligible delivery. Then, if applicable, include the next delivery that occurs after the 180-day period. Identify deliveries chronologically, including only one per 180-day period. ***Note:*** *The initial population for this measure is based on deliveries, not on members. All eligible deliveries that were not removed in steps 1–4 remain in the initial population.*
Denominator exclusions	**Deceased members.** Members who died any time on or before the last day of the measurement period, identified using data sources determined by the organization. Method and data sources are subject to review during the AMP audit. **Members in hospice or using hospice services.** Members who use hospice services (Hospice Encounter Value Set; Hospice Intervention Value Set) or elect to use a hospice benefit any time during the measurement period. Organizations that use the Monthly Membership Detail Data File to identify these members must use only the run date of the file.
Denominator	The initial population minus denominator exclusions.

Numerator	**Numerator 1: Timeliness of prenatal care.** A prenatal visit during the required time frame. Follow the steps below to identify numerator compliance. **Step 1.** Identify members who were continuously enrolled (with no gaps) from at least 219 days before delivery (or EDD) through 60 days after delivery. These members must have a prenatal visit during the first trimester. **Step 2.** Identify members who were not continuously enrolled from at least 219 days before delivery (or EDD) through 60 days after delivery. These members must have a prenatal visit any time during the period that begins 280 days prior to delivery and ends 42 days after the enrollment start date. Do not count visits that occur on or after the date of delivery. Visits that occur prior to the member's enrollment start date during the pregnancy meet criteria. **Step 3.** Identify prenatal visits that occurred during the required time frame (the time frame identified in step 1 or 2). Any of the following, where the practitioner type is an OB/GYN or other prenatal care practitioner or PCP, meet criteria for a prenatal visit: • A bundled service (Prenatal Bundled Services Value Set) where the organization can identify the date when prenatal care was initiated (because bundled service codes are used on the date of delivery, these codes may be used only if the claim form indicates when prenatal care was initiated). • A visit for prenatal care (Stand Alone Prenatal Visits Value Set†). • A visit (Prenatal and Postpartum Care Visits Value Set) ***with*** either a pregnancy-related diagnosis code (Pregnancy Diagnosis Value Set) or a modifier that indicates maternity care (HCPCS Modifier code TH). **Numerator 2*:* Postpartum care.** A postpartum visit on or between 7 and 84 days after delivery. Any of the following meet criteria: • A postpartum visit (Postpartum Care Value Set†). • An encounter for postpartum care (Encounter for Postpartum Care Value Set*). • A visit (Prenatal and Postpartum Care Visits Value Set) ***with*** a modifier that indicates maternity care (HCPCS Modifier code TH). • Cervical cytology (Cervical Cytology Lab Test Value Set; Cervical Cytology Result or Finding Value Set). • A bundled service (Postpartum Bundled Services Value Set) where the organization can identify the date when postpartum care was rendered (because bundled service codes are used on the date of delivery, not on the date of the postpartum visit, these codes may be used only if the claim form indicates when postpartum care was rendered). Exclude services provided in an acute inpatient setting (Acute Inpatient Value Set; Acute Inpatient POS Value Set). **Coding Guidance** *Do not include laboratory claims (claims with POS code 81). †Do not use codes with a modifier (CPT CAT II Modifier Value Set).

*Prenatal Immunization Status (PRS-E)**

***Developed with support from the Department of Health and Human Services (DHHS), Office of the Assistant Secretary for Health (OASH), National Vaccine Program Office (NVPO).**

MEASURE UPDATES OCTOBER 2026 FOR AMP MY 2027

- Updated the race and ethnicity stratification categories to capture declinations and unknown race and/or ethnicity more precisely.
- Revised deliveries language in the *Initial population* to accommodate value set consolidation.
- Revised the *Initial population* to only include deliveries with a gestational age of 37 weeks or greater and removed the corresponding denominator exclusion for deliveries that occurred at less than 37 weeks gestation.
- Added a note regarding the delivery date to the *Initial population* criteria.
- Updated hospice *Denominator exclusion* to align with source specification.

MODIFICATIONS FROM HEDIS

- None.

To report this measure, refer to the digital measure package available for purchase in the NCQA Store for the complete HEDIS digital measure specification.

Measure title	Prenatal Immunization Status	**Measure ID**	PRS-E
Description	The percentage of deliveries in the measurement period in which members received influenza and tetanus, diphtheria toxoids and acellular pertussis (Tdap) vaccinations.		
Measurement period	January 1–December 31.		
Clinical recommendation statement /rationale	This measure assesses whether individuals with a delivery in the measurement period have received appropriate vaccines for pregnant individuals including influenza and Tdap. This aligns with recommended immunization schedules for individuals that are or may become pregnant from the American Academy of Family Physicians (AAFP 2026a; AAFP 2026b), the American College of Obstetrics and Gynecology (ACOG 2026) and the U.S. Centers for Disease Control and Prevention Advisory Committee on Immunization Practices (Grohskopf et al. 2025; Havers et al. 2019; Issa et al. 2025; Wodi et al. 2025). Refer to the HEDIS Measure Library & Historical Data measure web page for additional information about the clinical rationale.		
Citations	American Academy of Family Physicians (AAFP). 2026. *Recommended Adult Immunization Schedule for Ages 19 Years or Older*. https://www.aafp.org/assets/image/upload/v1777392265/nyme0soclvvfkutpwgvh.pdf American Academy of Family Physicians (AAFP). 2026. *Recommended Child and Adolescent Immunization Schedule for Ages 18 Years or Younger.* https://www.aafp.org/assets/image/upload/v1774979609/bhmf8pcgmuhzn7jcekdd.pdf		

American College of Obstetrics and Gynecology (ACOG). 2026. *2026 Maternal Immunizations Schedule*. https://www.acog.org/-/media/project/acog/acogorg/files/pdfs/programs/immunization/maternal-immunization-schedule.pdf?rev=4b52fc2cc3444d03a9964ab67aa5a7b0&hash=751F4499B1D7C4954A5995052DED3C21

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Havers, F.P., P.L. Moro, P. Hunter, S. Hariri, H. Bernstein. 2019. "Use of Tetanus Toxoid, Reduced Diphtheria Toxoid, and Acellular Pertussis Vaccines: Updated Recommendations of the Advisory Committee on Immunization Practices—United States, 2019. *Morbidity and Mortality Weekly Report* 69(3). U.S. Centers for Disease Control and Prevention. http://dx.doi.org/10.15585/mmwr.mm6903a5

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Issa, A.N., P.A. Wodi, C.A. Moser, S. Cineas. 2025. "Advisory Committee on Immunization Practices Recommended Immunization Schedule for Children and Adolescents Aged 18 Years or Younger—United States, 2025." *Morbidity and Mortality Weekly Report* 74(2). U.S. Centers for Disease Control and Prevention. http://dx.doi.org/10.15585/mmwr.mm7402a2

Characteristics

Scoring	Proportion.
Type	Process.
Product lines	▪ Commercial HMO/POS. ▪ Medi-Cal Managed Care.
Stratification	Race. (Refer to *General Guideline: Race and Ethnicity Stratification*.) • American Indian or Alaska Native. • Asian. • Black or African American. • Middle Eastern or North African. • Native Hawaiian or Pacific Islander. • White. • Other Race. • Two or More Races. • Asked But Declined. • Unknown. • Total.

	Ethnicity. (Refer to *General Guideline: Race and Ethnicity Stratification*.) • Hispanic or Latino. • Not Hispanic or Latino. • Asked But Declined. • Unknown. • Total.
Risk adjustment	None.
Improvement notation	Increased score indicates improvement.
Guidance	**Data collection methodology:** ECDS. (Refer to *General Guideline: Data Collection Methods* for additional information.) **Date specificity:** Dates must be specific enough to determine that the event occurred in the period being measured. **Which services count?** When using claims, include all paid, suspended, pending, and denied claims. **Other guidance:** The measure is based on deliveries; therefore, it is possible for the denominator to include multiple deliveries for the same member. **Programming guidance:** The MY 2027 HEDIS Implementation Guide (IG) will be available in October 2026. To request access to the HEDIS IG, email hedis-ig@ncqa.org.
Definitions	
Pregnancy episode	Calculate pregnancy start date by subtracting the gestational age (in weeks) at the time of delivery from the delivery date. Use the last gestational age assessment or diagnosis within 1 day of the delivery date.
Initial population	*Measure item count:* Episode. *Attribution basis:* Enrollment. • *Benefits:* Medical. • *Continuous enrollment:* – For self-reporting POs: From 28 days prior to the delivery date through the delivery date in the PO (parent level). – For health plans: From 28 days prior to the delivery date through the delivery date in the health plan and the PO (parent level). • *Allowable gap:* None. *Ages:* None. *Event:* **Deliveries.** Deliveries (Deliveries Value Set) in any setting during the measurement period with a gestational age of 37 weeks or greater. The gestational age documentation must be within 1 day of the start or end of the delivery. Use either of the following to identify gestational age: • Gestational age assessment (Weeks of Gestation Value Set); value ≥37 weeks.

	• Gestational age diagnosis (Weeks of Gestation Greater Than or Equal to 37 Value Set). ***Note:*** *Delivery Date: The intent is to identify the date of delivery using the date as of the end of the delivery procedure; when available, use that date. When using inpatient claims to identify delivery date, use the following hierarchy to determine the date:* • *When a procedure date or date of service is available, use that date.* • *When a procedure date or date of service is not available, use the discharge date from the inpatient claim.* If a member has more than one delivery in a 180-day period, include only the first eligible delivery. Then, if applicable include the next delivery that occurs after the 180-day period. Identify deliveries chronologically, including only one per 180-day period. ***Note:*** *Removal of multiple deliveries in a 180-day period is based on eligible deliveries. Assess each delivery for exclusions and attribution before removing multiple deliveries in a 180-day period.*
Denominator exclusions	**Deceased members.** Members who died any time on or before the last day of the measurement period, identified using data sources determined by the organization. Method and data sources are subject to review during the AMP audit. **Members in hospice or using hospice services.** Members who use hospice services (Hospice Encounter Value Set; Hospice Intervention Value Set) or elect to use a hospice benefit any time during the measurement period. Organizations that use the Monthly Membership Detail Data File to identify these members must use only the run date of the file.
Denominator	The initial population minus denominator exclusions.
Numerator	**Numerator 1: Immunization Status—Influenza.** • Deliveries where members received an adult influenza vaccine (Adult Influenza Immunization Value Set; Adult Influenza Vaccine Procedure Value Set) on or between July 1 of the year prior to the measurement period and the delivery date, ***or*** • Deliveries where members had anaphylaxis due to the influenza vaccine (SNOMED CT code 471361000124100) on or before the delivery date. **Numerator 2: Immunization Status—Tdap.** • Deliveries where members received at least one Tdap vaccine (CVX code 115; CPT code 90715) during the pregnancy (including on the delivery date), ***or*** • Deliveries where members had either of the following: – Anaphylaxis due to the diphtheria, tetanus or pertussis vaccine (Anaphylaxis Due to Diphtheria, Tetanus or Pertussis Vaccine Value Set) on or before the delivery date. – Encephalitis due to the diphtheria, tetanus or pertussis vaccine (Encephalitis Due to Diphtheria, Tetanus or Pertussis Vaccine Value Set) on or before the delivery date. **Numerator 3: Immunization Status—Combination.** Deliveries that met criteria for both numerator 1 and numerator 2.

*Depression Screening and Follow-Up for Adolescents and Adults (DSF-E)**

***Adapted with financial support from the Centers for Medicare & Medicaid Services (CMS).**

MEASURE UPDATES OCTOBER 2026 FOR AMP MY 2027

- Added the Medicare Advantage product line for testing.
- Added manic episodes to and renamed the denominator exclusion to "Members with a history of manic episodes or bipolar disorder."

MODIFICATIONS FROM HEDIS

- None.

To report this measure, refer to the digital measure package available for purchase in the NCQA Store for the complete HEDIS digital measure specification.

Measure title	Depression Screening and Follow-Up for Adolescents and Adults	**Measure ID**	DSF-E
Description	The percentage of members 12 years of age and older who were screened for clinical depression using a standardized instrument and, if screened positive, received follow-up care. • *Depression Screening.* The percentage of members who were screened for clinical depression using a standardized instrument. • *Follow-Up on Positive Screen.* The percentage of members who received follow-up care within 30 days of a positive depression screen finding.		
Measurement period	January 1–December 31.		
Clinical recommendation statement/ rationale	The U.S. Preventive Services Task Force (USPSTF) recommends screening for depression among adolescents 12–18 years and the general adult population, including pregnant and postpartum women (B recommendation). The USPSTF also recommends that screening be implemented with adequate systems in place to ensure accurate diagnosis, effective treatment and appropriate follow-up (B recommendation). Refer to the HEDIS Measure Library & Historical Data measure web page for additional information about the clinical rationale.		
Citations	US Preventive Services Task Force et al. 2023. "Screening for Depression and Suicide Risk in Adults: US Preventive Services Task Force Recommendation Statement." *JAMA* vol. 329,23: 2057–67. US Preventive Services Task Force et al. 2022. "Screening for Depression and Suicide Risk in Children and Adolescents: US Preventive Services Task Force Recommendation Statement." *JAMA* vol. 328,15: 1534–42.		

Characteristics	
Scoring	Proportion.
Type	Process.
Product lines	• Commercial HMO/POS. • Medicare Advantage (testing). • Medi-Cal Managed Care.
Stratifications	Age as of the start of the measurement period. • 12–17 years (Commercial HMO/POS and Medi-Cal Managed Care only). • 18–64 years. • 65 years and older. • Total.
Risk adjustment	None.
Improvement notation	Increased score indicates improvement.
Guidance	**Data collection methodology:** ECDS. (Refer to *General Guideline: Data Collection Methods* for additional information.) **Date specificity:** Dates must be specific enough to determine that the event occurred in the period being measured. **Which services count?** When using claims, include all paid, suspended, pending, and denied claims. **Other guidance:** • Use the member's age to select an age-appropriate depression screening instrument. • Depression screening captured in health risk assessments or other types of health assessments are allowed if the questions align with a specific instrument that is validated for depression screening. – *For example,* a health risk assessment that includes questions from the PHQ-2 counts as screening if the questions are answered and a total score is calculated. **Programming guidance:** The MY 2027 HEDIS Implementation Guide (IG) will be available in October 2026. To request access to the HEDIS IG, email hedis-ig@ncqa.org.

Definitions

Depression screening instrument

A standard assessment instrument normalized and validated for the appropriate patient population. Eligible screening instruments with thresholds for positive findings include:

Instruments for Adolescents (≤17 years)	Total Score LOINC Codes	Positive Finding
Patient Health Questionnaire (PHQ-9)®	44261-6	Total score ≥10
Patient Health Questionnaire Modified for Teens (PHQ-9M)®	89204-2	Total score ≥10
Patient Health Questionnaire-2 (PHQ-2)®[1]	55758-7	Total score ≥3
Beck Depression Inventory-Fast Screen (BDI-FS)®[1,2]	89208-3	Total score ≥8
Center for Epidemiologic Studies Depression Scale—Revised (CESD-R)	89205-9	Total score ≥17
Edinburgh Postnatal Depression Scale (EPDS)	99046-5	Total score ≥10
PROMIS Depression	71965-8	Total score (T Score) ≥60

Instruments for Adults (18+ years)	Total Score LOINC Codes	Positive Finding
Patient Health Questionnaire (PHQ-9)®	44261-6	Total score ≥10
Patient Health Questionnaire-2 (PHQ-2)®[1]	55758-7	Total score ≥3
Beck Depression Inventory-Fast Screen (BDI-FS)®[1,2]	89208-3	Total score ≥8
Beck Depression Inventory (BDI-II)	89209-1	Total score ≥20
Center for Epidemiologic Studies Depression Scale—Revised (CESD-R)	89205-9	Total score ≥17
Duke Anxiety—Depression Scale (DUKE-AD)®[2]	90853-3	Total score ≥30
Geriatric Depression Scale Short Form (GDS)[1]	48545-8	Total score ≥5
Geriatric Depression Scale Long Form (GDS)	48544-1	Total score ≥10
Edinburgh Postnatal Depression Scale (EPDS)	99046-5	Total score ≥10

My Mood Monitor (M3)®	71777-7	Total score ≥5
PROMIS® Depression	71965-8	Total score (T Score) ≥60
PROMIS® Emotional Distress-Depression-Short Form	77861-3	Total score (T score) ≥60
Clinically Useful Depression Outcome Scale (CUDOS)	90221-3	Total score ≥31

[1]Brief screening instrument. All other instruments are full-length.
[2]Proprietary; may be cost or licensing requirement associated with use.

Initial population

Measure item count: Member.

Attribution basis: Enrollment.

- *Benefits:* Medical.
- *Continuous enrollment:*
  - For self-reporting POs: The measurement period in the PO (parent level).
  - For health plans: The measurement period in the health plan and the PO (parent level).
- *Allowable gap:*
  - For self-reporting POs: No more than one gap of ≤45 days during the measurement period. No gaps in enrollment in the PO (parent level, or, for eligible POs, subgroup level) or in an AMP plan on the last day of the measurement period.
  - For health plans: No more than one gap of ≤45 days during the measurement period. No gaps in enrollment in the health plan or in the PO (parent level, or, for eligible POs, subgroup level) on the last day of the measurement period.

Ages: 12 years of age and older at the start of the measurement period.

Event: None.

Denominator exclusions

Deceased members.
Members who died any time on or before the last day of the measurement period, identified using data sources determined by the organization. Method and data sources are subject to review during the AMP audit.

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

Members with a history of manic episodes or bipolar disorder.
Members with a history of manic episodes or bipolar disorder (Manic Episodes and Bipolar Disorder Value Set*) any time during the member's history through the last day of the year prior to the measurement period.

Members with depression.
Members with depression (Depression Value Set*) that starts during the year prior to the measurement period.

	Coding Guidance *Do not include laboratory claims (claims with POS code 81).
Denominator	**Denominator 1**: The initial population minus denominator exclusions. **Denominator 2**: Members from numerator 1 with a positive finding for depression between January 1 and December 1 of the measurement period.
Numerator	**Numerator 1—Depression screening.** Members with a documented result for depression screening, using an age-appropriate standardized instrument, performed between January 1 and December 1 of the measurement period. **Numerator 2—Follow-up on positive screen.** Members who received follow-up care on or up to 30 days after the date of the first positive screen (31 total days). Any of the following on or up to 30 days after the first positive screen: • An outpatient, telephone, e-visit or virtual check-in follow-up visit (Follow Up Visit Value Set) with a diagnosis of depression or other behavioral health condition (Depression or Other Behavioral Health Condition Value Set). • A depression case management encounter (Depression Case Management Encounter Value Set) that documents assessment for symptoms of depression (Symptoms of Depression Value Set) or a diagnosis of depression or other behavioral health condition (Depression or Other Behavioral Health Condition Value Set). • A behavioral health encounter, including assessment, therapy, collaborative care or medication management (Behavioral Health Encounter Value Set). • A diagnosis of encounter for exercise counseling (ICD-10-CM code Z71.82*). • A dispensed antidepressant medication (Antidepressant Medications List). ***OR*** • Documentation of additional depression screening on a full-length instrument indicating either no depression or no symptoms that require follow-up (i.e., a negative screen) on the same day as a positive screen on a brief screening instrument. – *For example,* if there is a positive screen resulting from a PHQ-2 score, documentation of a negative finding from a PHQ-9 performed on the same day qualifies as evidence of follow-up. **Coding Guidance** *Do not include laboratory claims (claims with POS code 81).

Data Quality Domain Technical Specifications

For AMP MY 2027

Encounter Rate by Service Type (ENRST)

MEASURE UPDATES OCTOBER 2026 FOR AMP MY 2027

- Updated the definition of "Member months."
- Updated the definition of "Determining claims/encounters."

Description

The encounter rate is the number of claims and encounters by service type for each PO. Each health plan calculates the rate for each PO with which it contracts and uses it to measure data completeness. The method for identifying encounters by service type is based on the HEDIS Use of Service measures and the General Guidelines. Each service type is calculated as a separate indicator. Supplemental data may not be used for any indicators in this measure.

Each indicator is reported by separate transaction type (i.e., report claims and encounters counts separately for each indicator). All ENRST indicators are reported as three rates (except Indicators 4b and 5b which only report a total rate, exempt from deduplication):

- Claims rate.
- Encounters rate.
- Overall deduplicated rate.

Note: *Health plans submit the denominator data for the measure as the total member months.*

Calculation

Health plans submit the denominator for each indicator as total member months. After submission, the denominator data is recalculated and reported as member years for each indicator. The reported encounter rate is total encounters and claims/total member years. Plans should report the total number of unduplicated encounters or claims for each service type and the member months only (refer to steps in "Member months" under *Definitions*). The deduplicated total is a calculated rate that may be less than the sum of claims and encounters. If a member has both a claim and an encounter for the same service type, provider, and date of service, they should be counted as a claim and an encounter, but should only be counted once in the deduplicated total.

For example, if a member has 1 claim and 1 encounter for the same Indicator 1 outpatient service with the same provider on the same date, the member should be counted once in the claims rate, once in the encounters rate, and once in the overall rate. If the member has 2 encounters and 2 claims on the same date of service by the same provider, deduplication applies at the stratification level as well. In this case, the member should be counted once in the claims rate, once in the encounters rate, and once in the overall rate.

Note: *Deduplication applies to all ENRST indicators* ***except*** *Indicators 4b and 5b; these indicators are not subject to deduplication or stratification by claim and encounter.*

POs are not expected to report this measure.

Definitions

Member months Calculate the member months of enrollment for the measurement year for all members. Include all members (adults and children) enrolled in the applicable line of business (Commercial HMO/POS, Medicare Advantage, or Medi-Cal Managed Care), regardless of the type of reimbursement contract. Member months will be the denominator submitted for all indicators.

Step 1 Determine the PO's total member months for a health plan using a specified day of each month (e.g., the 15th or the last day of the month), to be determined according to the health plan's administrative processes. The day selected must be consistent from member to member, month to month and year to year. For example, if the health plan or PO computes membership on the 15th of the month, and Ms. X is enrolled in the PO on January 15, Ms. X contributes 1 member month in January.

Step 2 Use the member's product line and PO affiliation on the specified day of each month to determine the product line and PO to which the member months will be contributed.

Member years

After member months are submitted, member years are calculated for each PO by dividing total member months by 12.

X member months/12 months = Y member years

Note: *Health plans are only expected to calculate and submit member months and are not expected to calculate member years.*

Encounter

An **encounter** differs from a **claim** in that it represents a service for which there is no claim for payment sent to the health plan (i.e., all member encounters are covered in the health plan's capitation payment), or a service where the PO may pay the provider a fee for service for the encounter but does not bill the health plan for the service. Follow these guidelines for determining encounters. Include all encounters and claims for services rendered, whether or not they were approved or paid by the PO or health plan.

Determining claims/ encounters

Count any code that represents a unique date of service, a unique provider identifier, and a unique patient.

Count multiple lab tests in 1 day by the same lab provider as one unique encounter. An encounter for the same date of service, provider, and patient that contains multiple types of services should be counted in each category, as appropriate (e.g., an office visit with lab procedures should be included in both categories).

Allow at least a 2-month lag in submission and count all member encounters or transactions for the applicable line of business with a date of service in the measurement year. For Commercial HMO/POS reporting, include out-of-network POS claims.

Report services without regard to practitioner type, training, or licensing. Include after-hours, nonemergency urgent care, nursing home visits, and outpatient surgical procedures.

IHA encourages detailed service reporting to facilitate comparability and complete reporting, even when the financial reimbursement arrangement does not require it.

When calculated, the deduplicated total rate only counts a member once if a claim and encounter share the same member, provider, and date of service. The member should be counted once in the claims stratification and once in the encounters stratification. This logic applies to all rates except Indicators 4b and 5b, which are exempt from deduplication.

Overall professional encounter rate

Sum of the numerators for indicators 1, 2, 3, 4a, and 5a, divided by member months for the PO. Member years will be calculated after submission.

Overall institutional encounter rate	Sum of the numerators for indicators 6, 7, and 8, divided by member months for the PO. Member years will be calculated after submission.
Overall rate	Sum of the numerators for indicators 1, 2, 3, 4a, 5a, and 6, divided by member months for the PO. Member years will be calculated after submission.

Eligible Population

Product lines

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

Required exclusions

- Duplicate claims/encounters within a service type.
  - Do not count multiple claims/encounters within this service type where the member, provider, and date of service are the same, regardless of whether the procedure (CPT)[11] codes are the same or different; if this occurs, only record one claim/encounter.
- Indicators 4b and 5b should count the actual number of tests performed and are not subject to deduplication by:
  - Member.
  - Provider.
  - Date of service.
  - Claim/encounter.
- Members who use hospice services (Hospice Encounter Value Set; Hospice Intervention Value Set) or elect to use a hospice benefit any time during the measurement year.

Encounter Indicator 1: Office and Other Outpatient Services

Denominator	Member years (submitted by health plans as member months and then calculated and reported as member years).
Numerator	Count the total number of unduplicated office and other outpatient services claims/encounters using the (Outpatient Services Value Set).

Note

- *Count office-based surgeries/procedures in this category.*

Encounter Indicator 2: Preventive Medicine

Denominator	Member years (submitted by health plans as member months and then calculated and reported as member years).
Numerator	Count the total number of unduplicated preventive medicine claims/encounters using the (Preventive Medicine Services Value Set).

Encounter Indicator 3: Ophthalmology and Optometry

Denominator	Member years (submitted by health plans as member months and then calculated and reported as member years).

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Numerator Count the total number of unduplicated ophthalmology or optometry claims/encounters (Ophthalmological Services Value Set). Report services without regard to practitioner type, training, or licensing.

Encounter Indicator 4: Laboratory/Pathology Services

Denominator Member years (submitted by health plans as member months and then calculated and reported as member years).

Numerator

Indicator 4a Count the total number of claims/encounters (Laboratory and Pathology Services Value Set).

Note: *Identify one claim/encounter as the same member receiving at least one test on the same day from the same (lab) provider. Do not count multiple tests (i.e., codes) separately that occurred on the same day with the same provider (either within the same claim/encounter record or in a different claim/encounter record).*

Indicator 4b Calculate the total number of tests (Laboratory and Pathology Services Value Set).

Count all laboratory/pathology procedure codes separately (even if codes are within the same claim/encounter record). For example, if an encounter record contains three different codes (i.e., for three different lab tests), record three "tests." Sum all the tests to calculate the total numerator.

Encounter Indicator 5: Radiology and Imaging

Denominator Member years (submitted by health plans as member months, and then calculated and reported as member years).

Numerator

Indicator 5a Count the total number of radiology and imaging claims/encounters using the Radiology and Imaging Services Value Set).

Note: *Identify one claim/encounter as the same member receiving at least one test on the same day from the same provider. Do not count multiple tests (e.g., CPT[12] codes) separately that occurred on the same day with the same provider (either within the same claim/encounter record or in a different claim/encounter record).*

Indicator 5b Calculate the total number of tests using the Radiology and Imaging Services Value Set.

Count all radiology procedure codes separately (even if codes are within the same claim/encounter record). For example, if an encounter record contains three different CPT codes (i.e., for three different imaging tests), record three "tests." Sum all the tests to calculate the total numerator.

Encounter Indicator 6: Ambulatory Surgery/Procedures

Denominator Member years (submitted by health plans as member months, and then calculated and reported as member years).

Numerator Count the total number of unduplicated ambulatory surgery/procedure claims/encounters.

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A claim with a code from any of the following value set combinations meets the criteria:

- Ambulatory Surgery Option A Value Set ***with*** Ambulatory Surgery POS Value Set.
- Ambulatory Surgery Option A Value Set ***with*** Ambulatory Surgery UBTOB Value Set.

Report services without regard to practitioner type, training, or licensing.

The health plan/PO must avoid double counting and report only ambulatory surgery/procedures performed at a hospital outpatient facility or at a free-standing surgery center. Count every ambulatory surgery/procedure claim/encounter, which is one discrete service date for a specific member at a specific site (regardless of the number of services provided at that site on that day for that member).

Note

- *Do not report office-based surgeries/procedures in this category; report them under Office and Other Outpatient Services.*

Encounter Indicator 7: ED Visits

Denominator Member years (submitted by health plans as member months, and then calculated and reported as member years).

Numerator Count each visit to an ED once, regardless of the intensity or duration of the visit. Count multiple ED visits on the same date of service as one visit. Identify ED visits using either of the following:

- An ED visit (ED Value Set).
- A procedure code (ED Procedure Code Value Set) ***with*** an ED place of service code (POS code 23).

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

Encounter Indicator 8: Inpatient Stays

Denominator Member years (submitted by health plans as member months, and then calculated and reported as member years).

Numerator Identify all acute inpatient discharges on or between January 1 and December 31 of the measurement year. To identify acute inpatient discharges:

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

Note

- *Supplemental data may not be used for any rates in this measure.*
- *Organizations may **only** exclude deceased members if the member had <1 month of medical and pharmacy coverage.*

Encounter Format (ENFMT)

MEASURE UPDATES OCTOBER 2026 FOR AMP MY 2027

- Updated definition of "Visits."

Description

Correct coding and formatting of the content in an encounter submission affects both its acceptance by a health plan and its usability for everything from care gap reporting and performance measurement to risk adjustment and rate setting.

The measure assesses whether key encounter data elements meet expectations on use of standard codes, consistency, and completeness.

- Review of codes:
  - Procedure Codes, including use of procedure modifiers.
  - Diagnosis Codes.
- Review of identifiers:
  - Billing Provider Identifier.
  - Rendering Provider Identifier.

Rates for each measure are reported by service type (institutional and professional) and transaction type (claims and encounters).

For additional information on timeliness measures, refer to the California Department of Health Care Services Quality Measures for Encounter Data.

Note: *Health plans and POs are not expected to report this measure. Cozeva will run this measure using health plans claim and encounter submissions for MY 2027.*

Definitions

Service line	All individual service records in a claim or encounter submitted to the health plan. Identified by each record that health plans submit to Cozeva.
Claims	A set of service lines reflected in a unique claim for health plan payment. Include all claims for services rendered, whether or not they were approved or paid by the PO.
Encounter	An **encounter** differs from a **claim** in that it represents a service for which there is no claim for payment sent to the health plan (i.e., all member encounters are covered in the health plan's capitation payment), or a service where the PO may pay the provider a fee for service for the encounter but does not bill the health plan for the service. Include all encounters for services rendered, whether or not they were approved or paid by the PO or health plan.
Visits	Records with a unique combination of date of service, a unique billing provider identifier, and a unique patient identifier. If one record is capitated in a claim/encounter, the event should be treated as an encounter; for example, a regular office visit (capitated) that had lab tests (fee-for-service). Allow at least a 3-month lag in submission (e.g., January 1–March 31 of the year following the measurement year) and count all member encounters or

transactions for the applicable line of business with a date of service in the measurement year. For Commercial HMO/POS reporting, include out-of-network POS claims.

Report services without regard to practitioner type, training, or licensing. Include after-hours, nonemergency urgent care, nursing home visits, and outpatient surgical procedures.

IHA encourages detailed service reporting to facilitate comparability and complete reporting, even when the financial reimbursement arrangement does not require it.

Institutional claims	Services submitted with a unique claim ID using an 837I format for health plan payment.
Institutional encounters	Services submitted with a unique claim ID using an 837I format for reasons other than reimbursement.
Professional claims	Services submitted with a unique claim ID using an 837P format for health plan payment.
Professional encounters	Services submitted with a unique claim ID using an 837P format for reasons other than reimbursement.
Pharmacy claims/ encounters	Prescription records submitted to health plans using an NCPDP format. There is currently no way to distinguish between pharmacy claims from encounters. Prescription records will be considered pharmacy claims.

Eligible Population

Product lines	Commercial HMO/POS, Medicare Advantage, Medi-Cal Managed Care (report each product line separately).
Required exclusion	Members who use hospice services (Hospice Encounter Value Set; Hospice Intervention Value Set) or elect to use a hospice benefit any time during the measurement year.

Encounter Format Calculation: Valid Standard Codes

Step 1 Identify all Institutional (837I) and Professional (837P) claims and/or encounters.

Step 2 *Calculate the percentage of all claims/encounters with a valid national standard field.* Divide the number of claims/encounters populated with a valid national standard field by the total count of claims/encounters. Refer to the list of valid national standard fields below.

Step 3 *Calculate the average number of valid national standard fields per claim and/or encounter.* Divide the total number of valid national standard fields by the number of all claims/ encounters submitted. Refer to the list of valid national standard fields below.

List of Valid National Standard Fields

Procedure Code	Include claims and/or encounters populated with a valid national standard procedure code (CPT[13] HCPCS) for professional and outpatient service.
Diagnosis Code	Include claims and/or encounters populated with a valid national standard diagnosis code (ICD-10-CM). To make information comparable across POs and consistent across AMP programs, diagnosis codes will be limited to 13 professional/13 institutional.

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Encounter Format Calculation: Billing Provider Identifier

Step 1 *Identify all Institutional (837I) and Professional (837P) claims and/or encounters.*

Step 2 *Calculate the percentage of all claims/encounters with a valid Billing Provider TIN.* Divide the number of claims/encounters with Billing Provider Identifier populated with a valid TIN by the total count of claims/encounters.

Encounter Format Calculation: Rendering Provider Identifier

Step 1 *Identify all Institutional (837I) and Professional (837P) claims and/or encounters.*

Step 2 *Identify all service lines from Institutional (837I) and Professional (837P) claims and/or encounters that include a procedure code.*

Step 3 *Calculate the percentage of service lines with a valid Rendering Provider Identifier NPI.* Divide the number of service lines with Rendering Provider Identifier populated with a valid NPI by the count of all service lines.

Encounter Format Calculation: Procedure Codes Per Visit

Step 1 *Identify all visits based on Institutional (837I) and Professional (837P) claims and/or encounters.* "Visits" are defined as the unique combination of billing provider, beneficiary, and DOS.

Step 2 *Calculate the percentage of visits with more than one procedure code.* Divide the number of visits with more than one procedure code by the total number of visits.

Step 3 *Calculate the average number of procedure codes per visit.* Divide the number of procedure codes by the total number of visits with a procedure code.

Encounter Format Calculation: Procedure Modifier Per Service Line

Step 1 *Identify all Institutional (837I) and Professional (837P) claims and/or encounters.*

Step 2 Identify all service lines from Institutional (837I) and Professional (837P) claims and/or encounters that include a procedure code.

Step 3 *Calculate the percentage of service lines with a valid procedure modifier code.* Divide the total count of service lines populated with a valid procedure modifier code by the total count of service lines with a procedure code for professional or outpatient institutional services.

Step 4 *Calculate the average number of modifiers per service line with a procedure code.* Divide the number of procedure modifiers by the total count of service lines with a procedure code for professional or institutional outpatient services.

Note

- *Organizations may **only** exclude deceased members if the member had <1 month of medical and pharmacy coverage.*

Encounter Timeliness (ENLAG)

MEASURE UPDATES OCTOBER 2026 FOR AMP MY 2027

- None.

Description

Encounter data timeliness assesses the elapsed time in days between the date when a patient receives care (date of service [DOS]) and the date when the claim or encounter is accepted by the health plan (paid/remittance date). The number of calendar days between those dates is the "lag time." Shortening the lag time between the DOS and the paid/remittance date ensures that the information provided on the encounter is available for health plan quality improvement initiatives, performance measurement reporting, and risk-score calculations.

The following three indicators are reported by service type (Institutional, Professional, Pharmacy) and by transaction type (claim and encounter).

- **Categories of Lag Time:** The percentage of claims/encounters where the lag time falls within the category duration. Reported categories are:
  - 0–30 days (higher is better).
  - 0–60 days (higher is better).
  - 0–90 days (higher is better).
  - 0–180 days (higher is better).
  - 0–365 days (higher is better).
  - >365 days (lower is better).
- **Average Lag Time by Service Date:** The average lag time for claims/encounters with dates of service during the measurement period and including the date of payment during the measurement year plus a 3-month runout (e.g., January 1–March 31 of the year following the measurement year).
- **Average Lag Time by Paid/Remittance Date:** The average lag time for claims/encounters with paid/remittance dates during the measurement period where the service date is during the year prior to the measurement year and during the measurement year**.**

For additional information on timeliness measures under consideration, refer to the California Department of Health Care Services Quality Measures for Encounter Data.

Note: *Health plans and POs are not expected to report this measure. Cozeva will run this measure using health plans claim and encounter submissions for MY 2027.*

Definitions

Service line	All individual service records within a claim or encounter submitted to the health plan. Identified by each record that health plans submit to Cozeva.
Claims	A set of service lines reflected in a unique claim for health plan payment. Include all claims for services rendered, whether or not they were approved or paid by the PO.

Encounter	An **encounter** differs from a **claim** in that it represents a service for which there is no claim for payment sent to the health plan (i.e., all member encounters are covered in the health plan's capitation payment), or a service where the PO may pay the provider a fee for service for the encounter but does not bill the health plan for the service. Include all encounters for services rendered, whether or not they were approved or paid by the PO or health plan.
Lag time	The elapsed time in days between the date when a patient receives care (DOS) and the date when claim/encounter is accepted by the health plan (paid/ remittance date).
Institutional claims	Services submitted with a unique claim ID using an 837I format for health plan payment.
Institutional encounters	Services submitted with a unique claim ID using an 837I format for reasons other than reimbursement.
Professional claims	Services submitted with a unique claim ID using an 837P format for health plan payment.
Professional encounters	Services submitted with a unique claim ID using an 837P format for reasons other than reimbursement.
Pharmacy claims/ encounters	Prescription records submitted to health plans using an NCPDP format. There is currently no way to distinguish between pharmacy claims from encounters. Prescription records will be considered pharmacy claims.

Eligible Population

Product lines	Commercial HMO/POS, Medicare Advantage, Medi-Cal Managed Care (report each product line separately).
Required exclusion	Members who use hospice services (Hospice Encounter Value Set; Hospice Intervention Value Set) or elect to use a hospice benefit any time during the measurement year.

Encounter Timeliness Lag Time Categories Calculation

Step 1 Distinguish encounters from claims.

Step 2 *Determine the lag time for each claim/encounter.* Health plans submit all claims/encounters through their medical claims file submission to Cozeva. Cozeva will identify the lag time for each member claim/encounter by identifying the elapsed time in days between the DOS and the paid/remittance date.

Step 3 Categorize all claims/encounters by service type (Institutional, Professional, Pharmacy) using the following determination:

- *Institutional:* Records for services that would be submitted using the UB04 format with a Type of Bill code populated under a fee-for-service arrangement.
- *Professional:* Records for services that would be submitted via CMS 1500 with a Place of Service Code populated under a fee-for-service arrangement.
- *Pharmacy:* Records for services for prescription drug coverage normally provided at a pharmacy that have a National Drug Code populated.

  - Pharmaceuticals provided as part of medical procedures or hospital stays would not be included here but would be grouped with the corresponding professional and institutional service.

Step 4 *Assign claims/encounters into the appropriate category based on lag time.* For the total number of Institutional, Professional, and Pharmacy claims/encounters with a service date during the measurement year and a paid/remittance date on or before March 31 of the year following the measurement year, calculate the percentage of claims/encounters whose lag time meets the following categories:

- 0–30 days.
- 0–60 days.
- 0–90 days.
- 0–180 days.
- 0–365 days.
- >365 days.

Step 5 *Calculate the percentage of claims/encounters that fall into each category.* For each claim/encounter type, count claims/encounters within a lag time category and divide by the count of all claims/encounters of that type.

Encounter Timeliness Average Lag Time Calculation

Step 1 *Calculate the average lag time by service date.* For all claims/encounters with a DOS occurring January 1–December 31 of the measurement year (and with a paid/remittance date on or before March 31 of the year following the measurement year), identify the average lag time of all claims/encounters in days. For each claim/encounter type, sum the lag times across all claims/encounters and divide by the count of all claims/encounters.

Step 2 *Calculate the average lag time by paid/remittance date.* For all claims/encounters with a paid/remittance date occurring January 1–December 31 of the measurement year, identify the average lag time of all claims/encounters in days for claims/encounters with a service date prior to the measurement year and during the measurement year. For each claim/encounter type, sum the lag times across all claims/encounters and divide by the count of all claims/encounters.

Note

- *Organizations may **only** exclude deceased members if the member had <1 month of medical and pharmacy coverage*.

Race/Ethnicity Description of Membership (RDM)

MEASURE UPDATES OCTOBER 2026 FOR AMP MY 2027

- Updated the race and ethnicity reporting categories and data element table to capture declinations and unknown race and/or ethnicity more precisely.

MODIFICATIONS FROM HEDIS

- None.

Description

An unduplicated count and percentage of members enrolled any time during the measurement year, by race and ethnicity.

Calculations

Product lines

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

Table instructions

Report the number of members by race/ethnicity for the population in each reporting category.

Data source

Report the number of members for whom data have been collected from each data source for race and ethnicity. Data sources must fall into one of four types (direct, imputed, unknown, no data), and include data collected directly from members (such as self-reported data collected by the health plan or self-reporting PO), data collected via state enrollment files or CMS databases and data collected from other sources (e.g., HIEs and clinical feeds).

Imputed data include information generated through imputation methods such as surname analysis or geocoding. Unknown data include data for which there is a recorded race or ethnicity value but no recorded source. “No data” reflects instances in which both the race or ethnicity value *and* the source are missing.

Table RDM-B-1/2/3 reports the percentage of each race (e.g., White, Black or African American) within each ethnicity (e.g., Hispanic or Latino, Not Hispanic or Latino) category.

Reporting Category Definitions

Refer to *General Guideline: Race and Ethnicity Stratification* for instructions on determining race reporting category and determining ethnicity reporting category. When using the combined race/ethnicity data format for collection, or if using CMS as the data source, refer to *General Guideline: Race and Ethnicity Stratification*, Table RES-A-1/2/3 and Table RES-B-1/2/3 for a crosswalk of reporting categories. Refer to Tables RES-C-1/2/3 and RES-D-1/2/3 for the value sets and direct reference codes that must be used to report the measure. Organizations that do not use these codes must map race and ethnicity data to them.

Reporting categories for race

- American Indian or Alaska Native.
- Asian.
- Black or African American.
- Middle Eastern or North African.

	• Native Hawaiian or Pacific Islander. • White. • Other Race. • Two or More Races. • Asked But Declined. • Unknown. • Total.
Reporting categories for ethnicity	• Hispanic or Latino. • Not Hispanic or Latino. • Asked But Declined. • Unknown. • Total.

Note

- *It is considered best practice to collect data directly from members because this method reflects members' self-identification. If data collected directly by the health plan or PO are not available, third-party data collected directly by another entity (e.g., the state, CMS, HIE, or clinical feeds) are desired. When multiple sources of data are used for race and ethnicity, disagreements in the data collected may exist. When disagreements exist, data sources should be prioritized based on an evaluation of anticipated accuracy. This includes use of specific categories over nonspecific categories, most frequent or consistently reported category, and selection of data with clear provenance (source, method of collection) over data without clear provenance.*
- *If detailed ethnicity information is collected, these data must be aggregated and reported in the OMB categories provided. If a combined race/ethnicity category question is used to collect data, data must be disaggregated, and race and ethnicity categories must be reported separately.*
- *The measure steward, NCQA, recommends the mapping strategy in Tables RES-A-1/2/3 and RES-B-1/2/3 based on research on the sensitivity and specificity of CMS data, expert input, and lessons from data collection learning initiatives. This crosswalk is a guide only. If organizations have more accurate race or ethnicity information, they may overwrite these data and code race or ethnicity to the more accurate categories. However, data must be reported using the defined AMP categories.*
- *Data on race and data on ethnicity may come from different categories of data source (direct, imputed, unknown, and no data). In such cases, report using the data category that applies to that data element (race, ethnicity). If the same category of information is received from two different data sources, prioritize data sources based on the first bullet above.*

Table RDM-A-1/2/3: Percentage of Members for Whom the Organization Has Race/Ethnicity Information by Data Source

Metric	Source	Data Element	Reporting Instructions
RaceSource	OrganizationCollected	MemberCount	For each Metric and Source
EthnicitySource	EnrollmentFiles	Rate	(Percent)
	Other		
	DirectTotal		
	Imputed		
	Unknown		
	NoData		

Note

- *Percentages include the sum of all race and ethnicity response options, which does not include "Unknown." The "Asked But Declined" response option is included in the Direct Data Collection Method percentages because it indicates that the organization asked about the member's race/ethnicity. The "Asked But Declined" category is only reported using direct data. "Unknown" includes members for whom the organization did not obtain race/ethnicity information and for whom the organization did not receive a declined response (i.e., "Asked but Declined"). The "Unknown" category is only reported using the no data category for data source, as "unknown" values cannot be attributed to a particular data source.*
- *The DirectTotal count is the sum of OrganizationCollected, EnrollmentFiles and Other.*
- *The total member counts (DirectTotal + Imputed + Unknown + No Data) for the Source of Race Information table must be identical to the total member count for the Source of Ethnicity Information table and the total member count for Table RDM-B-1/2/3.*
- *The OrganizationCollected data source category within DirectTotal includes gold-standard, member self-reported data that are collected in house by the health plan or self-reporting PO, which in this case has full control over the method by which the data are obtained (i.e., the member self-reported data sources do not capture data obtained through an intermediary or third party organization).*
- *"Unknown" data source category includes data for which the plan or self-reporting PO has a recorded race or ethnicity value but no recorded source (i.e., cases where an organization has a race or ethnicity value on file from a legacy system, but does not know the source).*
- *Any data reported via the no data category reflects instances where the organization did not obtain race or ethnicity information and did not obtain source information.*
- *Prioritize data sources as specified in the measure.*

Table RDM-B-1/2/3: Race/Ethnicity Categories Reported

Metric	Race	Ethnicity	Data Element	Reporting Instructions
RaceEthnicity	AmericanIndianOrAlaskaNative	HispanicOrLatino	MemberCount	For each Stratification
	Asian	NotHispanicOrLatino	Rate	(Percent)
	BlackOrAfricanAmerican	AskedButNoAnswer		
	MiddleEasternOrNorthAfrican	Unknown		
	NativeHawaiianOrPacificIslander	Total		
	White			
	OtherRace			
	TwoOrMoreRaces			
	AskedButDeclined			
	Unknown			
	Total			

Utilization Domain Technical Specifications

For AMP MY 2027

Overview

The use of standardized resource use measures in the AMP program aligns measurement across health plans. This allows for consistent identification of unwarranted variation in care delivery and provides an opportunity to ensure appropriate use of limited health care dollars in delivering quality care.

GUIDANCE UPDATES OCTOBER 2026 FOR AMP MY 2027

- Replaced references to "CC" with "condition category"; replaced references to "HCC" with "hierarchical condition category.
- Added guidance on Reporting Tables.

Measures

- All-Cause Readmissions (PCR).
- Emergency Department Utilization (EDU).
- Acute Hospital Utilization (AHU).

Measure Development and Testing

The Utilization measures were selected by a multi-stakeholder group of AMP Committee and IHA board members, based on resource use measures currently in use and their potential to improve efficient delivery of appropriate, quality care.

These measures are calculated by Cozeva from claims, encounter, eligibility, pharmacy, and appropriate use data submitted by participating health plans. POs and health plans do not self-report Utilization measures.

Calculating Measure Results

The information included in this section applies to **all** measures in the Utilization Domain. All measure calculations must align with the information below **and** with individual measure specifications.

Each measure is calculated in two ways:

1. **Results for each contracted health plan.** Rates are run on each health plan's data for each contracted PO. Each plan applies its actual costs for the PO to the utilization results provided, and shares savings generated by a PO's improvement over the previous year's performance.
2. **Results aggregated across all contracted health plans.** A PO's results for each measure are aggregated across all contracted plans. This lets POs understand how their utilization compares with that of other POs.

Observed-to-Expected Ratio

A common characteristic of the measures that include risk adjustment is the use of an "observed-to-expected" ratio (also known as an observed/expected [O/E] ratio). In all calculations, the observed rate (per the specifications) is divided by an expected rate, which considers the risk or illness burden of the PO's population. POs with higher-risk (i.e., sicker) members are expected to have higher utilization, and therefore, higher expected rates. Similarly, POs with lower risk scores are expected to have lower utilization and lower expected rates.

It is important to note that calculation of the expected rate is based on utilization and risk patterns in the AMP population, not on national or other external benchmarks. Specifically, to calculate the expected rate, a statistical model is developed that summarizes the relationship between observed rates and relative risk scores across the AMP population and provides an expected rate for a given level of risk. Because the distribution of observed rates by relative risk score varies by measure, the statistical model used to fit the data depends on the measure.

The O/E ratio compares the PO's observed rate to the expected rate and allows straightforward interpretation of how the PO's performance compared with the performance of the AMP population:

- An O/E ratio of 1.0 means the PO's rate was the same as expected, based on the risk of its population.
- An O/E ratio of 1.1 means the rate was 10% higher than expected.
- An O/E ratio of 0.9 means the rate was 10% lower than expected.

Reporting Tables

The reporting tables in the AMP Utilization measure specifications outline the data elements required for reporting.

Format The reporting tables in the measure specifications follow a standard format.

- *Metric*:
  - For single-metric measures, the metric describes the subject of the measure.
  - For multi-metric measures, the metrics describe the various concepts evaluated in the measure
  - In wide tables, the metric column may be shown above the table.
- *Stratification:* Only applies to measures that include one or more stratifications (e.g., age). For measures with multiple stratifications, the reporting instructions apply for all stratification combinations.
- *Data Element:* The data elements required for reporting.
- *Reporting Instructions:* These instructions specify how the data elements must be reported (e.g., for each metric, repeat per metric).

Example Data Elements for Reporting Table

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

AMP Utilization measures consist of one-to-many indicators for reporting. Each indicator corresponds to a unique combination of a metric and any stratifications (if applicable). For example, a measure with two metrics, three age stratifications and a total, and two gender stratifications and a total consist of twenty-four indicators.

All-Cause Readmissions (PCR)

MEASURE UPDATES OCTOBER 2026 FOR AMP MY 2027

- Added examples of facility types to the definition of *direct transfers.*
- Simplified hospital stay language in the *Numerator*.

MODIFICATIONS FROM HEDIS

- NCQA refers to this measure as "Plan All-Cause Readmissions."
- The 18–64 age band is not reported for Medicare Advantage.
- Expected rates are normalized by Cozeva to reflect the performance of the population being measured (e.g., Commercial HMO/POS, Medicare Advantage, or Medi-Cal Managed Care).
- The Skilled Nursing Care and SES Stratification for the Medicare Advantage product line is not reported.
- AMP only reports the total of all ages.

Measure title	All-Cause Readmissions	**Measure ID**	PCR
Description	For members 18 years of age and older, the risk-adjusted ratio of observed-to-expected unplanned acute readmissions (inpatient and observation stays) for any diagnosis within 30 days of an acute hospitalization (inpatient and observation stays). POs and health plans are not expected to run this measure. For reporting purposes, expected rates are normalized to reflect the performance of the population being measured (e.g., Commercial HMO/POS, Medicare Advantage, or Medi-Cal Managed Care). Cozeva will calculate the expected rates and normalize to reflect the performance of the population being measured.		
Measurement period	January 1–December 31.		
Clinical recommendation statement/ rationale	Readmission to the hospital within 30 days of discharge is frequently avoidable and can lead to adverse outcomes for patients. Any preventable hospitalization can have a negative impact on health outcomes, particularly for older adults and adults with multiple chronic conditions. Health risks associated with hospitalization include infection, adverse drug events, loss of function, isolation, lower quality of life and readmission. Refer to the HEDIS Measure Library & Historical Data measure web page for additional information about the clinical rationale.		
Citations	Medicare Payment Advisory Commission. "Data Book: Health Care Spending and the Medicare Program." Baltimore, MD: MedPAC, 2015. Available at http://medpac.gov/documents/reports/june-2015-report-to-the-congress-medicare-and-the-health-care-delivery-system.pdf?sfvrsn=0 Burke, R.E., E.A. Whitfield, D. Hittle, S.J. Min, C. Levy, A.V. Prochazka, E.A. Coleman, R. Schwartz, A.A. Ginde. 2016. "Hospital Readmission from Post-		

	Acute Care Facilities: Risk Factors, Timing, and Outcomes." *J Am Med Dir Assoc* 17(3):249–55. doi: 10.1016/j.jamda.2015.11.005 Hakkarainen, T.W., S. Arbabi, M.M. Willis, G.H. Davidson, D.R. Flum. 2016. "Outcomes of Patients Discharged to Skilled Nursing Facilities After Acute Care Hospitalizations." *Ann Surg* 263(2):280–5. doi:10.1097/SLA.0000000000001367.
Characteristics	
Scoring	Ratio.
Product lines	• Commercial HMO/POS. • Medicare Advantage. • Medi-Cal Managed Care.
Guidance	***Programming Guidance*** **Dual enrollment:** Members with dual Commercial HMO/POS and Medi-Cal Managed Care enrollment may only be reported in the Commercial HMO/POS product line. Members with dual Medi-Cal Managed Care and Medicare Advantage enrollment may only be reported in the Medicare Advantage product line. Dual enrollment is assessed after the continuous enrollment criteria are applied. To meet criteria for dual enrollment, members must have dual enrollment at the end of the continuous enrollment period. **Facilities:** The measure includes acute discharges from any type of facility (including behavioral health care facilities). ***Risk Adjustment Measure-Specific Guidance*** **Observation stays:** For observation stays (Observation Stay Value Set) that do not have a recorded admission or discharge date, set the admission date to the earliest date of service on the claim and set the discharge date to the last date of service on the claim. **Which services count?** • Use all paid, suspended, pending, and denied claims when applying risk adjustment comorbidity category determination and the hospice exclusion. • Do not include denied claims when identifying all other events (e.g., the IHS); only report claims the organization paid for or expects to pay for (i.e., claims incurred but not paid). **Supplemental data exceptions:** Supplemental data may only be used for the hospice exclusion. **Transfers:** • Treat transfers *between* institutions as separate admissions. • Base transfer reports *within* an institution on the type and level of services provided. • Report separate admissions when the transfer is between acute and nonacute levels of service or between mental health/substance use disorder treatment services and non-mental health/substance use disorder treatment services.

	• Count only one admission when the transfer takes place within the same service category, but to a different level of care (e.g., from intensive care to a lesser level of care; from a lesser level of care to intensive care). **Risk adjustment:** Organizations may not use risk assessment protocols to supplement diagnoses for calculation of the risk adjustment scores for these measures. The measurement model was developed and tested using only claims-based diagnoses; diagnoses from additional data sources would affect the validity of the models as they are currently implemented in the specification. ***General Rules*** **Data collection methodology:** Administrative. (Refer to *General Guideline: Data Collection Methods* for additional information.) **Date specificity:** Dates must be specific enough to determine the event occurred in the period being measured. **Other guidance**: The measure is based on episodes; therefore, it is possible for the denominator to include multiple events for the same member. **Improvement notation:** To interpret the rate as better or worse than expected, the rate must be calibrated. Organizations can calibrate rates by dividing individual organization rates or national percentiles by the national average rate. Organizations may be more successful at achieving fewer readmissions than expected, given the types of cases treated by the organization (calibrated rate with a value <1.0), or may be less successful (calibrated rate with a value >1.0).
Definitions	
Direct transfer	When the discharge date from the initial stay precedes the admission date to a subsequent stay by 1 calendar day or less. • *For example:* – A discharge on June 1, followed by a subsequent admission on June 1 or June 2, *is a direct transfer.* – A discharge on June 1, followed by a subsequent admission on June 3, *is not a direct transfer;* these are two distinct stays. – A discharge on June 1, followed by a subsequent admission on June 2 (with discharge on June 3), followed by a subsequent admission on June 4, *is a direct transfer.* Direct transfers may occur between different facilities, and between acute inpatient and observation, observation and acute inpatient or observation and observation.
IHS	Index hospital stay. An acute inpatient or observation stay with a discharge on or between January 1 and December 1 of the measurement period, as identified in the denominator.
Index admission date	The IHS admission date.
Index discharge date	The IHS discharge date. The index discharge date must occur on or between January 1 and December 1 of the measurement period.

Index readmission stay	An acute inpatient or observation stay for any diagnosis with an admission date within 30 days of a previous index discharge date.
Index readmission date	The admission date associated with the index readmission stay.
Planned hospital stay	A hospital stay is considered planned if it meets criteria as described in step 3 (exclusions) of the numerator.
Plan population	Members in the initial population prior to exclusion of outliers. The plan population is only used as a denominator for the outlier rate. Members must be 18 years and older as of the earliest index discharge date. The plan population is based on members, not on discharges. Count members only once in the plan population. Assign members to the product/product line in which they are enrolled at the start of the continuous enrollment period of their earliest IHS. If there is a gap at the beginning of this continuous enrollment period, assign the member to the product/product line in which they were enrolled as of their first enrollment segment during this continuous enrollment period.
Outlier	Members in Medi-Cal Managed Care and Medicare Advantage in the initial population with four or more IHS between January 1 and December 1 of the measurement period. Commercial HMO/POS members in the initial population with three or more IHS between January 1 and December 1 of the measurement period. When assigning outlier status, assign members to the product/product line in which they are enrolled at the start of the continuous enrollment period of their earliest IHS. If there is a gap at the beginning of the continuous enrollment period, assign members to the product/product line in which they were enrolled as of their first enrollment segment during the continuous enrollment period.
Nonoutlier	Commercial HMO/POS members in the initial population with two or fewer IHS between January 1 and December 1 of the measurement period. Medicare Advantage and Medi-Cal Managed Care members in the initial population with three or fewer IHS between January 1 and December 1 of the measurement period.
Initial population	*Measure item count:* Episode. *Attribution basis:* Enrollment. • *Benefits:* Medical. • *Continuous enrollment:* 365 days prior to the index discharge date through 30 days after the index discharge date in the health plan and PO (parent level). • *Allowable gap:* – *365 days to 1 day prior to the index discharge date:* No more than one gap of ≤45 days in the health plan or the PO (parent level, or, for eligible POs, subgroup level).

	– *Index discharge date and 30 days following the index discharge date:* No gaps in enrollment in the health plan or the PO (parent level, or, for eligible POs, subgroup level). *Ages:* • *Commercial HMO/POS and Medi-Cal Managed Care:* 18–64 years of age as of the index discharge date. • *Medicare Advantage:* 65 years of age and older as of the index discharge date. *Gender/Sex criteria:* • Administrative Gender of Female (AdministrativeGender code female). • Administrative Gender of Male (AdministrativeGender code male). *Exclusion:* **Members in hospice or using hospice services.** Members who use hospice services (Hospice Encounter Value Set; Hospice Intervention Value Set) or elect to use a hospice benefit any time during the measurement period. Organizations that use the Monthly Membership Detail Data File to identify these members must use only the run date of the file.
Denominator	**Acute inpatient or observation stay discharges.** **Step 1.** Identify all acute inpatient and observation stay discharges on or between January 1 and December 1 of the measurement period. To identify acute inpatient and observation stay discharges: 1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set) and observation stays (Observation Stay Value Set). 2. Exclude nonacute inpatient stays (Nonacute Inpatient Stay Value Set). 3. Identify the discharge date for the stay. Inpatient and observation stays where the discharge date from the first setting and the admission date to the second setting are 2 or more calendar days apart must be considered distinct stays. **Step 2.** For discharges with one or more direct transfers, use the last discharge. Using the discharges identified in step 1, identify direct transfers using the definition of “direct transfer.” Exclude the hospital stay if the direct transfer’s discharge date occurs after December 1 of the measurement period. **Step 3.** Exclude hospital stays where the index admission date is the same as the index discharge date. **Step 4.** Exclude hospital stays for any of the following reasons: • The member died during the stay. • A principal diagnosis of pregnancy (Pregnancy Value Set) or a condition originating in the perinatal period (Perinatal Conditions Value Set) on the discharge claim. ***Note:*** *For hospital stays where there was a direct transfer (identified in step 2), use the original stay and any direct transfer stays to identify exclusions in this step.* **Step 5.** Calculate continuous enrollment.

	Step 6. Remove hospital stays for outliers and report these members as outliers in Tables PCR-A-1/2 and PCR-A-3. ***Note:*** *Count discharges with one or more direct transfers (identified in step 2) as one discharge when identifying outliers.* **Step 7.** Assign each remaining acute inpatient or observation stay to an age and stratification category using the reporting instructions below.
Risk adjustment factors	***Risk Adjustment Determination*** For each IHS among nonoutliers, identify risk adjustment weights based on observation stay status at discharge, surgeries, discharge condition, COVID-19 discharge, comorbidity, age and gender. Weights are specific to product line (Commercial HMO/POS, Medicare Advantage 65+, Medi-Cal Managed Care). Refer to the reporting indicator column in the risk adjustment tables to ensure that weights are linked appropriately. **Observation stay:** Determine if the IHS at discharge was an observation stay (Observation Stay Value Set). For direct transfers, determine the hospitalization status using the last discharge. **Surgeries:** Determine if the member underwent surgery during the stay. Consider an IHS to include a surgery if at least one procedure code (Surgery Procedure Value Set) is present from any provider between the admission and discharge dates. **Discharge condition:** Assign a discharge condition category (CC) code or codes to the IHS based on its principal discharge diagnosis, using Table CC—Mapping. For direct transfers, use the principal discharge diagnosis from the last discharge. Exclude diagnoses that cannot be mapped to Table CC—Mapping. **COVID-19 discharge:** Assign a COVID-19 discharge code to the IHS if its principal discharge diagnosis was COVID-19 (ICD-10-CM code U07.1). For direct transfers, use the principal discharge diagnosis from the last discharge. **Comorbidities:** **Step 1.** Identify all diagnoses for encounters during the 365 days prior to and on the date of the index discharge date. Exclude the principal discharge diagnosis on the IHS. Include the following when identifying encounters: • Outpatient visits, ED visits, telephone visits, nonacute inpatient encounters and acute inpatient encounters (Outpatient, ED, Telephone, Acute Inpatient and Nonacute Inpatient Value Set) with a date of service in the period from 365 days before the index discharge date to (and including) the index discharge date. • Acute and nonacute inpatient discharges (Inpatient Stay Value Set) with a discharge date in the period from 365 days before the index discharge date to (and including) the index discharge date. **Step 2.** Assign each diagnosis to one or more comorbid CC category using Table CC—Mapping in the Risk Adjustment Shared Tables. If the code appears more than once in Table CC—Mapping, it is assigned to multiple CCs.

Exclude all diagnoses that cannot be assigned to a comorbid CC category. For denominator units with no qualifying diagnoses from face-to-face encounters, skip to *Risk Adjustment Calculation*.

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

Step 3. Determine hierarchical condition category (HCC) for each comorbid CC identified. Refer to Table HCC—Rank.

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

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

For comorbid CCs that do not match to Table HCC—Rank, use the comorbid CC as the HCC and assign a rank of 1. One comorbid CC can map to multiple HCCs; each HCC can have one or more comorbid CCs.

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

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

- *For example,* assume a denominator unit with the following comorbid CCs: CC-85, CC-17 and CC-19 (assume no other CCs).
  - CC-85 does not have a map to the ranking table and becomes HCC-85.
  - HCC-17 and HCC-19 are part of Diabetes Ranking Group 1. Because CC-17 is ranked higher than CC-19 in Ranking Group Diabetes 1, the comorbidity is assigned as HCC-17 for Ranking Group 1.

The final comorbidities for this denominator unit are HCC-17 and HCC-85.

Table HCC—Rank

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

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

Some combinations suggest a greater amount of risk when observed together.

- *For example,* when diabetes and CHF are present, an increased amount of risk is evident. Additional HCCs are selected to account for these relationships.

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

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

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

Table HCC—Comb

Comorbid HCC 1	Comorbid HCC 2	Comorbid HCC 3	HCC-Combination	HCC-Comb Description
HCC-17	HCC-85	NA	HCC-901	Combination: Diabetes and CHF
HCC-18	HCC-85	NA	HCC-901	Combination: Diabetes and CHF
HCC-19	HCC-85	NA	HCC-901	Combination: Diabetes and CHF

Risk adjustment

Risk Adjustment Calculation

For each IHS among nonoutliers, use the following steps to identify risk adjustment weights based on observation stays status at discharge, surgeries, discharge condition, COVID-19, comorbidity, age and gender.

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

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

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

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

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

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

Step 7. Sum all weights (observation stay, presence of surgery, principal discharge diagnosis, comorbidities, COVID-19 discharge, age and gender) associated with the IHS and use the formula below to calculate the estimated readmission risk for each IHS:

$$\text{Estimated Readmission Risk} = \frac{e^{(\sum \text{WeightsForIHS})}}{1+e^{(\sum \text{WeightsForIHS})}}$$

OR

Estimated Readmission Risk = [exp (sum of weights for IHS)] / [1 + exp (sum of weights for IHS)]

Note: *"Exp" refers to the exponential or antilog function.*

	Truncate the estimated readmission risk for each IHS to 10 decimal places. Do not truncate or round in previous steps. **Step 8.** Calculate the count of expected readmissions for each age and stratification category. The count of expected readmissions is the sum of the estimated readmission risk calculated in step 7 for each IHS in each age and stratification category. $$Count\ of\ Expected\ Readmissions = \sum (\text{Estimated Readmission Risk})$$ **Step 9.** Use the formula below and the estimated readmission risk calculated in step 7 to calculate the variance for each IHS. Variance = Estimated Readmission Risk x (1 – Estimated Readmission Risk) Truncate the variance *for each IHS* to 10 decimal places. • *For example*: If the estimated readmission risk is 0.1518450741 for an IHS, then the variance for this IHS is 0.1518450741 x 0.8481549259 = 0.1287881475. ***Note:*** *Organizations must sum the variances for each stratification and age when populating the Variance cells in the reporting tables. When reporting, round the variance to 4 decimal places using the .5 rule.*
Numerator	**At least one acute readmission for any diagnosis within 30 days of the index discharge date.** **Step 1.** Identify all acute inpatient and observation stays with an admission date on or between January 3 and December 31 of the measurement period: 1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set) and observation stays (Observation Stay Value Set). 2. Exclude nonacute inpatient stays (Nonacute Inpatient Stay Value Set). 3. Identify the admission date for the stay. **Step 2.** Using the stays identified in step 1, identify direct transfers between acute inpatient and observation using the definition of direct transfer. **Step 3.** Exclude stays with any of the following criteria on the discharge claim: • A principal diagnosis of pregnancy (Pregnancy Value Set) or a condition originating in the perinatal period (Perinatal Conditions Value Set). • A planned stay using any of the following: – A principal diagnosis of maintenance chemotherapy (Chemotherapy Encounter Value Set). – A principal diagnosis of rehabilitation (Rehabilitation Value Set). – An organ transplant (Kidney Transplant Value Set, Bone Marrow Transplant Value Set, Organ Transplant Other Than Kidney Value Set, Introduction of Autologous Pancreatic Cells Value Set). – A potentially planned procedure (Potentially Planned Procedures Value Set) without a principal acute diagnosis (Acute Condition Value Set). ***Note:*** *For hospital stays where there was a direct transfer (identified in step 2), use the original stay and any direct transfer stays to identify exclusions in this step.*

	Step 4. For each IHS identified in the denominator, determine if any of the stays identified in the numerator have an admission date within 30 days after the index discharge date. ***Note:*** • *Count each hospital stay only once toward the numerator for the last denominator event.* • *If a single numerator event meets criteria for multiple denominator events, only count the last denominator event.* For example, *consider the following events:* – *Acute inpatient stay 1: May 1–10.* – *Acute inpatient stay 2: May 15–25 (principal diagnosis of maintenance chemotherapy).* – *Acute inpatient stay 3: May 30–June 5.* *All three acute inpatient stays are included as denominator events. Stay 2 is excluded from the numerator because it is a planned hospitalization. Stay 3 is within 30 days of stay 1 and stay 2. Count stay 3 as a numerator event only toward the last denominator event (stay 2, May 15–25).*
Data element tables	***Reporting:*** **Number of members in plan population** **Step 1.** Determine the member's age as of the earliest index discharge date. **Step 2.** Report the count of members in the plan population for each age group as the MemberCount. ***Reporting:*** **Number of outliers** **Step 1.** Determine the member's age as of the earliest index discharge date. **Step 2.** Report the count of outlier members for each age group as the OutlierMemberCount. ***Calculated:*** **Outlier rate** The number of outlier members (OutlierMemberCount) divided by the number of members in the plan population (MemberCount), displayed as a permillage (multiplied by 1,000), for each age group and totals. Calculated as the OutlierRate. ***Reporting:*** **Denominator** Count the number of IHS among nonoutlier members for each age group. Report these values as the denominator. ***Reporting:*** **Numerator** Count the number of observed IHS among nonoutlier members with a readmission within 30 days of discharge for each age group and report these values as the ObservedCount. ***Calculated:*** **Observed readmission rate** The count of observed 30-day readmissions (ObservedCount) divided by the count of index stays (Denominator) for each age group and totals. Calculated as the ObservedRate. ***Reporting:*** **Count of expected 30-day readmissions** **Step 1.** Calculate the count of expected readmissions among nonoutliers for each age group.

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

Calculated: **Expected readmissions rate**
The count of expected 30-day readmissions (ExpectedCount) divided by the count of index stays (Denominator) for each age group and totals. Calculated as the ExpectedRate.

Reporting**: Variance**

Step 1. Calculate the total (sum) variance (*Risk Adjustment Calculation*, step 9) for each age group.

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

Calculated: **O/E ratio**
The count of observed 30-day readmissions (ObservedCount) divided by the count of expected 30-day readmissions (ExpectedCount) for each age group and totals. Calculated as the OE.

Table PCR-A-1/2: Data Element for All-Cause Readmissions (Medi-Cal Managed Care, Commercial HMO/POS)

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

Table PCR-A-3: Data Elements for All-Cause Readmissions (Medicare Advantage)

Metric	Age	Data Element	Reporting Instructions
AllCauseReadmissions	65-74	MemberCount	For each Stratification
	75-84	OutlierMemberCount	For each Stratification
	85+	OutlierRate	OutlierMemberCount / MemberCount (Permille)
	65+	Denominator	For each Stratification
		ObservedCount	For each Stratification
		ObservedRate	ObservedCount / Denominator (Percent)
		ExpectedCount	For each Stratification
		ExpectedRate	ExpectedCount / Denominator (Percent)
		CountVariance	For each Stratification
		OE	ObservedCount / ExpectedCount

Emergency Department Utilization (EDU)

MEASURE UPDATES OCTOBER 2026 FOR AMP MY 2027

- Added the Medi-Cal Managed Care product line for testing.

MODIFICATIONS FROM HEDIS

- Expected rates are normalized by Cozeva to reflect the performance of the population being measured (e.g., Commercial HMO/POS, Medi-Cal Managed Care).
- AMP only reports the total of all ages.

Measure title	Emergency Department Utilization	**Measure ID**	EDU
Description	For members 18 years of age and older, the risk-adjusted ratio of observed-to-expected emergency department (ED) visits during the measurement period. For reporting purposes, expected rates are normalized to reflect the performance of the population being measured (e.g., Commercial HMO/POS, Medi-Cal Managed Care). Cozeva will calculate the expected rates and normalize to reflect the performance of the population being measured. ***Note:*** *Cozeva will run this measure for MY 2027. Health plans and POs are not expected to report it.*		
Measurement period	January 1–December 31.		
Clinical recommendation statement/ rationale	Each year, approximately 1 out of 5 U.S. adults uses the ED for health care, and utilization rates have trended upward in recent years. Studies have estimated that up to 60% of all ED visits are potentially preventable or nonurgent, leading to overcrowding, increased wait times and reduction in the ability of hospital staff to provide efficient, quality care to patients with truly emergent conditions. To reduce avoidable ED visits, payers can provide appropriate disease management services, access to primary care clinics and care coordination. Refer to the HEDIS Measure Library & Historical Data measure web page for additional information about the clinical rationale.		
Citations	Gindi, R.M., L.I. Black, & R.A. Cohen. 2016. “Reasons for Emergency Room Use among U.S. Adults Aged 18–64: National Health Interview Survey, 2013–2014.” National Health Statistics Reports; No 90. Hyattsville, MD: National Center for Health Statistics. Sun, R., Z. Karaca, & S. Wong. 2018. “Trends in Hospital Emergency Department Visits by Age and Payer, 2006–2015.” HCUP Statistical Brief #238. Agency for Healthcare Research and Quality: Rockville, MD. https://www.hcup-us.ahrq.gov/reports/statbriefs/sb238-Emergency-Department-Age-Payer-2006-2015.pdf		

	Hu, T., K. Mortensen, & J. Chen. 2018. "Medicaid Managed Care in Florida and Racial and Ethnic Disparities in Preventable Emergency Department Visits." *Medical Care* 56: 477–83. Johnson, P.J., N. Ghildayal, A.C. Ward, B.C. Westgard, L.L. Boland, & J.S. Hokanson. 2012. "Disparities in Potentially Avoidable Emergency Department (ED) Care: ED Visits for Ambulatory Care Sensitive Conditions." *Medical Care* 50(12):1020–8.
Characteristics	
Scoring	Ratio.
Product lines	• Commercial HMO/POS. • Medi-Cal Managed Care (testing).
Guidance	***Programming Guidance*** **Dual enrollment:** Members with dual Commercial HMO/POS and Medi-Cal Managed Care enrollment may only be reported in the Commercial HMO/POS product line. Dual enrollment is assessed after the continuous enrollment criteria are applied. To meet criteria for dual enrollment, members must have dual enrollment at the end of the continuous enrollment period. ***Risk Adjustment Measure Specific Guidance*** **Observation stays:** For observation stays (Observation Stay Value Set) that do not have a recorded admission or discharge date, set the admission date to the earliest date of service on the claim and set the discharge date to the last date of service on the claim. **Which services count?** • Use all paid, suspended, pending and denied claims when applying risk adjustment comorbidity category determination and the hospice exclusion. • Do not include denied claims when identifying all other events (e.g., observed events); only report claims the organization paid for or expects to pay for (i.e., claims incurred but not paid), with the exception below. • When confirming that an ED visit does not result in an inpatient or observation stay, all inpatient and observation stays must be considered, regardless of payment status (paid, suspended, pending, denied). – *For example,* if an ED visit is paid but an inpatient stay is denied, the ED visit resulted in an inpatient stay and is not included in the Emergency Department Utilization measure when identifying observed ED visits. **Supplemental data exceptions:** Supplemental data may only be used for the hospice exclusion. **Transfers:** • Treat transfers *between* institutions as separate admissions. • Base transfer reports *within* an institution on the type and level of services provided. • Report separate admissions when the transfer is between acute and nonacute levels of service or between mental health/substance use disorder treatment services and non-mental health/substance use disorder treatment services.

	• Count only one admission when the transfer takes place within the same service category, but to a different level of care (e.g., from intensive care to a lesser level of care; from a lesser level of care to intensive care). **Risk adjustment:** Organizations may not use risk assessment protocols to supplement diagnoses for calculation of the risk adjustment scores for these measures. The measurement model was developed and tested using only claims-based diagnoses; diagnoses from additional data sources would affect the validity of the models as they are currently implemented in the specification. ***General Rules*** **Data collection methodology:** Administrative. (Refer to *General Guideline: Data Collection Methods* for additional information.) **Date specificity:** Dates must be specific enough to determine the event occurred in the period being measured. **Improvement notation:** To interpret the ratio as better or worse than expected, the ratio must be calibrated. Organizations can calibrate ratios by dividing individual organization ratios or national percentiles by the national average ratio. Organizations may be more successful at achieving fewer ED visits than expected, given the types of cases treated by the organization (calibrated ratio with a value <1.0), or may be less successful (calibrated ratio with a value >1.0).
Definitions	
Outlier	Commercial HMO/POS members 18 years of age and older with 4 or more ED visits in the measurement period. Medi-Cal Managed Care members 18-64 years of age with nine or more ED visits in the measurement period.
Nonoutlier	Commercial HMO/POS members 18 years of age and older with three or fewer ED visits during the measurement period. Medi-Cal Managed Care members 18-64 years of age with eight or fewer ED visits during the measurement period.
PPV	Predicted probability of a visit. The predicted probability of a member having an ED visit in the measurement period.
PUCV	Predicted unconditional count of visits. The unconditional count of ED visits during the measurement period.
Initial population	*Measure item count:* Member. *Attribution basis:* Enrollment. • *Benefits:* Medical. • *Continuous enrollment:* The measurement period and the year prior to the measurement period in the health plan and PO (parent level). • *Allowable gap:* No more than one gap of ≤45 days during each year of continuous enrollment. No gaps in enrollment in the health plan or the PO (parent level, or, for eligible POs, subgroup level) on the last day of the measurement period.

	Ages: • *Commercial HMO/POS:* 18 years of age and older as of the last day of the measurement period. • *Medi-Cal Managed Care:* 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). *Exclusion:* **Episodes for members in hospice or using hospice services.** Members who use hospice services (Hospice Encounter Value Set; Hospice Intervention Value Set) or elect to use a hospice benefit any time during the measurement period. Organizations that use the Monthly Membership Detail Data File to identify these members must use only the run date of the file.
Measure observation	**Calculation of observed events** **Step 1.** Count each visit to an ED once, regardless of the intensity or duration of the visit. Count multiple ED visits on the same date of service as one visit. Identify all ED visits during the measurement period using either of the following: • An ED Visit (ED Value Set). • A procedure code (ED Procedure Code Value Set) ***with*** an ED place of service code (POS code 23). Do not include ED visits that result in an inpatient stay (Inpatient Stay Value Set) or an observation stay (Observation Stay Value Set). **Step 2.** Exclude encounters with any of the following: • A principal diagnosis of mental health or substance use disorder (Mental and Behavioral Disorders Value Set). • Psychiatry (Psychiatry Value Set). • Electroconvulsive therapy (Electroconvulsive Therapy Value Set). **Step 3.** For the remaining ED visits, calculate the number of visits per member and remove visits for outlier members. Report these members as outliers. **Step 4.** Calculate the total using all ED visits identified after completing steps 1–3. Assign each remaining ED visit to an age and stratification category using the reporting instructions below.

Risk adjustment factors	***Risk Adjustment Determination*** For each member among nonoutliers, identify risk adjustment weights based on comorbidity, age and gender. Weights are specific to product line (Commercial HMO/POS, Medi-Cal Managed Care). Refer to the reporting indicator column in the risk adjustment tables to ensure that weights are linked appropriately. **Comorbidities:** **Step 1.** Identify all diagnoses for encounters during the year prior to the measurement period. Include the following when identifying encounters: • Outpatient visits, ED visits, telephone visits, nonacute inpatient encounters and acute inpatient encounters (Outpatient, ED, Telephone, Acute Inpatient and Nonacute Inpatient Value Set) with a date of service during the year prior to the measurement period. • Acute and nonacute inpatient discharges (Inpatient Stay Value Set) with a discharge date during the year prior to the measurement period. **Step 2.** Assign each diagnosis to one or more comorbid condition (CC) category using Table CC—Mapping in the Risk Adjustment Shared Tables. If the code appears more than once in Table CC—Mapping, it is assigned to multiple CCs. Exclude all diagnoses that cannot be assigned to a comorbid CC category. For members with no qualifying diagnoses from face-to-face encounters, skip to *Risk Adjustment Calculation*. All digits must match exactly when mapping diagnosis codes to the comorbid CCs. ***Step 3.*** Determine the hierarchical condition category (HCC) for each comorbid CC identified. Refer to Table HCC—Rank. For each member's comorbid CC list, match the comorbid CC code to the comorbid CC code in the table, and assign: • The ranking group. • The rank. • The HCC. For comorbid CCs that do not match to Table HCC—Rank, use the comorbid CC as the HCC and assign a rank of 1. One comorbid CC can map to multiple HCCs; each HCC can have one or more comorbid CCs. **Step 4.** Assess each ranking group separately and select only the highest ranked HCC in each ranking group using the "Rank" column (1 is the highest rank possible). Drop all other HCCs in each ranking group, and de-duplicate the HCC list if necessary. • *For example,* assume a member with the following comorbid CCs: CC-85, CC-17 and CC-19 (assume no other CCs). – CC-85 does not have a map to the ranking table and becomes HCC-85.

– HCC-17 and HCC-19 are part of Diabetes Ranking Group 1. Because CC-17 is ranked higher than CC-19 in Ranking Group Diabetes 1, the comorbidity is assigned as HCC-17 for Ranking Group 1.

The final comorbidities for this member are HCC-17 and HCC-85.

Table HCC—Rank

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

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

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

Compare each member's list of unique HCCs to those in the *Comorbid HCC* columns in Table HCC—Comb and assign any additional HCCs.

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

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

Table HCC—Comb

Comorbid HCC 1	Comorbid HCC 2	Comorbid HCC 3	HCC-Combination	HCC-Comb Description
HCC-17	HCC-85	NA	HCC-901	Combination: Diabetes and CHF
HCC-18	HCC-85	NA	HCC-901	Combination: Diabetes and CHF
HCC-19	HCC-85	NA	HCC-901	Combination: Diabetes and CHF

Risk adjustment

Risk Adjustment Calculation

Calculation of risk-adjusted outcomes (counts of ED visits) uses predetermined risk weights generated by two separate regression models. Weights from each model are combined to predict how many visits each member might have during the measurement period.

For each nonoutlier member in the initial population, assign PPV risk weights.

Step 1. For each member with a comorbidity HCC Category, link the PPV weights.

Step 2. Link the age-gender PPV weights for each member.

Step 3. Sum all PPV weights associated with the member (comorbidities, age and gender).

Step 4. Calculate the predicted probability of each member having at least one visit based on the sum of the weights for each member using the formula below.

$$\text{PPV} = \frac{e^{(\sum \text{PPV WeightsForEachMember})}}{1+e^{(\sum \text{PPV WeightsForEachMember})}}$$

Truncate the final PPV for each member to 10 decimal places. Do not truncate or round in previous steps.

For each member in the initial population, assign PUCV risk weights.

Step 1. For each member with a comorbidity HCC, link the PUCV weights. If a member does not have any comorbidities to which weights can be linked, assign a weight of 1.

Step 2. Link the age-gender PUCV weights for each member.

Step 3. Calculate the predicted unconditional count of visits in the measurement period by multiplying all PUCV weights (comorbidities, age and gender). Use the following formula:

PUCV = Age/Gender Weight * HCC Weight

Note: *Multiply by each HCC associated with the member. For example, assume a member with HCC-2, HCC-10, HCC-47. The formula would be:*

*PUCV = Age/gender Weight * HCC-2 * HCC-10 * HCC-47*

Truncate the final PUCV for each member to 10 decimal places. Do not truncate or round in previous steps.

Expected count of ED visits. Calculate the final member-level expected count of ED visits for each category using the formula below:

Expected Count of ED Visits = PPV x PUCV

Round the member-level results to 4 decimal places using the .5 rule and sum over all members in the category.

Step 4. Use the formula below to calculate the covariance of the predicted outcomes for each category. For categories with a single member (n_c=1), set the covariance to zero. Do not round the covariance before using it in step 5.

$$COV_c = \frac{\sum_{m=1}^{n_c}(PPV_m - mean(PPV)_c) \times (PUCV_m - mean(PUCV)_c)}{n_c - 1}$$

Where:

c	denotes an individual category
n_c	is the number of members in the category indicated by c
m	is an individual member within the category indicated by c
PPV_m	is the truncated PPV for the member denoted by m
$mean(PPV)_c$	is the unrounded and untruncated mean PPV in the category indicated by c

	$mean(PUCV)_c$ is the unrounded and untruncated mean PUCV $PUCV_m$ is the truncated PUCV for the member denoted by m in the category indicated by c **Step 5.** Once the covariance between PPV and PUCV for a given category is calculated, it can be used as indicated in the formula below to calculate the variance for that category. $$Variance_c = \sum_{m=1}^{n_c} (PPV_m \times PUCV_m)^2 \times \left(1 + (1 - PPV_m)^2 + \left(\frac{2 \times COV_c}{PPV_m \times PUCV_m}\right)\right)$$ Where: c denotes an individual category n_c is the number of members in the category indicated by c m is an individual member within the category indicated by c PPV_m is the truncated PPV for the member denoted by m $PUCV_m$ is the truncated PUCV for the member denoted by m n_c is the number of members in the category indicated by c Round the variance for reporting to 4 decimal places using the .5 rule.
Data element tables	***Reporting:*** **Number of nonoutliers** The number of nonoutlier members for each age group, reported as the NonOutlierMemberCount. ***Reporting:*** **Number of outliers** The number of outlier members for each age group, reported as the OutlierMemberCount. ***Calculated:*** **Number of members in the initial population** The number of members in the initial population (including outliers) for each age group and totals. Calculated as the MemberCount. ***Calculated:*** **Outlier rate** The number of outlier members (OutlierMemberCount) divided by the number of members in the initial population (MemberCount), multiplied by 1,000 for each age group and totals. Calculated as the OutlierRate. ***Reporting:*** **Number of observed events among nonoutlier members** The number of observed ED visits for each age group, reported as the ObservedCount. ***Calculated:*** **Observed visits per 1,000 nonoutlier members** The number of observed ED visits (ObservedCount) divided by the number of nonoutlier members in the initial population (NonOutlierMemberCount), multiplied by 1,000 for each age group and totals. Calculated as the ObservedRate. ***Reporting*****: Number of expected events among nonoutlier members** The number of expected ED visits for each age group, reported as the ExpectedCount.

***Calculated*: Expected visits per 1,000 nonoutlier members**
The number of expected ED visits (ExpectedCount) divided by the number of nonoutlier members in the initial population (NonOutlierMemberCount), multiplied by 1,000 for each age group and totals. Calculated as the ExpectedRate.

***Reporting*: Variance among nonoutlier members**
The variance (*Risk Adjustment Calculation,* PUCV, step 5) for each age group, reported as the CountVariance.

***Calculated:* O/E ratio**
The number of observed events among nonoutlier members (ObservedCount) divided by the number of expected events among nonoutlier members (ExpectedCount) for each age group and totals. Calculated as the OE.

Table EDU-1: Data Elements for Emergency Department Utilization (Medi-Cal Managed Care)

Metric	Age	Data Element	Reporting Instructions
EmergencyDepartmentUtilization	18-44	NonOutlierMemberCount	For each Stratification
	45-54	OutlierMemberCount	For each Stratification
	55-64	MemberCount	NonOutlierMemberCount + OutlierMemberCount
	Total	OutlierRate	OutlierMemberCount / MemberCount (Permille)
		ObservedCount	For each Stratification
		ObservedRate	1000 * ObservedCount/ NonOutlierMemberCount
		ExpectedCount	For each Stratification
		ExpectedRate	1000 * ExpectedCount / NonOutlierMemberCount
		CountVariance	For each Stratification
		OE	ObservedCount / ExpectedCount

Table EDU-2/3: Data Elements for Emergency Department Utilization (Commercial HMO/POS)

Metric	Age	Data Element	Reporting Instructions
EmergencyDepartmentUtilization	18-44	NonOutlierMemberCount	For each Stratification
	45-54	OutlierMemberCount	For each Stratification
	55-64	MemberCount	NonOutlierMemberCount + OutlierMemberCount
	18-64	OutlierRate	OutlierMemberCount / MemberCount (Permille)
	65-74	ObservedCount	For each Stratification
	75-84	ObservedRate	1000 * ObservedCount/ NonOutlierMemberCount

		85+	ExpectedCount	For each Stratification
		65+	ExpectedRate	1000 * ExpectedCount / NonOutlierMemberCount
		Total	CountVariance	For each Stratification
			OE	ObservedCount / ExpectedCount

Acute Hospital Utilization (AHU)

MEASURE UPDATES OCTOBER 2026 FOR AMP MY 2027

- Revised step 3 of the *Denominator* to clarify exclusion of inpatient and observation stay discharges where the member died during the stay.

MODIFICATIONS FROM HEDIS

- Expected rates are normalized by Cozeva to reflect the performance of the population being measured (e.g., Commercial HMO/POS and Medi-Cal Managed Care).
- AMP only reports the total of all ages.

Measure title	Acute Hospital Utilization	**Measure ID**	AHU
Description	For members 18 years of age and older, the risk-adjusted ratio of observed-to-expected acute inpatient and observation stay discharges during the measurement period. For reporting purposes, expected rates are normalized to reflect the performance of the population being measured (e.g., Commercial HMO/POS and Medi-Cal Managed Care). Cozeva will calculate the expected rates and normalize to reflect the performance of the population being measured. ***Note:*** *Cozeva will run this measure for MY 2027. Health plans and POs are not expected to report it.*		
Measurement period	January 1–December 31.		
Clinical recommendation statement/ rationale	Hospitalizations put patients at risk of adverse events and are costly, accounting for about a third of all annual health care expenditures in the US. While not all acute hospitalizations can be avoided, studies have shown that payer-level interventions (e.g., proper care coordination and case management for patients with complex medical needs or multiple comorbid conditions) are effective at reducing overall hospital utilization. Refer to the HEDIS Measure Library & Historical Data measure web page for additional information about the clinical rationale.		
Citations	Covinsky, K.E., E. Pierluissi, & C.B. Johnston. 2011. "Hospitalization-Associated Disability." *JAMA: The Journal of the American Medical Association* 306(16), 1782–93. McDermott, K.W., A. Elixhauser, R. Sun. 2017. "Trends in Hospital Inpatient Stays in the United States, 2005–2014." HCUP Statistical Brief #225. Agency for Healthcare Research and Quality, Rockville, MD. www.hcup-us.ahrq.gov/reports/statbriefs/sb225-Inpatient-US-Stays-Trends.pdf Mkanta, W.N., N.R. Chumbler, K. Yang, R. Saigal, and M. Abdollahi. 2016. "Cost and Predictors of Hospitalizations for Ambulatory Care - Sensitive Conditions Among Medicaid Enrollees in Comprehensive Managed Care Plans." *Health Services Research and Managerial Epidemiology* 3, 2333392816670301.		

	Kaiser Family Foundation (KFF). (2019). *An Overview of Medicare.* https://www.kff.org/medicare/issue-brief/an-overview-of-medicare/
Characteristics	
Scoring	Ratio.
Product lines	• Commercial HMO/POS. • Medi-Cal Managed Care.
Guidance	***Programming Guidance*** **Dual enrollment:** Members with dual Commercial HMO/POS and Medi-Cal Managed Care enrollment may only be reported in the AMP Commercial HMO/POS product line. Dual enrollment is assessed after the continuous enrollment criteria are applied. To meet criteria for dual enrollment, members must have dual enrollment at the end of the continuous enrollment period. ***Risk Adjustment Measure Specific Guidance*** **Observation stays:** For observation stays (Observation Stay Value Set) that do not have a recorded admission or discharge date, set the admission date to the earliest date of service on the claim and set the discharge date to the last date of service on the claim. **Which services count?** • Use all paid, suspended, pending, and denied claims when applying risk adjustment comorbidity category determination and the hospice exclusion. • Do not include denied claims when identifying all other events (e.g., observed events); only report claims the organization paid for or expects to pay for (i.e., claims incurred but not paid). **Supplemental data exceptions:** Supplemental data may only be used for the hospice exclusion. **Transfers:** • Treat transfers *between* institutions as separate admissions. • Base transfer reports *within* an institution on the type and level of services provided. • Report separate admissions when the transfer is between acute and nonacute levels of service or between mental health/substance use disorder treatment services and non-mental health/substance use disorder treatment services. • Count only one admission when the transfer takes place within the same service category, but to a different level of care (e.g., from intensive care to a lesser level of care; from a lesser level of care to intensive care).

	Risk adjustment: Organizations may not use risk assessment protocols to supplement diagnoses for calculation of the risk adjustment scores for this measure. The measurement model was developed and tested using only claims-based diagnoses; diagnoses from additional data sources would affect the validity of the models as they are currently implemented in the specification. ***General Rules*** **Data collection methodology:** Administrative. (Refer to *General Guideline: Data Collection Methods* for additional information.) **Date specificity:** Dates must be specific enough to determine the event occurred in the period being measured. **Improvement notation:** To interpret the ratio as better or worse than expected, the ratio must be calibrated. Organizations can calibrate ratios by dividing individual organization ratios or national percentiles by the national average ratio. Organizations may be more successful at achieving fewer hospitalizations than expected, given the types of cases treated by the organization (calibrated ratio with a value <1.0), or may be less successful (calibrated ratio with a value >1.0).
Definitions	
Direct transfer	When the discharge date from the initial stay precedes the admission date to a subsequent stay by 1 calendar day or less. • *For example:* – A discharge on June 1, followed by a subsequent admission on June 1 or June 2, *is a direct transfer.* – A discharge on June 1, followed by a subsequent admission on June 3, *is not a direct transfer;* these are two distinct stays. – A discharge on June 1, followed by a subsequent admission on June 2 (with discharge on June 3), followed by a subsequent admission on June 4, *is a direct transfer.* Direct transfers may occur between different facilities, and between acute inpatient and observation.
Outlier	Commercial HMO/POS members with three or more inpatient or observation stay discharges during the measurement period. Medi-Cal Managed Care members with six or more inpatient or observation stay discharges during the measurement period.
Nonoutlier	Commercial HMO/POS members with two or fewer inpatient or observation stay discharges during the measurement period. Medi-Cal Managed Care members with five or fewer inpatient or observation stay discharges during the measurement period.
Planned hospital stay	A hospital stay is considered planned if it meets criteria in step 3 of the measure observation.
PPD	Predicted probability of discharge. The predicted probability of a member having any discharge in the measurement period.

PUCD	Predicted unconditional count of discharges. The predicted unconditional count of discharges for members during the measurement period.
Initial population	*Measure item count:* Member. *Attribution basis:* Enrollment. • *Benefits:* Medical. • *Continuous enrollment:* The measurement period and the year prior to the measurement period in the health plan and PO (parent level). • *Allowable gaps:* No more than one gap of ≤45 days during each year of continuous enrollment. No gaps in enrollment in the health plan or the PO (parent level, or, for eligible POs, subgroup level) on the last day of the measurement period. *Ages:* • *Commercial HMO/POS:* 18 years of age and older as of the last day of the measurement period. • *Medi-Cal Managed Care:* 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). *Exclusion:* **Members in hospice or using hospice services.** Members who use hospice services (Hospice Encounter Value Set; Hospice Intervention Value Set) or elect to use a hospice benefit any time during the measurement period. Organizations that use the Monthly Membership Detail Data File to identify these members must use only the run date of the file.
Measure observation	**Calculation of observed events** Use the following steps to identify and categorize acute inpatient and observation stay discharges. **Step 1.** Identify all acute inpatient and observation stay discharges during the measurement period. 1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set) and observation stays (Observation Stay Value Set). 2. Exclude nonacute inpatient stays (Nonacute Inpatient Stay Value Set). 3. Identify the discharge date for the stay. **Step 2.** For discharges with one or more direct transfers, use the last discharge. Using the discharges identified in step 1, identify direct transfers between acute inpatient and observation using the definition of direct transfer. **Step 3.** For the remaining acute inpatient and observation stay discharges, exclude inpatient and observation stay discharges with any of the following criteria: • A principal diagnosis of mental health or substance use disorder (Mental and Behavioral Disorders Value Set) on the discharge claim.

	• A principal diagnosis of live-born infant (Deliveries Infant Record Value Set) or maternity-related principal diagnosis (Maternity Diagnosis Value Set) on the discharge claim. • A maternity-related stay (Maternity Value Set) on the discharge claim. • A planned hospital stay using any of the following on the discharge claim: – A principal diagnosis of maintenance chemotherapy (Chemotherapy Encounter Value Set). – A principal diagnosis of rehabilitation (Rehabilitation Value Set). – An organ transplant (Kidney Transplant Value Set, Bone Marrow Transplant Value Set, Organ Transplant Other Than Kidney Value Set, Introduction of Autologous Pancreatic Cells Value Set). – A potentially planned procedure (Potentially Planned Procedures Value Set) without a principal acute diagnosis (Acute Condition Value Set). • The member died during the stay. ***Note:*** *For hospital stays where there was a direct transfer (identified in step 2), use the original stay and any direct transfer stays to identify exclusions in this step.* **Step 4.** Remove discharges for outliers and report these members as outliers. Count discharges with one or more direct transfers (identified in step 2) as one discharge when identifying outliers. **Step 5.** Calculate the total using all discharges identified after completing steps 1–4.
Risk adjustment factors	***Risk Adjustment Determination*** For each discharge among nonoutliers, identify risk adjustment weights based on comorbidity, age and gender. Weights are specific to product line (Commercial HMO/POS, Medi-Cal Managed Care). Refer to the reporting indicator column in the risk adjustment tables to ensure that weights are linked appropriately. **Comorbidities:** **Step 1.** Identify all diagnoses for encounters during the year prior to the measurement period. Include the following when identifying encounters: • Outpatient visits, ED visits, telephone visits, nonacute inpatient encounters and acute inpatient encounters (Outpatient, ED, Telephone, Acute Inpatient and Nonacute Inpatient Value Set) with a date of service during the year prior to the measurement period. • Acute and nonacute inpatient discharges (Inpatient Stay Value Set) with a discharge date during the year prior to the measurement period. **Step 2.** Assign each diagnosis to one or more comorbid condition (CC) category using Table CC—Mapping in the Risk Adjustment Shared Tables. If the code appears more than once in Table CC—Mapping, it is assigned to multiple CCs. Exclude all diagnoses that cannot be assigned to a comorbid CC category. For members with no qualifying diagnoses from face-to-face encounters, skip to Risk Adjustment Calculation.

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

Step 3. Determine the hierarchical condition category (HCC) for each comorbid CC identified. Refer to Table HCC—Rank.

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

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

For comorbid CCs that do not match to Table HCC—Rank, use the comorbid CC as the HCC and assign a rank of 1. One comorbid CC can map to multiple HCCs; each HCC can have one or more comorbid CCs.

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

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

- *For example,* assume a member with the following comorbid CCs: CC-85, CC-17, and CC-19 (assume no other CCs).
  - CC-85 does not have a map to the ranking table and becomes HCC-85.
  - HCC-17 and HCC-19 are part of Diabetes Ranking Group 1. Because CC-17 is ranked higher than CC-19 in Ranking Group Diabetes 1, the comorbidity is assigned as HCC-17 for Ranking Group 1.

  The final comorbidities for this member are HCC-17 and HCC-85.

Table HCC—Rank

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

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

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

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

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

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

Table HCC—Comb

Comorbid HCC 1	Comorbid HCC 2	Comorbid HCC 3	HCC-Combination	HCC-Comb Description
HCC-17	HCC-85	NA	HCC-901	Combination: Diabetes and CHF
HCC-18	HCC-85	NA	HCC-901	Combination: Diabetes and CHF
HCC-19	HCC-85	NA	HCC-901	Combination: Diabetes and CHF

Risk adjustment

Risk Adjustment Calculation

Calculation of risk-adjusted outcomes (counts of discharges) uses predetermined risk weights generated by two separate regression models. Weights from each model are combined to predict how many visits each member might have during the measurement period.

For each nonoutlier member in the initial population, assign PPD risk weights. Calculate the PPD.

Step 1. For each member with a comorbidity HCC, link the PPD weights.

Step 2. Link the age-gender PPD weights for each member.

Step 3. Sum all PPD weights (comorbidities, age and gender) associated with the member.

Step 4. Calculate the predicted probability of having at least one discharge in the measurement period based on the sum of the weights for each member using the formula below.

$$\text{PPD} = \frac{e^{(\sum \text{PPD WeightsForEachMember})}}{1+e^{(\sum \text{PPD WeightsForEachMember})}}$$

Truncate the final PPD f*or each member* to 10 decimal places. Do not truncate or round in previous steps.

For each nonoutlier member in the initial population, assign PUCD risk weights.

Step 1. For each member with a comorbidity HCC Category, link the PUCD weights. If a member does not have any comorbidities to which a weight could be linked, assign a weight of 1.

Step 2. Link the age-gender PUCD weights for each member.

Step 3. Calculate the predicted unconditional count of discharges in the measurement period by multiplying all PUCD weights (comorbidities, age and gender) associated with the member. Use the following formula:

PUCD = Age/Gender Weight * HCC Weight

Note: *Multiply by each HCC associated with the member. For example, assume a member with HCC-2, HCC-10, HCC-47. The formula would be:*

*PUCD = Age/Gender Weight * HCC-2 * HCC-10 * HCC-47*

Truncate the final PUCD *for each member* to 10 decimal places. Do not truncate or round in previous steps.

Expected count of discharges. Calculate the final member-level expected count of discharges using the formula below.

Expected Count of Discharges = PPD x PUCD

Round the member-level results to 4 decimal places using the .5 rule and sum over all members in the category.

Step 4. Use the formula below to calculate the covariance of the predicted outcomes for each category. For categories with a single member (n_c=1), set the covariance to zero. Do not round the covariance before using it in step 5.

$$COV_c = \frac{\sum_{m=1}^{n_c}(PPD_m - mean(PPD)_c) \times (PUCD_m - mean(PUCD)_c)}{n_c - 1}$$

Where:

c	denotes an individual category
n_c	is the number of members in the category indicated by c
m	is an individual member within the category indicated by c
PPD_m	is the truncated PPD for the member denoted by m
$mean(PPD)_c$	is the unrounded and untruncated mean PPD in the category indicated by c
$PUCD_m$	is the truncated PUCD for the member denoted by m
$mean(PUCD)_c$	is the unrounded and untruncated mean PUCD in the category indicated by c

Step 5. Once the covariance between PPD and PUCD for a given category is calculated, it can be used as indicated in the formula below to calculate the variance for that category.

$$Variance_c = \sum_{m=1}^{n_c}(PPD_m \times PUCD_m)^2 \times \left(1 + (1 - PPD_m)^2 + \left(\frac{2 \times COV_c}{PPD_m \times PUCD_m}\right)\right)$$

Where:

c	denotes an individual category
n_c	is the number of members in the category indicated by c
m	is an individual member within the category indicated by c
PPD_m	is the truncated PPD for the member denoted by m
$PUCD_m$	is the truncated PUCD for the member denoted by m

Round the variance for reporting to 4 decimal places using the .5 rule.

Data element tables	***Reporting:* Number of nonoutliers** The number of nonoutlier members for each age group, reported as the NonOutlierMemberCount. ***Reporting:* Number of outliers** The number of outlier members for each age group, reported as the OutlierMemberCount. ***Calculated:* Number of members in the initial population** The number of members in the initial population (including outliers) for each age group and totals. Calculated as the MemberCount. ***Calculated:* Outlier rate** The number of outlier members (OutlierMemberCount) divided by the number of members in the initial population (MemberCount) multiplied by 1,000 for each age group and totals. Calculated as the OutlierRate. ***Reporting:* Number of observed events among nonoutlier members** The number of observed discharges within each age group, reported as the ObservedCount. ***Calculated:* Observed discharges per 1,000 nonoutlier members** The number of observed discharges (ObservedCount) divided by the number of nonoutlier members in the initial population (NonOutlierMemberCount), multiplied by 1,000 within each age group and totals. Calculated as the ObservedRate. ***Reporting:* Number of expected events among nonoutlier members** The number of expected discharges within each age group, reported as the ExpectedCount. ***Calculated:* Expected discharges per 1,000 nonoutlier members** The number of expected discharges (ExpectedCount) divided by the number of nonoutlier members in the initial population (NonOutlierMemberCount), multiplied by 1,000 within each age group and totals. Calculated as the ExpectedRate. ***Reporting:* Variance among nonoutlier members** The variance (*Risk Adjustment Calculation*, PUCD, step 5) within each age group, reported as the CountVariance. ***Calculated:* O/E ratio** The number of observed discharges among nonoutlier members (ObservedCount) divided by the number of expected discharges among nonoutlier members (ExpectedCount) for each age group and totals. Calculated as the OE.

Table AHU-1: Data Elements for Acute Hospital Utilization: Medi-Cal Managed Care

Metric	Age	Data Element	Reporting Instructions
AcuteHospitalUtilization	18-21	NonOutlierMemberCount	For each Stratification
	22-34	OutlierMemberCount	For each Stratification
	35-44	MemberCount	NonOutlierMemberCount + OutlierMemberCount
	18-44	OutlierRate	OutlierMemberCount / MemberCount (Permille)
	45-54	ObservedCount	For each Stratification
	55-64	ObservedRate	1000 * ObservedCount / NonOutlierMemberCount
	18-64	ExpectedCount	For each Stratification
		ExpectedRate	1000 * ExpectedCount / NonOutlierMemberCount
		CountVariance	For each Stratification
		OE	ObservedCount / ExpectedCount

Table AHU-2/3: Data Elements for Acute Hospital Utilization: Commercial HMO/POS

Metric	Age	Data Element	Reporting Instructions
AcuteHospitalUtilization	18-44	NonOutlierMemberCount	For each Stratification
	45-54	OutlierMemberCount	For each Stratification
	55-64	MemberCount	NonOutlierMemberCount + OutlierMemberCount
	18-64	OutlierRate	OutlierMemberCount / MemberCount (Permille)
	65-74	ObservedCount	For each Stratification
	75-84	ObservedRate	1000 * ObservedCount / NonOutlierMemberCount
	85+	ExpectedCount	For each Stratification
	65+	ExpectedRate	1000 * ExpectedCount / NonOutlierMemberCount
	Total	CountVariance	For each Stratification
		OE	ObservedCount / ExpectedCount

Cost Domain
Technical Specifications

For AMP MY 2027

Total Cost of Care (TCOC)

MEASURE UPDATES OCTOBER 2026 FOR AMP MY 2027

- Two versions of TCOC will be calculated by Cozeva: one using the DSG Cost file submitted by plans and the other using allowed amounts in claims submitted by plans.
- Updated the *Description*.
- Expanded TCOC inclusion categories to align with OHCA non-claims payment categories.
- Updated the Risk Adjust Determination steps.

MODIFICATIONS FROM HEALTHPARTNERS

- AMP includes members 65 and over for Medicare Advantage.
- AMP uses a $250,000 truncation level amount; HealthPartners uses a $125,000 amount.
- AMP applies a geographic adjustment in addition to risk adjustment.
- AMP includes capitated costs in the measure.
- AMP includes exclusion criteria for select services and payments.

Description

The average geography- and risk-adjusted costs per member per month (PMPM) for the care provided to a PO's members. Reported indicators include:

- Observed costs PMPM.
- Risk-adjusted costs PMPM.
- Geography and risk-adjusted costs PMPM.

The endorsed specifications are available here and have been translated to AMP specifications below with permission from HealthPartners. This measure will only be generated by Cozeva from data submitted by health plans and will not be reported by POs. Participating health plans provide member-level summarized payments to Cozeva, along with member eligibility, claims, and encounter detail, for each contracted PO. Cozeva will generate two versions of TCOC: one using the DSG cost file and the other using allowed amounts in claims. This measure is based on actual costs associated with care for members enrolled with a PO, including all covered professional, pharmacy, hospital, and ancillary care, as well as administrative payments and adjustments. Health plans include both capitation payments and fee-for-service (FFS) payments, including member copayments, paid to the PO or other providers caring for members of the PO. It does not include costs associated with mental health/substance use disorder, chiropractic, acupuncture, vision, or dental services. Per member annual costs above $250,000 are truncated.

The total paid amount is divided by the sum of the member months attributed to the PO and then risk adjusted and adjusted for geography. Risk adjustment is performed using the Johns Hopkins' Adjusted Clinical Groups (ACG) System. Geographic adjustment is performed using the Geographic Adjustment Factors (GAF) published by CMS and based on the Hospital Wage Index (HWI).

Eligible Population

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

Ages	>1 to 64 years of age for Commercial HMO/POS and Medi-Cal Managed Care; >64 years of age for Medicare Advantage. Determine age based on the last day of the measurement period (i.e., December 31 of the measurement period).
Continuous enrollment	For Commercial HMO/POS, Medicare Advantage, and Medi-Cal Managed Care, include members with at least 9 months of enrollment in the health plan and the PO during the measurement period.
Allowable gap	None.
Benefits	Medical.
Measurement period	The measurement period is January 1–December 31. Include services with a date of service between January 1 and December 31 of the measurement period, and a date of payment between January 1 of the measurement period, and March 31 of the reporting year.
Member months	Member months are the basis for reporting this measure and come from a member's eligibility records. Determine the number of months during the measurement period when the eligible member was enrolled in both the health plan and the PO. ***Note:*** *A member cannot have more pharmacy member months than medical member months. Each member will have a medical member month total and a pharmacy member month total.*

Total Cost of Care Calculation

Step 1 Identify the eligible population as defined above.

Step 2 *Obtain member-level observed cost.* This is the payment information supplied by the health plan for a member's cost while enrolled with a specific PO. It includes all professional, facility (inpatient and outpatient), pharmacy (including drug rebates, where available), and other payments for services provided to the member.

The following services and payments are excluded from the observed cost amount:

- Mental health.
- Substance use disorder.
- Dental.
- AMP quality incentive payments.
- Vision.
- Chiropractic.
- Acupuncture.

If any services above are included in a PO's capitation agreement, the plan uses its own actuarial method to exclude.

The following payments to a PO, not directly related to delivery of services to individuals, are included and attributed to members on a prorated basis:

- Capital infusions.
- Capitation administrative fee.
- Capitation deductions and adjustments.
- Capitation floors and guarantees.
- Non-AMP incentive payments.
- Special case rates for particular populations.
- Stop loss provisions.
- Non-claim payments, including bulk adjustments and drug rebates.
- Shared risk payments.
- EHR/HIT Infrastructure and other data analytics payments.

- Care management/care coordination/population. health/medication reconciliation program(s).
- Primary care and behavioral health integration.
- Social care integration.
- Practice transformation payments.
- Bundled/episode/condition payments with and without risk/recoupments.
- Medical home payments.
- Payments for workforce expenditure (e.g., nurse care managers, community health workers, care navigators).

Step 3 *Calculate observed costs PMPM for each member.*

Total observed costs PMPM = (Total medical cost/Medical member months) + (Total pharmacy cost/Pharmacy member months)

Step 4 *Report Total Cost of Care service category costs PMPM.* For each member, report the following subcategories of cost.

Overall	TCOC Service Categories	Service Category Breakdown
Total Cost of Care	Cost: Medical	IHA generates this measure, which is the sum of Total Inpatient Facility plus Total Outpatient Facility plus Other Facility costs plus Professional FFS plus Total Capitation
	Cost: Total Facility	IHA generates this measure, which is the sum of Total Inpatient Facility plus Total Outpatient Facility plus Other Facility costs
	Cost: Total Inpatient Facility	Maternity Related
		Newborn
		Non-Maternity Related
	Cost: Total Outpatient Facility	Hospital
		Ambulatory Surgery Center
		Emergency Department
		Other Outpatient Facility
	Cost: Other Facility FFS	NA
	Cost: Professional FFS	NA
	Cost: Total Pharmacy FFS	Pharmacy Cost: Specialty
		Pharmacy Cost: All Other
	Cost: Total Capitation	Capitation Cost: Global
		Capitation Cost: Professional Services
		Capitation Cost: Primary Care Only
		Capitation Cost: Facility Services
	Cost: Other	Other FFS Cost

Overall	TCOC Service Categories	Service Category Breakdown
	**This cost is not accounted for in any other service categories and excludes behavioral health cost.*	Other Non-FFS Cost
(Exclude from TCOC)	Cost: Behavioral Health	NA

Risk-Adjustment Determination

Step 1 *Calculate risk scores.* For each member in the eligible population, a member-level relative risk score (RRS) is calculated using the Johns Hopkins' ACG concurrent inputs (based on the claims/encounters submitted by the health plan).

- Age.
- Gender.
- ICD-10 Dx codes.
- Revenue code.
- RVN CPT4, CPT4, and CPT/Revenue CPT4 Modifier.[14]
- Place of service.

Step 2 *Calculate the average risk score for the population being measured.*

Average risk score for population being measured = Sumproduct (member-level RRS, member medical months) / Sum (member medical months).

Step 3 *Calculate the average observed total cost PMPM for the population being measured, with and without $250,000 truncation.*

Average observed cost PMPM for population being measured = (Sum (member-level medical cost) / Sum (member medical months)) + (Sum (member-level pharmacy cost) / Sum (member pharmacy months))

When applying truncation, keep up to $250,000 observed total cost per member and remove the amount above $250,000.

1. Calculate the amount exceeding $250,000: observed total cost - $250,000.
2. Allocate the excess to medical and pharmacy in proportion to each component's share of observed total cost, and subtract each allocation from that component's observed cost. This should sum to an observed total truncated cost of $250,000.

Step 4 *Calculate the risk-adjusted total cost of care PMPM for the population being measured.*

Risk-adjusted total cost of care PMPM for population being measured = average observed cost PMPM/ average risk score.

Geographic Adjustment Determination

Calculate the geography- and risk-adjusted total cost of care PMPM.

Geography and risk-adjusted total cost of care PMPM = Risk-adjusted total cost of care PMPM/GAF, where the GAF is based on the CMS HWI.

Normalize the CMS HWI by dividing it by the average PO HWI to create the GAF.

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Primary Care Spending (PCS)

MEASURE UPDATES OCTOBER 2026 FOR AMP MY 2027

- Updated the Office of Health Care Affordability (OHCA) links to April 2026 version of the Total Health Care Expenditures (THCE) Data Submission Guide.
- Fee schedule for filling in missing FFS-equivalent allowed amounts will be across all plans, not plan-specific.

MODIFICATIONS FROM OHCA

- AMP does not apply step 2 of the Office of Health Care Affordability's (OHCA) claims-based primary care identification process, which uses the California Department of Managed Health Care (DMHC)'s Annual Network Review data to confirm primary care status for certain provider taxonomies.
- AMP's current health plan data submission process includes some, but not all, information requested by OHCA in the Total Health Care Expenditures (THCE) Data Submission Guide related to non-claims based primary care spending and behavioral health spending in primary care.
- AMP reports two rates for primary care spending: (1) primary care spending as a percentage of total cost of care and (2) primary care spending per member per month. The OHCA specifications focus solely on measuring primary care spending as a percentage of total cost.

Description

Two rates are reported:

Rate 1: Primary care spending as a percentage of total cost of care.[15]

Rate 2: Primary care spending per member per month.

Primary care spending includes:

- Claims-based primary care spending, determined by provider taxonomy code, service code, and place of service.
- Non-claims-based primary care spending, including capitation, performance incentive payments, and shared savings.[16]

This measure will be based on the Office of Health Care Affordability (OHCA)'s Primary Care Spending Measurement Definition and Methodology. It will only be generated by Cozeva from data submitted by health plans and will not be reported by POs. Participating health plans provide member eligibility, medical claims and encounters, pharmacy claims, and incentive data for each contracted PO.

Eligible Population

[15] The term "total cost of care" as used by OHCA for the Primary Care Spending measure is different from the Total Cost of Care (TCOC) specification stewarded by HealthPartners and used by IHA for the AMP program. "Total cost of care" in the Primary Care Spending measure refers to an observed total sum of payments, and is not risk-adjusted; TCOC is a geography- and risk-adjusted average per-member-per month (PMPM) cost of care amount.

[16] IHA's current health plan data submission process includes some but not all information requested by OHCA in the Total Health Care Expenditures (THCE) Data Submission Guide related to non-claims-based primary care spending and behavioral health spending in primary care. AMP generally captures the largest non-claims spending categories (capitation, performance incentives, and shared savings) as determined by a 2021 PO survey conducted by IHA. In the interest of minimizing participant reporting burden, this specification uses data already captured in AMP to measure spending.

Product line	Commercial HMO/POS, Medicare Advantage, Medi-Cal Managed Care (report each product line separately).
Benefits	Medical and Pharmacy.
Measurement period	The measurement period is January 1–December 31. Include services with a date of service in the measurement period and a date of payment between January 1 of the measurement period and March 31 of the reporting year.
Member months	Member months are used to calculate primary care PMPM. Member months come from a member's eligibility records (submitted by health plans to Cozeva in the Eligibility file). Determine the number of months during the measurement period when the eligible member was enrolled in the health plan and in the PO. ***Note:*** *A member cannot have more pharmacy member months than medical member months. Each member will have a medical member month total and a pharmacy member month total.*

Primary Care Spending Calculation

Identifying Claims-Based Payment for Primary Care

Step 1 Determine if the claim was rendered by a provider with a taxonomy defined as primary care by OHCA. If the claim was not rendered by a provider with a taxonomy on the Primary Care Providers Taxonomy List in OHCA Primary Care Addendum Total Health Care Expenditures (THCE) Data Submission Guide, do not include the claim. If the rendering provider has a taxonomy in the list, proceed to step 2.

Step 2 Determine if the claim represents a service provided at a care setting that OHCA defines as primary care. The list of CMS Place of Service (POS) codes that OHCA defines as primary care settings can be found in OHCA Primary Care Addendum THCE Data Submission Guide. If the POS code is on the list, proceed to step 3. If the POS code is not on the list, do not include the claim.

Step 3 Confirm that the service on the claim provided by a primary care provider at a primary care place of service is for a primary care service as defined by OHCA. If the Healthcare Common Procedure Coding System (HCPCS)/Current Procedural Terminology (CPT) code on the claim line is in the list of service codes in OHCA Primary Care Addendum THCE Data Submission Guide, include the claim line with that service in the primary care spending amount. If the claim line has a service not on the list, do not include the claim line.

Note: Include in the primary care spending amount UB-04 payments with the facility type code 73 (Freestanding Clinic) that meet the primary care provider taxonomy and HCPCS/CPT service code requirements in this step.

Step 4 Determine if the qualifying primary care claim line was paid fee-for-service (FFS) or was covered under capitation using the payment arrangement type indicator in medical claims. If the indicator is 02 (for FFS), include the allowed amount[17] here. If the indicator is 01 (for capitation), include it under non-claims payments in the section below.

[17] The allowed amount is the sum of plan paid amount and member cost sharing amount, and can be found as a field in the Medical Claims and Pharmacy Claims files in the IHA Data Submission Guide.

Step 5 Calculate the amount for primary care paid via claims by summing the allowed amounts (which includes the member responsibility and plan paid amount) from all qualifying primary care claim lines that were paid FFS.

Identifying Non-Claims Based Payments for Primary Care

Capitation Payments

Step 1 For primary care capitation arrangements, use the whole primary care capitation amount from the IHA Data Submission Guide (DSG) cost file and go directly to the *Shared Savings Payments/Incentive Payments* section.

Step 2 For all qualifying primary care claim lines that were covered under professional capitation and global capitation arrangements (from step 4 in *Identifying Primary Care Paid via Claims*), use the allowed amount when supplied. If no allowed amount is supplied, Cozeva will create a FFS-equivalent fee schedule by taking the median allowed amount for each procedure code, payer type, and year from FFS claims with a paid amount greater than $0. The fee schedule will be calculated across all IHA participating plans. The fee schedule amount for a procedure code, payer type, and year will be considered the allowed amount for that service.

Note*: If there is a facility capitation arrangement, it does not need to be included in any calculations and do not include any of the capitation payment as primary care.*

Step 3 Sum the allowed amounts for all qualifying primary care services covered under professional capitation or global capitation.

Step 4 For all non-primary care service claim lines covered under professional capitation or global capitation arrangements, use the allowed amount when supplied in the medical claims file, or apply the appropriate fee schedule amount. If no allowed amount is supplied, Cozeva will create a FFS-equivalent fee schedule by taking the median allowed amount for each procedure code, payer type, and year from FFS claims with a paid amount greater than $0. The fee schedule will be calculated across all IHA participating plans. The fee schedule amount for a procedure code, payer type, and year will be considered the allowed amount for that service.

Step 5 Sum the allowed amounts for all non-primary care services covered under capitation.

Step 6 Calculate the ratio of allowed amounts for primary care capitated services to allowed amounts for all capitated services. Ratio = amount from step 3 / [the sum of the amount from step 3 and the amount from step 5].

Step 7 Multiply the ratio from step 6 by the relevant capitation amount (professional capitation or global capitation) reported in the IHA DSG cost file to calculate the primary care proportion of the actual capitation paid. Use this amount for capitation associated with primary care.

Shared Savings Payments/Incentive Payments

Step 1 Use health plan reported incentive payment amounts by PO for a particular payer type, product type, and PO, with a flag for ACO.

Step 2 Allocate an equal percentage of the incentive payment amount to each member who is part of the health plan, payer type and product type, PO, and ACO.

Step 3 Bucket members as appropriate, into categories (adult/pediatric stratification, payer type, health plan, product type, PO, ACO flag [Y/N], region) and sum the incentive payments for each member in a particular category.

For example, reporting by Covered CA region is generated by summing the member-level incentive payments for all members attributed to the Covered CA region. Within the Covered CA region, members can be sub-categorized by adult/pediatric stratification, payer type, product type, ACO flag, and so on.

Note: The member-level incentive payment follows the member into each appropriate category.

Step 4 Allocate only a portion of these incentive payments as primary care spending, by limiting the portion of the incentive to the ratio of [professional claims payments] to [the sum of professional claims payments, hospital inpatient claims payments, and hospital outpatient claims payments], and multiply that ratio by the incentive payment for each category.

Note: *For reference, in general, the ratio has been approximately 0.4 for the Commercial HMO/POS product line.*

Step 5 Calculate the amount for primary care paid via non-claims by summing the primary care portion of capitation payments (from step 1 for primary care capitation arrangements and step 7 for professional or global capitation arrangements of the Capitation Payments section) and the allocation of shared savings payments/incentive payments (from step 4 immediately above).

Rate 1: Primary Care Spending as a Percentage of Total Cost of Care

Denominator	Total-claims based payments + Total non-claims-based payments
Numerator	Claims-based payments for primary care + Non-claims-based payments for primary care

Multiply the rate by 100 to obtain Primary care spending as a percentage.

Rate 2: Primary Care Spending Per Member Per Month

Denominator	Total member months enrolled with medical coverage
Numerator	Claims-based payments for primary care + Non-claims-based payments for primary care

Testing Measures

Overview

The following measures have been selected for MY 2027 testing in the AMP program. Health plans and self-reporting POs are strongly encouraged to participate in testing in order to get a first look at their performance and help assess the validity of the measures for use in AMP.

Clinical Quality	• Depression Screening and Follow-Up for Adolescents and Adults (DSF-E) is an MY 2027 testing measure for the AMP Medicare Advantage product line. Please refer to the Clinical Domain for the DSF-E measure specification. • Follow-Up After Positive Colorectal Cancer Non-Invasive Screening Test (COF-E) is an MY 2027 testing measure for the Commercial HMO/POS and Medi-Cal Managed Care product lines. • Prenatal Depression Screening (PND-E) is an MY 2027 testing measure for the Commercial HMO/POS and Medi-Cal Managed Care product lines. • Postpartum Depression Screening (PDS-E) is an MY 2027 testing measure for the Commercial HMO/POS and Medi-Cal Managed Care product lines.
Data quality	None.
Utilization	• Emergency Department Utilization (EDU) is an MY 2027 testing measure for the Medi-Cal Managed Care product line. Please refer to the Utilization Domain for the EDU measure specification.
Cost	None.

*Follow-Up After Positive Colorectal Cancer Non-Invasive Screening Test (COF-E)**

***This measure was supported by the Centers for Disease Control and Prevention of the U.S. Department of Health and Human Services (HHS) as part of a financial assistance award to the Council of Medical Specialty Societies (CMSS) totaling $1,563,853, with 100% funded by CDC/HHS. The contents are those of the authors and do not necessarily represent the official views of, nor endorsement by, CDC/HHS or the U.S. Government.**

MEASURE UPDATES OCTOBER 2026 FOR AMP MY 2027

- Added as a testing measure for AMP MY 2027.

MODIFICATIONS FROM HEDIS

- None.

To report this measure, refer to the digital measure package available for purchase in the NCQA Store for the complete HEDIS digital measure specification.

Measure title	Follow-Up After Positive Colorectal Cancer Non-Invasive Screening Test	**Measure ID**	COF-E
Description	The percentage of members 45–75 years of age who received a colonoscopy for a positive colorectal cancer non-invasive screening test.		
Measurement period	January 1–December 31.		
Clinical recommendation statement/ rationale	The U.S. Preventive Services Task Force recommends colorectal cancer screening for adults ages 50–75 (A recommendation) and 45–49 (B recommendation). The U.S. Multi-Society Task Force and American Cancer Society recommends starting screening at age 45 for average-risk adults and strongly recommends screening for ages 50–75. Screening methods include annual guaiac-based fecal occult blood test (gFOBT), annual fecal immunochemical test (FIT) and multitargeted stool DNA with FIT test (sDNA FIT) every 1-3 years, flexible sigmoidoscopy every 5 years, CT colonography every 5 years, or colonoscopy every 10 years. Refer to the HEDIS Measure Library & Historical Data measure web page for additional information about the clinical rationale.		
Citations	Patel, S.G., F.P. May, J.C. Anderson, et al. 2022. "Updates on Age to Start and Stop Colorectal Cancer Screening: Recommendations From the U.S. Multi-Society Task Force on Colorectal Cancer." *Am J Gastroenterol* 117(1):57-69. doi:10.14309/ajg.0000000000001548 Rex, D.K., R.C. Boland, J.A. Dominitz, et al. 2017. "Colorectal Cancer Screening: Recommendations for Physicians and Patients from the U.S. Multi-Society Task Force on Colorectal Cancer." *American Journal of Gastroenterology* 112(7):1016-1030. doi:10.1038/ajg.2017.174 U.S. Preventive Services Task Force. 2021. "Screening for Colorectal Cancer: U.S. Preventive Services Task Force Recommendation Statement." *JAMA*		

	325(19):1965–1977. doi:10.1001/jama.2021.6238 Wolf, A.M.D., E.T.H. Fontham, T.R. Church, et al. 2018. "Colorectal Cancer Screening for Average-Risk Adults: 2018 Guideline Update From the American Cancer Society." *CA A Cancer J Clinicians* 68(4):250-281. doi:10.3322/caac.21457
Characteristics	
Scoring	Proportion.
Type	Process.
Product lines	• Commercial HMO/POS. • Medi-Cal Managed Care.
Stratifications	None.
Risk adjustment	None.
Improvement notation	Increased score indicates improvement.
Guidance	**Data collection methodology:** ECDS. (Refer to *General Guideline: Data Collection Methods* for additional information.) **Date specificity:** Dates must be specific enough to determine the event occurred in the period being measured. **Which services count?** When using claims, include all paid, suspended, pending and denied claims. **Programming guidance:** The MY 2027 HEDIS Implementation Guide (IG) will be available in October 2026. To request access to the HEDIS IG, email hedis-ig@ncqa.org.
Definitions	
IESD	Index episode start date. The earliest date during the intake period when a member has a positive stool-based test result.
Intake period	July 1 of the year prior to the measurement period to June 30 of the measurement period.
Initial population	*Measure item count:* Member. *Attribution basis:* Enrollment. • *Benefits:* Medical. • *Continuous enrollment:* – For self-reporting POs: Date of the IESD through 180 days after the IESD in the PO (parent level). – For health plans: Date of the IESD through 180 days after the IESD in the health plan and the PO (parent level).

	• *Allowable gap:* – For self-reporting POs: No more than one gap of ≤45 days during the continuous enrollment period. No gaps in enrollment in the PO (parent level, or for eligible POs, subgroup level) or in an AMP plan on the IESD. – For health plans: No more than one gap of ≤45 days during the continuous enrollment period. No gaps in enrollment in the health plan or the PO (parent level, or for eligible POs, subgroup level) on the IESD. *Ages:* 45–75 years of age as of the IESD. *Event:* **Positive stool-based colorectal cancer screening test.** **Step 1.** Identify members with a positive stool-based screening test during the intake period using either of the following criteria: • Fecal occult blood tests (Colorectal Cancer Screening Lab Test Value Set) with a positive result (Positive Colorectal Cancer Screening Lab Test Result or Finding Value Set) during the intake period. – Do not include fecal occult blood tests that occurred during an inpatient stay, observation stay or ED visit (Inpatient, Observation and ED Facility Revenue Value Set) or an inpatient, observation or ED encounter (Inpatient, Observation and ED Encounter Class Value Set). • Stool DNA with FIT tests (LOINC code 77354-9) with a positive result (Positive Colorectal Cancer Screening Lab Test Result or Finding Value Set) during the intake period. **Step 2.** Identify the IESD. Using all of the eligible positive stool-based tests identified in step 1, determine the earliest positive stool-based test result during the intake period. If the member had more than one positive stool-based test, include only the first test.
Denominator exclusions	**Deceased members.** Members who died any time on or before the last day of the measurement period, identified using data sources determined by the organization. Method and data sources are subject to review during the AMP audit. **Members in hospice or using hospice services.** Members who use hospice services (Hospice Encounter Value Set; Hospice Intervention Value Set) or elect to use a hospice benefit any time during the measurement period. Organizations that use the Monthly Membership Detail Data File to identify these members must use only the run date of the file. **Members receiving palliative care.** Members receiving palliative care (Palliative Care Observations Value Set; Palliative Care Procedures Value Set) or who had an encounter for palliative care (ICD-10-CM code Z51.5*) any time during the intake period through the last day of the measurement period. **Members 66 of age or older by the last day of the measurement period, with both frailty and advanced illness.** 1. **Frailty.** At least two indications of frailty (Frailty Device Value Set; Frailty Diagnosis Value Set*; Frailty Encounter Value Set; Frailty Symptom Value

	Set*) with different dates of service during the intake period through the last day of the measurement period. 2. **Advanced illness.** Either of the following during the measurement period or the year prior to the measurement period: – Advanced illness (Advanced Illness Value Set*) on at least two different dates of service. – Dispensed dementia medication (Dementia Medications List). **History of colorectal cancer and/or total colectomy.** Colorectal cancer (Colorectal Cancer and History of Colorectal Cancer Value Set*) or a total colectomy (Total Colectomy Value Set; SNOMEDCT code 119771000119101) any time during the member's history through the day prior to the IESD. **Members who received a colonoscopy in the year prior.** Colonoscopy (Colonoscopy Value Set; SNOMED CT code 851000119109) during the 365 days prior to the IESD. **Coding Guidance** *Do not include laboratory claims (claims with POS code 81).
Denominator	The initial population minus denominator exclusions.
Numerator	**Follow-up colonoscopy.** Identify members who received a follow-up colonoscopy (Colonoscopy Value Set) on the IESD or in the 180-day period after the IESD.

*Prenatal Depression Screening (PND-E)**

Developed with support from the California HealthCare Foundation (CHCF). CHCF works to ensure that people have access to the care they need, when they need it, at a price they can afford. Visit https://www.chcf.org/ to learn more. Also supported by the Zoma Foundation.

MEASURE UPDATES OCTOBER 2026 FOR AMP MY 2027

- Added as a testing measure for AMP MY 2027.

MODIFICATIONS FROM HEDIS

- NCQA refers to this measure as "Prenatal Depression Screening and Follow-Up."
- AMP only reports the Depression Screening indicator.

To report this measure, refer to the digital measure package available for purchase in the NCQA Store for the complete HEDIS digital measure specification.

Measure title	Prenatal Depression Screening	**Measure ID**	PND-E
Description	The percentage of deliveries in which members were screened for clinical depression while pregnant. • *Depression Screening*. The percentage of deliveries in which members were screened for clinical depression during pregnancy using a standardized instrument.		
Measurement period	January 1–December 31.		
Clinical recommendation statement/ rationale	The U.S. Preventive Services Task Force (USPSTF) recommends screening for depression among adolescents and adults, including pregnant and postpartum women (B recommendation). The American College of Obstetricians and Gynecologists (ACOG) recommends that clinicians screen patients at the initial prenatal visit, later in pregnancy, and at postpartum visits using a standardized, validated tool. The USPSTF and ACOG also recommend that screening be implemented with adequate systems in place to ensure accurate diagnosis, effective treatment and appropriate follow-up (B recommendation). Additional information about the clinical rationale is available on HEDIS Measure Library & Historical Data measure web page.		
Citations	American College of Obstetricians and Gynecologists. 2023. "Screening and Diagnosis of Mental Health Conditions During Pregnancy and Postpartum: ACOG Clinical Practice Guideline No. 4." *Obstet Gynecol* 141.6: 1232–61. U.S. Preventive Services Task Force et al. 2023. "Screening for Depression and Suicide Risk in Adults: U.S. Preventive Task Force Recommendation Statement." *JAMA* vol. 329,23: 2057–67. U.S. Preventive Services Task Force et al. 2022. "Screening for Depression and Suicide Risk in Children and Adolescents: U.S. Preventive Task Force Recommendation Statement." *JAMA* vol. 328,15: 1534–42.		

Characteristics	
Scoring	Proportion.
Type	Process.
Product lines	• Commercial HMO/POS. • Medi-Cal Managed Care.
Stratifications	Race. (Refer to *General Guideline: Race and Ethnicity Stratification.)* • American Indian or Alaska Native. • Asian. • Black or African American. • Middle Eastern or North African. • Native Hawaiian or Pacific Islander. • White. • Other Race. • Two or More Races. • Asked But Declined. • Unknown. • Total. Ethnicity. (Refer to *General Guideline: Race and Ethnicity Stratification.*) • Hispanic or Latino. • Not Hispanic or Latino. • Asked But Declined. • Unknown. • Total.
Risk adjustment	None.
Improvement notation	Increased score indicates improvement.
Guidance	**Data collection methodology:** ECDS. (Refer to *General Guideline: Data Collection Methods* for additional information.) **Date specificity:** Dates must be specific enough to determine that the event occurred in the period being measured. **Which services count?** When using claims, include all paid, suspended, pending and denied claims. **Other guidance:** The measure is based on deliveries; therefore, it is possible for denominator to include multiple deliveries for the same member. **Programming guidance:** The MY 2027 HEDIS Implementation Guide (IG) will be available in October 2026. To request access to the HEDIS IG, email hedis-ig@ncqa.org.

<table>
<tr><th colspan="2">Definitions</th></tr>
<tr><td>Pregnancy start date</td><td>Pregnancy start date is calculated by subtracting the gestational age (in weeks) at the time of delivery from the delivery date. Use the last gestational age assessment or diagnosis within 1 day of the delivery date.</td></tr>
<tr><td>Depression screening instrument</td><td>A standard assessment instrument normalized and validated for the appropriate patient population. Eligible screening instruments with thresholds for positive findings include:
<table>
<tr><th>Instruments for Adolescents (≤17 Years)</th><th>Total Score LOINC Codes</th></tr>
<tr><td>Patient Health Questionnaire (PHQ-9)®</td><td>44261-6</td></tr>
<tr><td>Patient Health Questionnaire Modified for Teens (PHQ- 9M)®</td><td>89204-2</td></tr>
<tr><td>Patient Health Questionnaire-2 (PHQ-2)®[1]</td><td>55758-7</td></tr>
<tr><td>Beck Depression Inventory®—Fast Screen (BDI-FS)®[1,2]</td><td>89208-3</td></tr>
<tr><td>Center for Epidemiologic Studies Depression Scale—Revised (CESD-R)</td><td>89205-9</td></tr>
<tr><td>Edinburgh Postnatal Depression Scale (EPDS)</td><td>99046-5</td></tr>
<tr><td>PROMIS® Depression</td><td>71965-8</td></tr>
</table>
[1]Brief screening instrument. All other instruments are full-length.
[2]Proprietary; there may be a cost or licensing requirement associated with use.
<table>
<tr><th>Instruments for Adults (18+ Years)</th><th>Total Score LOINC Codes</th></tr>
<tr><td>Patient Health Questionnaire (PHQ-9)®</td><td>44261-6</td></tr>
<tr><td>Patient Health Questionnaire-2 (PHQ-2)®[1]</td><td>55758-7</td></tr>
<tr><td>Beck Depression Inventory®—Fast Screen (BDI-FS)®[1,2]</td><td>89208-3</td></tr>
<tr><td>Beck Depression Inventory®-II(BDI-II)®</td><td>89209-1</td></tr>
<tr><td>Center for Epidemiologic Studies Depression Scale—Revised (CESD-R)</td><td>89205-9</td></tr>
<tr><td>Duke Anxiety-Depression Scale (DUKE-AD)®[2]</td><td>90853-3</td></tr>
<tr><td>Edinburgh Postnatal Depression Scale (EPDS)</td><td>99046-5</td></tr>
<tr><td>My Mood Monitor (M-3)®</td><td>71777-7</td></tr>
<tr><td>PROMIS® Depression</td><td>71965-8</td></tr>
<tr><td>PROMIS® Emotional Distress—Depression—Short Form</td><td>77861-3</td></tr>
<tr><td>Clinically Useful Depression Outcome Scale (CUDOS)</td><td>90221-3</td></tr>
</table>
[1]Brief screening instrument. All other instruments are full-length.
[2]Proprietary; there may be a cost or licensing requirement associated with use.</td></tr>
</table>

Initial population	*Measure item count:* Episode. *Attribution basis:* Enrollment. • *Benefits:* Medical. • *Continuous enrollment:* – For self-reporting POs: 28 days prior to the delivery date through the delivery date in the PO (parent level). – For health plans: 28 days prior to the delivery date through the delivery date in the health plan and the PO (parent level). • *Allowable gap:* None. *Ages:* None. *Event:* **Deliveries.** Deliveries (Deliveries Value Set) in any setting during the measurement period with a gestational age of 37 weeks or greater. The gestational age documentation must be within 1 day of the start or end of the delivery. Use either of the following to identify gestational age: • Gestational age assessment (Weeks of Gestation Value Set); value ≥37 weeks. • Gestational age diagnosis (Weeks of Gestation Greater Than or Equal to 37 Value Set). ***Note:*** *Delivery Date: The intent is to identify the date of delivery using the date as of the end of the delivery procedure; when available, use that date. When using inpatient claims to identify delivery date, use the following hierarchy to determine the date:* • *When a procedure date or date of service is available, use that date.* • *When a procedure date or date of service is not available, use the discharge date from the inpatient claim.* If a member has more than one delivery in a 180-day period, include only the first eligible delivery. Then, if applicable include the next delivery that occurs after the 180-day period. Identify deliveries chronologically, including only one per 180-day period. ***Note:*** *Removal of multiple deliveries in a 180-day period is based on eligible deliveries. Assess each delivery for exclusions and attribution before removing multiple deliveries in a 180-day period.*
Denominator exclusions	**Deceased members.** Members who died any time on or before the last day of the measurement period, identified using data sources determined by the organization. Method and data sources are subject to review during the AMP audit. **Members in hospice or using hospice services.** Members who use hospice services (Hospice Encounter Value Set; Hospice Intervention Value Set) or elect to use a hospice benefit any time during the measurement period. Organizations that use the Monthly Membership Detail Data File to identify these members must use only the run date of the file.

Denominator	The initial population minus denominator exclusions.
Numerator	**Depression screening.** Deliveries in which members had a documented result for depression screening, using an age-appropriate standardized screening instrument performed during pregnancy (on or between pregnancy start date and the delivery date). • *Deliveries between January 1 and December 1 of the measurement period:* Screening should be performed between the pregnancy start date and the delivery date (including on the delivery date). • *Deliveries between December 2 and December 31 of the measurement period:* Screening should be performed between the pregnancy start date and December 1 of the measurement period. Depression screening captured in health risk assessments or other types of health assessments are allowed if the questions align with a specific instrument that is validated for depression screening. For example, if a health risk assessment includes questions from the PHQ-2, it counts as screening if the member answered the questions and a total score is calculated.

*Postpartum Depression Screening (PDS-E)**

Developed with support from the California HealthCare Foundation (CHCF). CHCF works to ensure that people have access to the care they need, when they need it, at a price they can afford. Visit https://www.chcf.org/ to learn more. Also supported by the Zoma Foundation.

MEASURE UPDATES OCTOBER 2026 FOR AMP MY 2027

- Added as a testing measure for AMP MY 2027.

MODIFICATIONS FROM HEDIS

- NCQA refers to this measure as "Postpartum Depression Screening and Follow-Up."
- AMP only reports the Depression Screening indicator.

To report this measure, refer to the digital measure package available for purchase in the NCQA Store for the complete HEDIS digital measure specification.

Measure title	Postpartum Depression Screening	**Measure ID**	PDS-E
Description	The percentage of deliveries in which members were screened for clinical depression during the postpartum period. • *Depression Screening.* The percentage of deliveries in which members were screened for clinical depression using a standardized instrument during the postpartum period.		
Measurement period	January 1–December 31.		
Clinical recommendation statement/ rationale	The U.S. Preventive Services Task Force (USPSTF) recommends screening for depression among adolescents and adults, including pregnant and postpartum women (B recommendation). The American College of Obstetricians and Gynecologists (ACOG) recommends that screening for perinatal depression and anxiety occur at the initial prenatal visit, later in pregnancy, and at postpartum visits with a standardized, validated instrument. The American Academy of Pediatrics recommends that pediatricians screen mothers for postpartum depression at the infant's 1-, 2-, 4- and 6-month visits. The USPSTF and ACOG also recommend that screening be implemented with adequate systems in place to ensure accurate diagnosis, effective treatment and appropriate follow-up (B recommendation). Refer to the State of Health Care Quality measure web page for additional information about the clinical rationale.		
Citations	American College of Obstetricians and Gynecologists. 2023. "Screening and Diagnosis of Mental Health Conditions During Pregnancy and Postpartum: ACOG Clinical Practice Guideline No. 4." *Obstet Gynecol* 141.6: 1232–61. Stone, J., & L. Allen. 2021. "Increasing Postpartum Depression Screening in the Pediatric Setting." *Carolina Journal of Interdisciplinary Medicine* 1(1), 43–52. https://doi.org/10.47265/cjim.v1i1.539		

	U.S. Preventive Services Task Force et al. 2023. "Screening for Depression and Suicide Risk in Adults: U.S. Preventive Task Force Recommendation Statement." *JAMA* vol. 329,23: 2057–67. U.S. Preventive Services Task Force et al. 2022. "Screening for Depression and Suicide Risk in Children and Adolescents: U.S. Preventive Task Force Recommendation Statement." *JAMA* vol. 328,15: 1534–42. Additional information about the clinical rationale is available on HEDIS Measure Library & Historical Data measure web page.
Characteristics	
Scoring	Proportion.
Type	Process.
Product lines	• Commercial HMO/POS. • Medi-Cal Managed Care.
Stratifications	Race. (Refer to *General Guideline: Race and Ethnicity Stratification*.) • American Indian or Alaska Native. • Asian. • Black or African American. • Middle Eastern or North African. • Native Hawaiian or Pacific Islander. • White. • Other Race. • Two or More Races. • Asked But Declined. • Unknown. • Total. Ethnicity. (Refer to *General Guideline: Race and Ethnicity Stratification.*) • Hispanic or Latino. • Not Hispanic or Latino. • Asked But Declined. • Unknown. • Total.
Risk adjustment	None.
Improvement notation	Increased score indicates improvement.

Guidance	**Data collection methodology:** ECDS. (Refer to *General Guideline: Data Collection Methods* for additional information.) **Date specificity:** Dates must be specific enough to determine that the event occurred in the period being measured. **Which services count?** When using claims, include all paid, suspended, pending and denied claims. **Other guidance:** The measure is based on deliveries; therefore, it is possible for denominator to include multiple deliveries for the same member. **Programming guidance:** The MY 2027 HEDIS Implementation Guide (IG) will be available in October 2026. To request access to the HEDIS IG, email hedis-ig@ncqa.org.
Definitions	
Depression screening instrument	A standard assessment instrument normalized and validated for the appropriate patient population. Eligible screening instruments with thresholds for positive findings include:

Instruments for Adolescents (≤17 Years)	Total Score LOINC Codes
Patient Health Questionnaire (PHQ-9)®	44261-6
Patient Health Questionnaire Modified for Teens (PHQ-9M)®	89204-2
Patient Health Questionnaire-2 (PHQ-2)®[1]	55758-7
Beck Depression Inventory®-Fast Screen (BDI-FS)®[1,2]	89208-3
Center for Epidemiologic Studies Depression Scale—Revised (CESD-R)	89205-9
Edinburgh Postnatal Depression Scale (EPDS)	99046-5
PROMIS® Depression	71965-8

[1]Brief screening instrument. All other instruments are full-length.
[2]Proprietary; may have cost or licensing requirement associated with use.

Instruments for Adults (18+ Years)	Total Score LOINC Codes
Patient Health Questionnaire (PHQ-9)®	44261-6
Patient Health Questionnaire-2 (PHQ-2)®[1]	55758-7
Beck Depression Inventory®-Fast Screen (BDI-FS)®[1,2]	89208-3
Beck Depression Inventory®-II (BDI-II)®	89209-1
Center for Epidemiologic Studies Depression Scale—Revised (CESD-R)	89205-9
Duke Anxiety-Depression Scale (DUKE-AD)®[2]	90853-3
Edinburgh Postnatal Depression Scale (EPDS)	99046-5

Instruments for Adults (18+ years)	Total Score LOINC Codes
My Mood Monitor (M-3)®	71777-7
PROMIS® Depression	71965-8
PROMIS® Emotional Distress—Depression—Short Form	77861-3
Clinically Useful Depression Outcome Scale (CUDOS)	90221-3

[1]Brief screening instrument. All other instruments are full-length.
[2]Proprietary; may have cost or licensing requirement associated with use.

Initial population

Measure item count: Episode.

Attribution basis: Enrollment.

- *Benefits:* Medical.
- *Continuous enrollment:*
  - For self-reporting POs: The delivery date through 60 days following the delivery date in the PO (parent level).
  - For health plans: The delivery date through 60 days following the delivery date in the health plan and the PO (parent level).
- *Allowable gap:* None.

Ages: None.

Event: **Deliveries.**

Deliveries (Deliveries Value Set), in any setting, during September 8 of the year prior to the measurement period through September 7 of the measurement period.

Note: *Delivery Date: The intent is to identify the date of delivery using the date as of the end of the delivery procedure; when available, use that date. When using inpatient claims to identify delivery date, use the following hierarchy to determine the date:*

- *When a procedure date or date of service is available, use that date.*
- *When a procedure date or date of service is not available, use the discharge date from the inpatient claim.*

If a member has more than one delivery in a 180-day period, include only the first eligible delivery. Then, if applicable include the next delivery that occurs after the 180-day period. Identify deliveries chronologically, including only one per 180-day period.

Note: *Removal of multiple deliveries in a 180-day period is based on eligible deliveries. Assess each delivery for exclusions and attribution before removing multiple deliveries in a 180-day period.*

Denominator exclusions

Deceased members.
Members who died any time on or before the last day of the measurement period, identified using data sources determined by the organization. Method and data sources are subject to review during the AMP audit.

	Members in hospice or using hospice services. Members who use hospice services (Hospice Encounter Value Set; Hospice Intervention Value Set) or elect to use a hospice benefit any time during the measurement period. Organizations that use the Monthly Membership Detail Data File to identify these members must use only the run date of the file.
Denominator	The initial population minus denominator exclusions.
Numerator	**Depression screening.** Deliveries in which members had a documented result for depression screening, using an age-appropriate standardized instrument, performed during the 7–84 days following the delivery date. Depression screening captured in health risk assessments or other types of health assessments are allowed if the questions align with a specific instrument that is validated for depression screening. For example, if a health risk assessment includes questions from the PHQ-2, it counts as screening if the member answered the questions and a total score is calculated.

Appendices

APPENDIX 1

SUMMARY OF MY 2027 AMP MEASURE SPECIFICATION CHANGES

MY 2027 Measures	Date of Update/Modification from the Measure Steward	Measure Specification Update
Follow-Up After Acute and Urgent Care Visits for Asthma (AAF-E)	October 2026	• Removed the definition of direct transfer. • Revised the *Initial population* to add instructions for readmissions or direct transfers readmissions. • Added a value set to identify urgent care visits billed on facility claims. • Updated hospice *Denominator exclusion* to align with source specification.
	Modifications from HEDIS	• AMP reports the COPD diagnosis stratification separately from the age stratifications.
Blood Pressure Control for Patients With Hypertension (BPC-E)	October 2026	• Updated the race and ethnicity stratification categories to capture declinations and unknown race and/or ethnicity more precisely. • Updated value set name for nephrectomy in the end-stage renal disease *Denominator exclusion.*
	Modifications from HEDIS	• The denominator exclusion for members living long-term in an institution (LTI) is optional for POs that do not have access to the LTI flag in the Monthly Membership Detail Data File.
Controlling High Blood Pressure (CBP)	October 2026	• Updated the race and ethnicity stratification categories to capture declinations and unknown race and/or ethnicity more precisely. • Updated value set name for nephrectomy in the end-stage renal disease *Denominator exclusion.*
	Modifications from HEDIS	• The denominator exclusion for members living long-term in an institution (LTI) is optional for POs that do not have access to the LTI flag in the Monthly Membership Detail Data File.
Proportion of Days Covered by Medications: Renin Angiotensin System (PDC-RASA)	October 2026	• None.
	Modifications from PQA	• None.

MY 2027 Measures	Date of Update/Modification from the Measure Steward	Measure Specification Update
Proportion of Days Covered: Statins (PDC-STA)	October 2026	• Added *Denominator exclusions* for (1) rhabdomyolysis, myopathy, or myositis diagnosis, (2) pregnancy diagnosis, lactation diagnosis, invitro fertilization, or fertility prescription, (3) cirrhosis diagnosis, and (4) myalgia diagnosis.
	Modifications from PQA	• None.
Proportion of Days Covered: Diabetes All Class (PDC-DR)	October 2026	• Added a definition for Diabetes diagnosis. • Updated the *Description* and Event criteria in the *Initial population* to require a diabetes diagnosis at any time during the measurement period.
	Modifications from PQA	• None.
Glycemic Status Assessment for Patients With Diabetes (GSD)	October 2026	• Updated the race and ethnicity stratification categories to capture declinations and unknown race and/or ethnicity more precisely.
	Modifications from HEDIS	• The denominator exclusion for members living long-term in an institution (LTI) is optional for POs that do not have access to the LTI flag in the Monthly Membership Detail Data File.
Eye Exam for Patients With Diabetes (EED)	October 2026	• Updated the race and ethnicity stratification categories to capture declinations and unknown race and/or ethnicity more precisely.
	Modifications from HEDIS	• AMP does not include Medicare SES Stratifications. • The denominator exclusion for members living long-term in an institution (LTI) is optional for POs that do not have access to the LTI flag in the Monthly Membership Detail Data File.
Kidney Health Evaluation for Patients With Diabetes (KED)	October 2026	• Updated the race and ethnicity stratification categories to capture declinations and unknown race and/or ethnicity more precisely.
	Modifications from HEDIS	• The denominator exclusion for members living long-term (LTI) in an institution is optional for POs that do not have access to the LTI flag in the Monthly Membership Detail Data File.
Statin Use in Persons with Diabetes (SUPD)	October 2026	• Added a definition for Diabetes diagnosis. • Updated the *Description* and Event criteria in the *Initial population* to require a diabetes diagnosis at any time during the measurement period. • Renamed "Rhabdomyolysis and Myopathy", to "Rhabdomyolysis, Myopathy, or Myositis" in *Denominator exclusions.* • Added in vitro fertilization and renamed denominator exclusion to "Pregnancy diagnosis, lactation diagnosis, or in vitro fertilization, or fertility prescription."
	Modifications from PQA	• None.

MY 2027 Measures	Date of Update/Modification from the Measure Steward	Measure Specification Update
Osteoporosis Management in Women Who Had a Fracture (OMW)	October 2026	• Updated Value Set name from Bone Mineral Density Test Procedures Value Set to Bone Mineral Density Test Services Value Set.
	Modifications from HEDIS	• The denominator exclusion for members living long-term in an institution (LTI) is optional for POs that do not have access to the LTI flag in the Monthly Membership Detail Data File.
Child and Adolescent Well-Care Visits (WCV)	October 2026	• Removed references to "OB/GYN" to align with the definition of PCP in Appendix 2, which includes OB/GYNs. • Updated the race and ethnicity stratification categories to capture declinations and unknown race and/or ethnicity more precisely. • Updated hospice *Denominator exclusion* to align with source specification.
	Modifications from HEDIS	• None.
Well-Child Visits in the First 30 Months of Life (W30)	October 2026	• Updated the race and ethnicity stratification categories to capture declinations and unknown race and/or ethnicity more precisely. • Updated hospice *Denominator exclusion* to align with source specification.
	Modifications from HEDIS	• None.
Childhood Immunization Status (CIS-E)	October 2026	• Updated the race and ethnicity stratification categories to capture declinations and unknown race and/or ethnicity more precisely. • Updated hospice *Denominator exclusion* to align with source specification.
	Modifications from HEDIS	• None.
Immunizations for Adolescents (IMA-E)	October 2026	• Updated the race and ethnicity stratification categories to capture declinations and unknown race and/or ethnicity more precisely. • Updated hospice *Denominator exclusion* to align with source specification.
	Modifications from HEDIS	• None.

MY 2027 Measures	Date of Update/Modification from the Measure Steward	Measure Specification Update
Cervical Cancer Screening (CCS-E)	October 2026	• Updated the race and ethnicity stratification categories to capture declinations and unknown race and/or ethnicity more precisely. • Added a note regarding potential changes to PO and health plan continuous enrollment requirements under consideration through the 2026 public comment process. • Updated hospice *Denominator exclusion* to align with source specification. • Removed the note from the *Numerator*.
	Modifications from HEDIS	• None.
Breast Cancer Screening (BCS-E)	October 2026	• Updated the race and ethnicity stratification categories to capture declinations and unknown race and/or ethnicity more precisely. • Added a note regarding potential changes to PO and health plan continuous enrollment requirements under consideration through the 2026 public comment process. • Updated value sets in the *Numerator*.
	Modifications from HEDIS	• AMP does not include the Medicare SES Stratifications. • The denominator exclusion for members living long-term in an institution (LTI) is optional for POs that do not have access to the LTI flag in the Monthly Membership Detail Data File.
Colorectal Cancer Screening (COL-E)	October 2026	• Updated the race and ethnicity stratification categories to capture declinations and unknown race and/or ethnicity more precisely. • Added a note regarding potential changes to PO and health plan continuous enrollment requirements under consideration through the 2026 public comment process. • Updated value sets for CT colonography in the *Numerator*.
	Modifications from HEDIS	• AMP does not include the Medicare SES Stratifications. • AMP specifies a different continuous enrollment criteria for the Medi-Cal Managed Care product line. • The denominator exclusion for members living long-term in an institution (LTI) is optional for POs that do not have access to the LTI flag in the Monthly Membership Detail Data File.
Transitions of Care (TRC)	October 2026	• Clarified that medication reconciliation performed by a pharmacist (no longer limited to just clinical) meets criteria.
	Modifications from HEDIS	• AMP only reports the Medication Reconciliation Post-Discharge indicator.

MY 2027 Measures	Date of Update/Modification from the Measure Steward	Measure Specification Update
Prenatal and Postpartum Care (PPC)	October 2026	• Updated the race and ethnicity stratification categories to capture declinations and unknown race and/or ethnicity more precisely. • Added a note to step 1 of the *Initial population* for additional guidance on delivery dates. • Updated hospice *Denominator exclusion* to align with source specification. • Updated value set names in *Numerator* to align with 2027 changes to maternity billing.
	Modifications from HEDIS	• None.
Prenatal Immunization Status (PRS-E)	October 2026	• Updated the race and ethnicity stratification categories to capture declinations and unknown race and/or ethnicity more precisely. • Revised deliveries language in the *Initial population* to accommodate value set consolidation. • Revised the *Initial population* to only include deliveries with a gestational age of 37 weeks or greater and removed the corresponding denominator exclusion for deliveries that occurred at less than 37 weeks gestation. • Added a note regarding the delivery date to the *Initial population* criteria. • Updated hospice *Denominator exclusion* to align with source specification.
	Modifications from HEDIS	• None.
Depression Screening and Follow-Up for Adolescents and Adults (DSF-E)	October 2026	• Added the Medicare Advantage product line for testing. • Added manic episodes to and renamed the denominator exclusion to "Members with a history of manic episodes or bipolar disorder."
	Modifications from HEDIS	• None.
Encounter Rate by Service Type (ENRST)	October 2026	• Updated the definition of "Member months." • Updated the definition of "Determining claims/encounters."
Encounter Format (ENFMT)	October 2026	• Updated definition of "Visits."
Encounter Timeliness (ENLAG)	October 2026	• None.

MY 2027 Measures	Date of Update/Modification from the Measure Steward	Measure Specification Update
Race/Ethnicity Description of Membership (RDM)	October 2026	• Updated the race and ethnicity reporting categories and data element table to capture declinations and unknown race and/or ethnicity more precisely.
	Modifications from HEDIS	• None.
All-Cause Readmissions (PCR)	October 2026	• Added examples of facility types to the definition of *direct transfers*. • Simplified hospital stay language in the *Numerator*.
	Modifications from HEDIS	• NCQA refers to this measure as "Plan All-Cause Readmissions." • The 18–64 age band is not reported for Medicare Advantage. • Expected rates are normalized by Cozeva to reflect the performance of the population being measured (e.g., Commercial HMO/POS, Medicare Advantage, or Medi-Cal Managed Care). • The Skilled Nursing Care and SES Stratification for the Medicare Advantage product line is not reported. • AMP only reports the total of all ages.
Emergency Department Utilization (EDU)	October 2026	• Added the Medi-Cal Managed Care product line for testing.
	Modifications from HEDIS	• Expected rates are normalized by Cozeva to reflect the performance of the population being measured (e.g., Commercial HMO/POS, Medi-Cal Managed Care). • AMP only reports the total of all ages.
Acute Hospital Utilization (AHU)	October 2026	• Revised step 3 of the *Denominator* to clarify exclusion of inpatient and observation stay discharges where the member died during the stay.
	Modifications from HEDIS	• Expected rates are normalized by Cozeva to reflect the performance of the population being measured (e.g., Commercial HMO/POS and Medi-Cal Managed Care). • AMP only reports the total of all ages.
Total Cost of Care (TCOC)	October 2026	• Two versions of TCOC will be calculated by Cozeva: one using the DSG cost file submitted by plans and the other using allowed amounts in claims submitted by plans. • Updated the *Description.* • Expanded TCOC inclusion categories to align with OHCA non-claims payment categories. • Updated the Risk Adjustment Determination steps.

MY 2027 Measures	Date of Update/Modification from the Measure Steward	Measure Specification Update
	Modifications from HealthPartners	• AMP includes members 65 and over for Medicare Advantage. • AMP uses a $250,000 truncation level amount; HealthPartners uses a $125,000 amount. • AMP applies a geographic adjustment in addition to risk adjustment. • AMP includes capitated costs in the measure. • AMP includes exclusion criteria for select services and payments.
Primary Care Spending (PCS)	October 2026	• Updated the Office of Health Care Affordability (OHCA) links to April 2026 version of the Total Health Care Expenditures (THCE) Data Submission Guide. • Fee schedule for filling in missing FFS-equivalent allowed amounts will be across all plans, not plan-specific.
	Modifications from OHCA	• AMP does not apply step 2 of the Office of Health Care Affordability (OHCA)'s claims-based primary care identification process, which uses the California Department of Managed Health Care (DMHC)'s Annual Network Review data to confirm primary care status for certain provider taxonomies. • AMP's current health plan data submission process includes some, but not all, information requested by OHCA in the Total Health Care Expenditures (THCE) Data Submission Guide related to non-claims based primary care spending and behavioral health spending in primary care. • AMP reports two rates for primary care spending: (1) primary care spending as a percentage of total cost of care and (2) primary care spending per member per month. The OHCA specifications focus solely on measuring primary care spending as a percentage of total cost.

Summary Table of MY 2027 AMP Measure Removals

Measure Removed	Date of Removal
Chlamydia Screening (CHL)	October 2026

Summary Table of MY 2027 AMP Measure Additions

Measure Added	Date of Addition/Modification from the Measure Steward	Measure Specification Update
Follow-Up After Positive Colorectal Cancer Non-Invasive Screening Test (COF-E)	October 2026	• Added as a testing measure for AMP MY 2027.
	Modifications from HEDIS	• None.

Measure Added	Date of Addition/Modification from the Measure Steward	Measure Specification Update
Prenatal Depression Screening (PND-E)	October 2026	• Added as a testing measure for AMP MY 2027.
	Modifications from HEDIS	• NCQA refers to this measure as "Prenatal Depression Screening and Follow-Up." • AMP only reports the Depression Screening indicator.
Postpartum Depression Screening (PDS-E)	October 2026	• Added as a testing measure for AMP MY 2027.
	Modifications from HEDIS	• NCQA refers to this measure as "Postpartum Depression Screening and Follow-Up." • AMP only reports the Depression screening indicator.

APPENDIX 2
GLOSSARY

continuous enrollment	The minimum amount of time, including allowed gaps, that a member must be enrolled in an organization to be eligible for a measure.
CQL	Clinical Quality Language. A Health Level Seven International® (HL7®) domain-specific language focused on clinical quality and targeted at measure authors. The CQL specification describes a machine-readable canonical representation, ELM, that is designed to enable sharing of clinical knowledge.
direct reference code	A single code that meets criteria for a service or condition. Listed in the measure specification; also included in the Direct Reference Codes spreadsheet of the VSD. ***Note:*** *Value sets that contain only one code will be phased out (and turned into direct reference codes) as measures are digitalized.*
ECDS	Electronic clinical data systems. A reporting standard for organizations that collect and submit quality measures to IHA. This reporting standard defines the data sources and types of electronic data acceptable for use. Data systems that may be eligible for ECDS reporting include, but are not limited to, administrative claims, clinical registries, health information exchanges, immunization information systems, disease/case management systems, and electronic health records.
ELM	Expression Logical Model. A Unified Modeling Language™ specification for representing measure logic independent of syntax and special-purpose constructs, introduced at the syntactic level. It is intended to enable distribution and sharing of computable quality logic.
FAQ	Frequently asked questions posted to the IHA website on the 15th of each month.
FHIR®	Fast Healthcare Interoperability Resources. A specification standard for exchanging health care information electronically that supports exchange of structured and standardized data. Resources are defined and represented in common ways, and are built from data types that define common, reusable patterns of elements and share a common set of metadata.
I-SNP	Institutional-Special Needs Plan. I-SNPs are their own benefit category for CMS Special Needs Plans. I-SNPs are for Medicare Advantage members who have had, or are expected to need, care in an institutional setting for 90 days or longer.
initial population	The initial population includes all members who satisfy attribution criteria, including age, continuous enrollment, allowable gap, benefit, and event criteria.
LTI flag	Long Term Institutional flag. Identifies members who are long-term residents in an institution. This flag is populated in CMS's Monthly Membership Detail Data File.

	For AMP reporting, the exclusion for members living LTI is optional for POs that do not have access to the LTI flag in the Monthly Membership Detail Data file.
measurement period	The period of time during which a measure is calculated.
measurement year	The year that an organization evaluates AMP measures.
medication list	Some measures require the use of clinical pharmacy data or pharmacy claims data to identify dispensed medications. The specifications reference medication lists that must be used for AMP reporting for each pharmacy-dependent measure. In the specifications, medication list references are underlined (e.g., Diabetes Medications List). Medication lists used for AMP reporting are included in the HEDIS Medication List Directory. A medication list includes the National Drug Codes (NDC) and RxNorm codes that may be used for reporting along with the generic name, the brand name (if applicable), the strength/dose and the route for each code.
supplemental data	Data other than claims and encounters used by the organization to collect information about its members and about delivery of health services to its members.
telehealth	Synchronous telehealth requires real-time interactive audio and video telecommunications. Asynchronous telehealth, sometimes referred to as an "e-visit" or "virtual check-in," is not in real-time, but still requires two-way interaction between the member and provider. For example, asynchronous telehealth can occur through a patient portal, secure text messaging or email.
value sets	A value set contains two or more codes that meet criteria for a service or condition that is being measured. In the specifications, value set references are capitalized and underlined (e.g., Essential Hypertension Value Set). Organizations refer to the Value Set Directory (VSD) for codes in the value sets.

Practitioner Types

mental health provider	A provider who delivers mental health services and meets any of the following criteria: • An MD or doctor of osteopathy (DO) who is certified as a psychiatrist or child psychiatrist by the American Medical Specialties Board of Psychiatry and Neurology or by the American Osteopathic Board of Neurology and Psychiatry; or, if not certified, who successfully completed an accredited program of graduate medical or osteopathic education in psychiatry or child psychiatry and is licensed to practice patient care psychiatry or child psychiatry, if required by the state of practice. • An individual who is licensed as a psychologist in their state of practice, if required by the state of practice. • An individual who is certified in clinical social work by the American Board of Examiners; who is listed on the National Association of Social Worker's Clinical Register; or who has a master's degree in social work

and is licensed or certified to practice as a social worker, if required by the state of practice.

- A registered nurse (RN) who is certified by the American Nurses Credentialing Center (a subsidiary of the American Nurses Association) as a psychiatric nurse or mental health clinical nurse specialist, or who has a master's degree in nursing with a specialization in psychiatric/ mental health and 2 years of supervised clinical experience, and is licensed to practice as a psychiatric or mental health nurse, if required by the state of practice.
- An individual (normally with a master's or a doctoral degree in marital and family therapy and at least 2 years of supervised clinical experience) who practices as a marital and family therapist and is licensed as a certified counselor by the state of practice, or, if licensure or certification is not required by the state of practice, who is eligible for clinical membership in the American Association for Marriage and Family Therapy.
- An individual (normally with a master's or doctoral degree in counseling and at least 2 years of supervised clinical experience) who practices as a professional counselor and is licensed or certified to do so by the state of practice, or, if licensure or certification is not equired by the state of practice, is a National Certified Counselor with a Specialty Certification in Clinical Mental Health Counseling from the National Board for Certified Counselors.
- A physician assistant who is certified to practice psychiatry by the National Commission on Certification of Physician Assistants.
- A certified community mental health center (CMHC), or the comparable term (e.g., behavioral health organization, mental health agency, behavioral health agency) used in the state of location, or a Certified Community Behavioral Health Clinic (CCBHC).

  Only authorized CMHCs are considered mental health providers. To be authorized as a CMHC, an entity must meet one of the following criteria:

  – The entity has been certified by CMS to meet the conditions of participation (CoPs) that community mental health centers (CMHCs) must meet in order to participate in the Medicare Advantage program, as defined in the Code of Federal Regulations Title 42. CMS defines a CMHC as an entity that meets applicable licensing or certification requirements for CMHCs in the State in which it is located and provides the set of services specified in section 1913(c)(1) of the Public Health Service Act (PHS Act).

  – The entity has been licensed, operated, authorized, or otherwise recognized as a CMHC by a state or county in which it is located.

  Only authorized CCBHCs are considered mental health providers. To be authorized as a CCBHC, an entity must meet one of the following criteria:

  – Has been certified by a State Medi-Cal Managed Care agency as meeting criteria established by the Secretary for participation in the Medicaid CCBHC demonstration program pursuant to Protecting Access to Medicare Act § 223(a) (42 U.S.C. § 1396a note); or as meeting criteria within the State's Medicaid Plan to be considered a CCBHC.

- Has been recognized by the Substance Abuse and Mental Health Services Administration, through the award of grant funds or otherwise, as a CCBHC that meets certification criteria of a CCBHC.

OB/GYN and other prenatal care practitioner	Includes: • Physicians certified as obstetricians or gynecologists by the American Medical Specialties Board of Obstetrics or Gynecology or the American Osteopathic Association; or, if not certified, who successfully completed an accredited program of graduate medical or osteopathic education in obstetrics and gynecology. • Certified nurse midwives, nurse practitioners, or physician assistants who deliver prenatal care services in a specialty setting (under the direction of an OB/GYN certified or accredited provider). • Direct entry midwives who deliver prenatal and postpartum services, in a specialty setting (under the direction of an OB/GYN certified or accredited provider) and are licensed in their state of practice.
PCP	Primary care practitioner. A physician (e.g., general or family practice, geriatrician, general internal medicine, general pediatrician, OB/GYN) or nonphysician (e.g., nurse practitioner, physician assistant, certified nurse midwife) who offers primary care medical services. Licensed practical nurses and registered nurses are not considered PCPs. Certified Federally Qualified Health Centers (FQHC) are considered PCPs. This must be reviewed and approved by an auditor. To be certified as an FQHC, an entity must meet any one of the following criteria: • Is receiving a grant under Section 330 of the Public Health Service (PHS) Act (42 United States Code Section 254a) or is receiving funding from such a grant and meets other requirements. • Is not receiving a grant under Section 330 of the PHS Act but is determined by the Secretary of the Department of Health and Human Services (HHS) to meet the requirements for receiving such a grant (qualifies as a "FQHC look-alike") based on the recommendation of the Health Resources and Services Administration. • Was treated by the Secretary of HHS for purposes of Medicare Part B as a comprehensive federally funded health center as of January 1, 1990. • Is operating as an outpatient health program or facility of a tribe or tribal organization under the Indian Self Determination Act or as an urban Indian organization receiving funds under Title V of the Indian Health Care Improvement Act as of October 1991. • For certification as an FQHC, the entity must meet all of the following criteria (in addition to one of the criteria above): – Provide comprehensive services and have an ongoing quality assurance program. – Meet other health and safety requirements. – Not be concurrently approved as a Rural Health Clinic (RHC). ▪ Certified RHCs are considered PCPs. This must be reviewed and approved by an auditor.

	▪ To be certified as an RHC, the entity must meet CMS requirements to qualify for payment via an all-inclusive rate (AIR) for medically-necessary primary health services and qualified preventive health services furnished by an RHC practitioner.
pharmacist	A pharmacist with extensive education in the biomedical, pharmaceutical, sociobehavioral and clinical sciences. Pharmacists are experts in the therapeutic use of medications and are a primary source of scientifically valid information and advice regarding the safe, appropriate and cost-effective use of medications. Most pharmacists have a Doctor of Pharmacy (PharmD) or Registered Pharmacist (RPh) degree, and many have completed one or more years of post-graduate training (e.g., a general and/or specialty pharmacy residency). In some states, pharmacists have prescriptive authority.
prescribing practitioner	A practitioner with prescribing privileges, including nurse practitioners, physician assistants and other non-MDs who have the authority to prescribe medications.